Bedford Hospital NHS Trust
Quality Account 2012/13
Contents

Part 1 - Statement on quality from the Chief Executive of Bedford Hospital NHS Trust ................................................................. 1
Part 2 - Review of quality performance 2012/13 ............................................................................................................................................ 4
Bedford Hospital .................................................................................................................................................................................. 7

Patient safety priority 1: A seamless discharge process ......................................................................................................................... 7
Patient safety priority 2: Reduction in variation of clinical care .............................................................................................................. 8
Patient safety priority 3: Nutrition and hydration ................................................................................................................................. 8
Patient experience priority 1: Improve information about medicines .................................................................................................. 10
Patient experience priority 2: Positive patient recommendation .................................................................................................... 11
Patient experience priority 3: Improved ward environment .................................................................................................................. 12
Clinical effectiveness priority 1: Improve the quality of care for patients in the first 24 hours after emergency admission .................. 12
Clinical effectiveness priority 2: Care for patients admitted to hospital to be of a consistent quality irrespective of when admitted .......................................................................................................................... 12
Clinical effectiveness priority 3: Dementia ............................................................................................................................................. 13

Milton Keynes Community Health Services .......................................................................................................................................... 14

Patient safety: Transfer of care ................................................................................................................................................................. 14
Patient safety: Infection prevention and control ........................................................................................................................................ 15
Patient safety: Safeguarding children .................................................................................................................................................... 18
Patient safety: Safeguarding adults .......................................................................................................................................................... 19
Clinical effectiveness: High quality workforce .......................................................................................................................................... 20
Clinical effectiveness: Safety thermometer ............................................................................................................................................... 22
Patient experience ...................................................................................................................................................................................... 24

Campaign 1: The introduction of the friends and family questionnaire ................................................................................................. 25
Campaign 2: Mental health service transformation - engagement during transition ........................................................................ 26
Campaign 3: Pressure ulcers – how does it feel to be a patient? ............................................................................................................ 27
Campaign 4: Achieving consistent, directorate wide feedback in children’s services ........................................................................ 28
Campaign 5: Access to podiatry clinics .................................................................................................................................................. 29
Campaign 6: Collecting user experience feedback from people with learning disabilities ........................................................................ 30

Our priorities for quality improvement during 2013/14 .......................................................................................................................... 32

Patient safety: Reducing infections .......................................................................................................................................................... 32
Patient experience: Achieving improvements in areas of most concern to patients .............................................................................. 37
Clinical effectiveness: Preventing avoidable deaths ................................................................................................................................. 38

Statement of assurance from the Board about the quality of NHS services provided at Bedford Hospital NHS Trust ..................... 41

Review of Services ...................................................................................................................................................................................... 41

Participation in clinical audit ...................................................................................................................................................................... 41
Participation in clinical research: ............................................................................................................................................................... 49
Quality improvement goals we agreed with our commissioners ........................................................................................................... 51
Use of the CQUIN framework ................................................................................................................................................................. 51

What others say about our services ......................................................................................................................................................... 52
Care Quality Commission ............................................................................................................................................................................ 52
Data quality .............................................................................................................................................................................................. 54

NHS Number and General Medical Practice Code Validity .................................................................................................................... 55

Clinical Coding Accuracy ......................................................................................................................................................................... 56

National Quality Indicators - Bedford Hospital .................................................................................................................................. 58

National Quality Indicators - Milton Keynes Community Health Services ........................................................................................ 68

Part 3 - National Priorities for 2012/13 – Bedford Hospital ...................................................................................................................... 75

Complaints – Bedford Hospital ................................................................................................................................................................ 76

Annex 1 – Health Services provided during 2012/13 ............................................................................................................................ 77

Annex 2 – CQUIN Indicators and Performance ....................................................................................................................................... 81

Bedford Hospital – 2012/13 ........................................................................................................................................................................ 81
Bedford Hospital – 2013/14 ........................................................................................................................................................................ 82

Milton Keynes Community Health Services – 2012/13 .......................................................................................................................... 84

Page 2 of 105
Part 1 - Statement on quality from the Chief Executive of Bedford Hospital NHS Trust

Bedford Hospital NHS Trust aims to provide safe and effective care at all times. This means that patient safety and quality are at the heart of everything that we do. I am extremely proud of what we have developed during the last year to further improve the quality and safety of our services. I am delighted to have the opportunity to share with you some of our achievements in this Quality Account and to let you know of the plans we have to continue to improve our services.

In November 2011, Milton Keynes Community Health Services transferred under the legal umbrella of Bedford Hospital NHS Trust but as an autonomous division where their branding and identity remained intact. In this year’s account, to accommodate our hosting of the Milton Keynes Community Health Services (MKCHS), we present information in relation to the services and performance of Bedford Hospital and MKCHS separately. When referring to Bedford Hospital NHS Trust, this is incorporating MKCHS. On 1st April 2013, MKCHS was acquired by Central and North West London NHS Foundation Trust.

We believe the integrated nature of our service provision supports improved experience for the person receiving the service. More joined up care means less duplication, better co-ordination and a faster response. We hope to build further on our integrated way of working with social care and also with primary and hospital care.

During the last year Bedford Hospital had three unannounced inspections by the Care Quality Commission (CQC), the first two visits identified areas of non compliance. The final CQC inspection in March 2013 found us fully compliant. MKCHS also had an unannounced visit by the CQC to the mental health inpatient unit, the Campbell Centre. We were assessed as in compliance with the standards against which we were assessed but moderate concerns were identified in six areas. The results of a re-inspection of the Campbell Centre, that took place during March and April 2013, identified that further action was still required before MKCHS could be deemed compliant and our improvement work continues to ensure we meet the required standards.

During the last year our work to improve quality has been based on our three core objectives:

1. Improve patient experience
2. Improve patient safety
3. Improve clinical effectiveness

You will read about the work that we have undertaken to improve our discharge processes and the work that our Director of Nursing and Patient Services has led to ensure that patients are nourished and hydrated whilst they are in hospital.

We are particularly pleased to have been able to introduce additional matron posts as we recognised that these expert nurses undertake an essential role in delivering safe and effective care.

We are sharing with you some of the ways our doctors have changed the way that they work in order to improve the consistency of care each and every day and to improve the
supervision we are able to give to junior doctors. As you read through Part 2 of the Quality Account, I hope that you will see how we plan to continue to build on our work to further improve the quality and safety of our services. Our priority is to involve and listen to the patients and carers who use our services. To develop this we have a newly formed Patient Council who have helped us to identify which areas of improvement we should prioritise during 2013/14. The Patient Council works with the Trust to improve the services provided by the Trust for the patients and the communities served. It represents patients’ views, receives and considers the results of staff and patient surveys, considers information received from Patient Advice and Liaison Services (PALS). Within the Patient Council there are a number of sub-groups actively involved in shaping and supporting the delivery of improvements in areas that matter most to patients.

We have also used feedback from the ‘Friends and Family Test’ to influence the development of our services. From April 2013 all patients will be asked a simple question to tell us if they would recommend our hospital to their friends and family. This will be used to highlight priority areas for action throughout the year.

During the last financial year the Trust reported its first two “Never Events”. Never Events are defined as “adverse events that are serious, largely preventable, and of concern to both the public and health care providers”. In the event of a Never Event happening, the Trust is open with the patient and apologises, the Trust reports the event and performs a root cause analysis to identify how we can learn from the event and how we can prevent the incident from happening again.

Our first Never Event related to the mismanagement of insulin and the second to a retained swab following vaginal delivery. Action Plans have been developed from the findings of the investigations. Learning and actions from the incidents included the following:

- **Mismanagement of Insulin**: some of the learning identified included the need to take forward a workforce review to drive appropriate staffing levels out of hours.
- **Retained vaginal swab**: some of the learning identified included a review of training, clinical supervision and liaison with the usual place of employment of the agency Doctor involved.

A thematic review of all our serious incidents occurring at Bedford Hospital was also undertaken.

This year Bedford Hospital NHS Trust has introduced a Serious Incident Review Panel led by the Director of Nursing and the Medical Director to ensure that shared learning is achieved in each case to prevent a similar event happening again.

I hope you will enjoy reading about the many examples of the improvement work that teams across the organisation are pursuing. We strive to provide safe, clean and personal care, which meets the high standards that our patients deserve. We want Bedford Hospital Trust to continue to be the healthcare provider that patients trust and the organisation of which our staff are proud of.
Finally I would like to take this opportunity to pay tribute to our staff. Without their shared vision, hard work and commitment we would not be able to achieve any of the successes that we have set out in this Quality Account.

To the best of my knowledge and belief, the information contained in this document is accurate.

Stephen Conroy
Chief Executive (Acting)
Part 2 - Review of quality performance 2012/13

Part 2 is the section in our Quality Account that looks back over the last year and reviews progress against our quality priorities for 2012/13. It also includes some of the other achievements that have been made to improve quality at Bedford Hospital and Milton Keynes Community Health Service.

This part will be broken down into two sections: The first referring to Bedford Hospital and the second referring to MKCHS. Part 2 will also identify the priorities for improvement for 2013/14 at Bedford Hospital. As MKCHS was transferred to Central and North West London NHS Foundation Trust on 1st April 2013, no priorities for improvement in 2013/14 have been set in relation to the service provided by Bedford Hospital NHS Trust.

Bedford Hospital

Patient safety priority 1: A seamless discharge process

In 2012, we said that we would improve how we planned and managed discharges from our hospital.

We are pleased to report that we have improved our discharge process across the Trust over the last year. These are some of our achievements:

- Our pre-operative assessment team start collecting the information we need to plan a person’s discharge from the hospital.
- On each ward our doctors, nurses and therapists meet to discuss the discharge of patients, and we always set a date when we expect they will be discharged.
- All frail, elderly patients have a nurse co-ordinating their discharge and one of our matrons co-ordinates the discharge of all patients who have complex needs.
- We have implemented a checklist to make sure nothing is missed when we discharge patients and we have improved our discharge paperwork.
- To help patients stay at home once they have been discharged from hospital we now contact patients at home, 24 hours after discharge, to check that everything is as planned.
- We have introduced link workers to support the discharge of patients with alcohol related conditions.
- Our Early Supportive Discharge (ESD) service supports the discharge of patients with chronic lung disease to enable continued quality of care in the patient’s home environment.

We also achieved the discharge CQUIN for one quarter during 2012/13. A further measure of successful discharge is the percentage of patients requiring re-admission within 28 days of discharge. Our readmission rates can be found in the Quality Indicator table on page 61.
We know how important it is to getting discharge right for our patients, therefore, during 2013, improving discharge will continue to be a priority for us and we are planning to build on the work we have undertaken during the last year.

**Patient safety priority 2: Reduction in variation of clinical care**

We said that during 2012/13 we would ensure staff continue to attend the training programmes they need to undertake their roles.

Throughout last year we have invested in the training of our staff. This has meant that all of the professional organisations that we work with have confirmed that Bedford Hospital complies with training requirements for students and trainees.

Nursing students were required to complete their training prior to taking up their first placement. This was accessed through e-learning using the Core Learning Unit and University led programmes and achieved 100% compliance.

The training requirement for trainee doctors was determined by the Deanery and this group of staff were 100% compliant in the areas listed below. This was due to them being given access to the Deanery e-induction system which required them to complete the following seven modules prior to them joining Bedford Hospital:

- Consent
- Health and Safety
- Infection Control
- Moving and Handling
- Patient Safety/Risk Management
- Safeguarding of Vulnerable Adults/MCA 2005
- Safer Prescribing

Our other achievements for the year 2012/13 include the following:

- 76% of our staff had an annual appraisal which was used to help identify their training needs. In 2011/12 our appraisal rate was 86% which meant that our appraisal rate reduced slightly during 2012/13. This was mainly due to higher numbers of staff being employed compared to the previous year. We remain committed to increasing our appraisal rate to 90% during 2013/14.
- 96% of new staff joining the Trust went through our induction programme, giving them a better understanding of what we expected from them. This was slightly lower than the previous year (98%) although we remain committed to achieving 100% within 2 months of staff joining the organisation.
- Statutory training compliance was 86% and mandatory training compliance was 68% in 2012/13. Due to a change in the reporting format, we are unable to give a clear comparison with the previous year.

**Patient safety priority 3: Nutrition and hydration**

We know that keeping patients appropriately nourished and hydrated is essential. We therefore said that during 2012/13 we would improve how we identify and help those patients who would need our assistance to stay nourished and hydrated. Our Director of Nursing and Patient Services now reviews our performance against standards we have
set ourselves. On the occasions that we fall below our standards the matrons work with the nursing teams to improve our performance.

We are very proud of the improvements our staff have made and are pleased to confirm that in March 2013, 97% of our patients had a nutrition risk assessment undertaken when they were admitted to our hospital. This was a great improvement from the 64% of assessments that we recorded in April 2012 and gave us an overall compliance figure for 2012/13 of 80%.

The following table shows a section of the Nursing and Midwifery Quality Dashboard which demonstrates these achievements. It includes the percentage of compliance of all patients surveyed during March 2013:

<table>
<thead>
<tr>
<th>Nutrition and Hydration</th>
<th>97%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a Nutritional Assessment (MUST) completed on admission?</td>
<td></td>
</tr>
<tr>
<td>Was the patient’s weight documented on admission to the ward?</td>
<td>98%</td>
</tr>
<tr>
<td>If the patient is identified as moderate to high risk has a care plan been completed?</td>
<td>92%</td>
</tr>
<tr>
<td>Has the Nutritional Assessment been re-assessed at least weekly?</td>
<td>98%</td>
</tr>
<tr>
<td>If the patient is at high risk have they been weighed in accordance with their care plan?</td>
<td>96%</td>
</tr>
<tr>
<td>If the patient requires assisted feeding is the red tray in use?</td>
<td>100%</td>
</tr>
</tbody>
</table>

The data is collected by the matrons as part of a wider monthly audit of nursing quality metrics, the Nursing Quality Dashboard. The nursing notes for fifty per cent of inpatients are examined and the admission documentation and last forty-eight hours of care included. The results are reported at ward level, and the clinical business units report to the Quality Board in their exception report.
In March 2013 we were pleased to note that 100% of our patients who had been identified as needing help at meal times were using the red tray system and 96% of our high risk patients were weighed in accordance with their personal care plan.

Some of our other improvements include:

- Introducing a picture chart that is easier for patients, their family and friends to record what they had to eat or drink.
- Being more proactive in letting patients know that if they are hungry between meals we can provide snack boxes.
- Updating information leaflets about nutrition and hydration for people with dementia so that family and friends can understand these better.

**Patient experience priority 1: Improve information about medicines**

You told us that during 2012/13 we needed to improve how we helped patients better understand the medicines that they were prescribed.

We have completed a lot of work to improve this priority and are pleased to share some of our achievements with you.

- Patients now receive an individual medicine Patient Information Leaflet detailing their inpatient and discharge medicines.
- We advise patients on any new medicines started during their inpatient stay, including discussion of possible side effects and dosage information.
- All of our discharge medicine packs contain a leaflet giving contact details and advice should more information be required after discharge.
- We discuss medicines with each patient before they are discharged to ensure their understanding of on-going treatment.
- We telephone patients 24 hours after discharge to understand if they have any concerns.

These achievements have been confirmed by our internal clinical auditing process during 2012/13 and feedback on this priority has also been measured and reported internally, every month, through our patient survey question ‘Did a member of staff tell you about medication side effects to watch for when you went home?’
During 2012/13, 87.17% of our patients responded positively by saying that they were advised about medication side effects completely or to some extent or they did not need an explanation. This was against our target of 90%. Please note that these figures are different to those reported in the national in-patient survey but helped with quality improvement initiatives throughout the year.

This priority has been taken forward into our 2013/14 priorities so that the Trust can ensure that this work continues and is fully embedded into the organisation.

**Patient experience priority 2: Positive patient recommendation**

We want all of our patients to have a positive experience when they use our services. To help us measure this and make improvements we said that we would use the Friends and Family Test question and report a Net Promoter Score. The Friends and Family test question asks our patients how likely they would be to recommend our hospital ward to their friends and family if they needed similar care or treatment.

We agreed with our commissioners that we would achieve a 10 point increase in our baseline Net Promoter Score of 52 achieved in 2011/12 as a way of showing that we were continuing to improve the experience of our patients.

Unfortunately we only managed to increase our score by 8 points to 60 by the end of 2012/13. The following graph shows the trajectory that we agreed and how we did in the 12 month period.

![Net Promoter Score Performance](chart.png)

Because our patients and staff have told us that we need to continue to focus on improving the experience of patients in our hospital, we are keeping this as one of our priorities for 2013/14. The Friends and Family Test is being rolled out to the Accident and Emergency Department (A&E) from April 2013 and Maternity from October 2013. It will also include 16 and 17 year old patients as a way to get a good cross section of feedback to drive improvements in patient and customer experience.

We have also been working on different ways to enable patients and carers to give us feedback on how we are doing. We are pleased to let you know that, as part of this work, we have now introduced a patient survey that specifically allows individuals with learning disabilities to provide us with feedback.
Other improvements during the year include:

- The creation of a Complex Elderly Care Unit on the fourth floor of the hospital. This helps clinical teams come together to improve the patient care pathway with integrated health and social care planning for discharge.
- Setting up a Dementia Steering Group with representation from both voluntary organisations and carers (service users).

We have also maintained our Carers Lounge so that family members and visitors can receive help, guidance and support.

**Patient experience priority 3: Improved ward environment**

From the feedback patients provided we understood that we needed to improve our ward environment.

We are pleased to let you know that we have started to create small dining areas for patients on some of our wards so that meals can be eaten away from the bedside.

During 2012/13 we have, where possible, given more consideration to how we use our single rooms.

Through listening to feedback, our nursing staff, supported by our matrons, now work more closely with families to ensure that we have become better at meeting the privacy needs for patients and their families when someone is dying.

**Clinical effectiveness priority 1: Improve the quality of care for patients in the first 24 hours after emergency admission**

To help us provide a more effective service to patients with emergency needs we said that during 2012/13 we would improve our emergency services.

Our nursing and clinical team in A&E have worked very hard to make the following improvements:

- We now have a consultant reviewing all patients attending the department every day of the week.
- By using an Early Warning Score system we are more successful at identifying a patient whose condition is deteriorating.
- GPs now receive an automated letter informing them that one of their patients has been admitted to Bedford Hospital.

**Clinical effectiveness priority 2: Care for patients admitted to hospital to be of a consistent quality irrespective of when admitted**

Last year, we recognised that we needed to get better at providing consistent care each and every day, and we said that during 2012/13 we would do this.

Our matrons are important in helping us make these improvements, therefore last year we invested in our matrons and we are pleased to let you know that we now have
matron cover seven days per week across the hospital. Plus, we also have two additional matrons starting in April 2013 and are recruiting more.

We have also been working with our consultants to ensure that all patients are assessed and reviewed on a daily basis. As a result we can now confirm that our consultants undertake ward rounds every day. We have also been able to increase our consultant physician cover at weekends so as to help ensure consistency of care.

In addition we recognised that we needed to change the hours that some of our support services are open. As a result, we improved how our staff can access our pharmacy service outside of normal working hours.

**Clinical effectiveness priority 3: Dementia**

We promised to ensure that the acute care and treatment provided by the hospital takes account of the needs of people with dementia and their families at each stage of admission.

Our clinical teams have made a number of changes to how they work, including:

- Using more evidence-based practices (Kind Bundle +) to improve outcomes for patients with dementia.
- Introducing a special management plan for frail elderly patients, which is led by the care of the elderly physician, and helps to ensure patients return home as soon as they are fit.
- Ensuring that all frail elderly patients have an assessment of medication, are screened for dementia, and are referred to the mental health services should this be necessary.

We are also pleased to report that we are working with other local organisations to develop a Bedfordshire Dementia Strategy. This work includes improving how individuals access emergency and routine services and to reducing any blocks that may occur.

We were successful in obtaining additional funding to improve the safety of vulnerable patients, particularly those with dementia. We have used this money to increase the WanderGuard system to all wards. In addition, we have purchased bed and chair alarms.
Milton Keynes Community Health Services

This section of our Quality Account highlights the positive work that has been progressed through the last 12 months in Milton Keynes Community Health Services. It follows the areas we highlighted in the 2011/12 Quality Account which we prioritised for improvement in 2012/13.

Patient safety: Transfer of care

When people transfer from one clinical setting to another or to home, we need to have effective systems in place to ensure that they are transferred safely. This is of particular importance for some of our most vulnerable service users who need complex arrangements to be put in place involving many different health and social care professionals.

Did we achieve progress?

Over recent years there has been an emphasis on supporting people to remain at home to receive care and treatment and for those admitted to hospital to return home as soon as possible. This can often result in reduced time for discharge planning to take place. To counter any risks associated with this, we worked with our partner organisations, Milton Keynes Council and Milton Keynes Hospital NHS Foundation Trust, to develop a joint policy and protocols which set standards for good practice. We have run more multi-agency training events and workshops to share good practice and improved understanding.

Listed below are just some of the initiatives that Milton Keynes Community Health Services provided in partnership with other local organisations:

**Home to Stay Team** – Provided care co-ordination and support for people with complex needs for the first 30 days following discharge from hospital.

**Rapid Assessment and Intervention Team (RAIT)** – Worked with GPs, community teams, A&E and admission units to support people to remain at home or discharge back home as soon as medically appropriate. In 2012/13, additional funding was received and three key aspects of intermediate care services were developed to provide:

- Additional Admission Avoidance Activity
- Extension of the Stroke Pathway
- Psychological support for people living with Long Term Conditions

**Intermediate Care** – Provided a range of multi-disciplinary, community or inpatient re-ablement support for people to regain as much independence as possible by learning, or re-learning the skills necessary for daily living following an episode of illness, injury or crisis.

**Intravenous Treatment** – Community nursing provided support for people to return home to continue with a course of intravenous therapy at home.

**End of Life Care Team** – Provided training, advice and support to services and organisations across Milton Keynes to improve end of life care and support for patients and
their relatives.

**Diabetic Specialist Team** – Worked with hospital consultants to support self-management for people with unstable or newly diagnosed diabetes.

**Community Matrons and Telecare** – Worked with Milton Keynes Council to provide support for people with complex long-term health conditions to monitor and proactively manage their condition.

**How did we monitor and measure?**

We continued to include Transfer of Care as a campaign in the Patient Experience Strategy and we sought the views of people who used our services and their carers.

We continued to monitor adverse events (complaints, safeguarding referrals and incidents) and carry out regular audits to highlight areas for improvement.

One of the key methods used for monitoring how well discharges were planned and supported was through the incident reporting process.

**Patient safety: Infection prevention and control**

Effective infection prevention and control standards and avoidance of healthcare associated infections (HCAI’s) were essential to ensuring the safety of patients in our care, wherever that care was provided. We knew, from speaking with patients and the public during the last year, that good infection control, and the cleanliness of all our facilities, was really important to them. We are proud of our infection control achievements, some of which are set out below.

**What are the outcomes from the work developed?**

**Hand Hygiene**

Studies show that infection rates can be reduced by 10-50% when healthcare staff regularly clean their hands. In the past twelve months we have continued to focus heavily on ensuring staff are using effective techniques when cleaning their hands. We have done this through educational sessions and by facilitating staff to audit each other’s hand hygiene practices.

Each year, we undertake an organisation-wide audit in December. Last year saw a further increase in most aspects of hand hygiene practice. The following graph shows the improvements over the last five years.
In addition, monitoring that staff were adhering to the ‘bare below the elbows’ principle was part of our on-going hand hygiene audits in inpatient settings. This, together with raising staff awareness about the need for ‘bare below the elbow’ principles, helped to ensure the safety of all of our patients whilst they were in our care.

**Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia**

We continued to play a significant role in maintaining low numbers of patients admitted to hospital with MRSA bacteraemia (MRSA in the bloodstream). We did this via a whole system approach. Our community Infection Prevention and Control Team not only worked with our own services, but also with GP Practices and residential nursing homes.

In 2012/13 Milton Keynes Community Health Services was given an individual target of no more than one MRSA bacteraemia case attributed to our services. We achieved this target with zero cases attributed to us.

Data from the MRSA patient pathway project was used to consider how patients diagnosed with MRSA could be better supported. Patients with MRSA accessed all parts of the health economy so these issues were considered through a system wide Milton Keynes Infection Prevention and Control Committee.

**Clostridium difficile**

Incidence of *Clostridium difficile* was also monitored very closely and reported as a key performance indicator on a monthly basis. In 2012/13, our target was to ensure no more than two *Clostridium difficile* cases were attributed to our services. We achieved this target with zero cases attributed to us. Further information can be found in the Quality Indicator table on page 71.

**Clean environments**

Improvement of infection prevention and control standards required a multi-faceted approach. It was widely recognised that environmental cleanliness was a key component in
the provision of safe, clean care. Milton Keynes Community Health Service was unusual in that it had integrated domestic services fully with the infection prevention and control team. This meant much closer working and the ability to provide a much more responsive service in relation to infection prevention and control.

Cleanliness quality control audits were conducted every month across the organisation. The graph below combines all monthly quality control scores and compares them against the combined monthly quality control targets to show an overall compliance position.

The graph below shows our overall Cleanliness Score (by month) for April 2012-March 2013

Using the scores in the chart above it is possible to identify an annual cleanliness performance score for the organisation against an overall annual target. This information can be found in the table below.

<table>
<thead>
<tr>
<th>MKCHS 2012-13 Target Score</th>
<th>MKCHS 2012-13 Score Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>88.6%</td>
<td>91.6%</td>
</tr>
</tbody>
</table>

**Patient Environment Action Team (PEAT) audits**

Every year all NHS providers in the UK are required to undertake an in-depth assessment of qualifying inpatient settings as part of a national programme managed by the NHS Information Centre. The results from this programme are published as an official statistic and are used as a performance tool by the Care Quality Commission, contributing to five outcomes on a trust’s quality risk profile.

Within Milton Keynes Community Health Services three premises qualified for the assessment, the Campbell Centre, Windsor Intermediate Care Unit and the Older People’s Assessment Service. The assessment programme focused on the patient perspective and patient journey, and we ensured that patient representation was included on every assessment through Milton Keynes Local Involvement Network (LiNK:MK - as of 1st April 2013 referred to as Healthwatch Milton Keynes).
The patient environment action team audits have been replaced for 2013/14 with a new assessment system, Patient Led Assessment of the Care Environment (PLACE). The initial programme took place between April and June 2013.

The following results and information relate to the 2012 patient environment action team programme which was undertaken between January and March 2012 and the scores were released in June 2012.

Table: PEAT scores 2012 with national comparison

<table>
<thead>
<tr>
<th>PEAT Section</th>
<th>National Average</th>
<th>Campbell Centre</th>
<th>The Older Peoples Assessment Service</th>
<th>Windsor Intermediate Care Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Food</td>
<td>Excellent</td>
<td>Acceptable</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>Excellent</td>
<td>Excellent</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

The environment score for PEAT remained ‘good’ across all three sites for 2012. This section of the assessment was diverse, covering a wide range of factors, and therefore it was difficult to achieve the 96% required for ‘excellent’. ‘Good’ was the national average score for the environment.

Windsor Intermediate Care Unit retained its ‘excellent’ score for food, and The Older People’s Assessment Service improved from ‘good’ to ‘excellent’.

The Campbell Centre’s food score reduced in 2012 following a change to the lunchtime catering arrangements which did not reach the same standards. Significant work was undertaken following this audit to improve the lunchtime catering and it is anticipated that improvements will be clearly visible against the new assessment requirements of the Patient Led Assessment of the Care Environment.

The privacy and dignity score remained ‘excellent’ across all three sites for 2012.

**Patient safety: Safeguarding children**

*Why was this a priority?*

Safeguarding children is the action taken to promote the welfare of children and protect them from harm. It is everyone’s responsibility and everyone who comes into contact with children and their families has a role to play. The national media often reminds us of the devastating outcomes that can happen when systems to protect vulnerable children fail.

Working Together to Safeguard Children (2013) is the Government’s statutory multi-agency child protection guidance which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people.
**What were the outcomes from the work developed?**

Milton Keynes Community Health Services had a doctor and a small team of nurses who were specially trained to offer advice, support and training to staff about safeguarding children.

In the past year the Safeguarding Children Team continued to:

- Deliver a comprehensive training programme for staff to ensure they were all up-to-date with what they needed to know about safeguarding children.
- Undertake audits of practice and reviews of safeguarding children cases so we could learn lessons for improving practice.
- Ensure a robust governance structure within the organisation to monitor safeguarding activity.
- Be an active partner in supporting the work of the Milton Keynes Safeguarding Children Board (MKSCB) - a multi-agency board - which required all organisations that work with children to co-operate to keep children safe from harm.
- Contribute to the Milton Keynes Children and Families Partnership, which ensured better partnership working between local agencies, to improve the lives of children and young people and their families in Milton Keynes.

**Patient safety: Safeguarding adults**

MKCHS maintained its strong presence in multi-agency Safeguarding Adults fora in Milton Keynes over the last year, with consistent representation on the local Safeguarding Adults Board and on all four of its sub-groups.

Internally, there were significant changes to our Safeguarding Adults response. As mentioned in last year’s Quality Account, we had our own Safeguarding Adults Advisory Group (SAAG), consisting of senior staff from clinical teams as well as senior managers. This group led on the organisational response to both internal and external safeguarding adults work, such as the Safeguarding Adults Self-assessment and Assurance Framework (SAAF) which monitored our work in this work area and was sent to our commissioners.

The SAAG was also responsible for work which saw Safeguarding Adults basic awareness training becoming mandatory for all staff. This reflected the same level of compliance as that for Safeguarding Children. Work continued into updating the electronic staff record so that attendance could be properly reported on. The SAAG oversaw the development of an internal Safeguarding Adults strategy, which reflected the local joint policy but clearly defined our internal structures to manage compliance.

**Why was this a priority?**

The Francis Report into Mid Staffordshire Hospital and the successful prosecutions of staff from Winterbourne View kept the theme of Safeguarding Adults firmly in the public eye over the past year. Public interest had never been greater, and it was vitally important that MKCHS could show a robust response to these and similar issues.
What are the outcomes from the work developed?

Last year saw a particular challenge to our Safeguarding Adults response with the Care Quality Commission (CQC) visit to the Campbell Centre in August. Their report highlighted, amongst other things, the need for work to raise awareness about Safeguarding Adults at the Campbell Centre. This led to a programme of training and incident monitoring that saw 95% of staff given training to support them in their role and to ensure that concerns were more appropriately raised. Alerts sent to the Adult Social Care Access Team (ASCAT – the local authority team that deals with Safeguarding Adults alerts) increased markedly following the commencement of the training programme. Furthermore, a new post of Safeguarding Adults Lead Investigator was created within Mental Health services, and a team of specialist investigators will be created around it to manage investigations in a more structured and transparent way.

From January 2013, Safeguarding Adults basic awareness training was made a mandatory session for all MKCHS staff. This brought the subject into line with requirements for Safeguarding Children. Work continued to ensure that staff compliance was monitored. This involved not just providing appropriate training opportunities, but also updating the Electronic Staff Record system so that attendance was recorded in line with other mandatory courses.

A further development was the benchmarking exercise where Clinical Governance staff and colleagues from social care jointly monitored clinical incidents to ensure that Safeguarding Adults alerts were being raised appropriately by staff across MKCHS. This showed a good degree of consensus and indicated that the thresholds for raising alerts were understood by both parties. This was important as it ensured that advice given to clinical staff reflected good practice.

Clinical effectiveness: High quality workforce

Milton Keynes Community Health Services employs around 1000 staff, around two thirds of whom hold professional qualifications, either as doctors, nurses, therapists or other technical staff.

Why was this area a priority?

The key to providing excellent care to those who used our services was to ensure that we recruited and retained a skilled and competent workforce. Most of the healthcare budget is spent on staff. Therefore, the quality of our staff, and how motivated and committed they were to their jobs, affected the standard of care provided to our patients and service users. It was important to ensure that staff were effectively trained, given opportunities for development and felt engaged in the work they were doing.

Staff Charter

Last year we implemented a ‘staff charter’ which set out the values of the organisation. These centred around treating people with dignity and respect, working in partnership and being committed to high quality, person-centred care. To make this real for people we set out our commitment to staff, and our expectations of them, in all our job descriptions and policies.
This helped to ensure that we could deliver health care in a way that met the needs of the people who used our services.

**Training**

We have been working hard to ensure that our staff received all the training defined as mandatory. This covered issues such as infection control, load and patient handling and safeguarding children. Our training statistics increased from 81% in 2011/12 to 83% in 2012/13 and we continue to work towards increasing this further.

In addition, we have been developing the use of e-learning across a range of subjects and this has increased staff access to training, as borne out by the staff survey results shown below.

Furthermore, staff have accessed training to develop their skills in a wide range of areas, for example, we held a conference on sharing best practice around dementia and over 100 of our staff attended.

**Staff Survey 2012**

We were pleased that the Staff Survey 2012, which benchmarked us against similar organisations, indicated that staff motivation and ability to contribute to improvements at work were above average and that the overall staff engagement score was one of the best in the country and had improved significantly since the previous year. Indeed, in seven areas of the staff survey, such as quality of work and patient care, receiving job relevant training and staff motivation we had the highest score of all community services organisations.

The following table below highlights some results from the survey, which benchmarked us to similar organisations. We were pleased to see that staff generally enjoyed their work, were well trained and were able to contribute to making improvements at work:

<table>
<thead>
<tr>
<th>Issue</th>
<th>2011</th>
<th>2012</th>
<th>Similar Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of work and patient care</td>
<td>74%</td>
<td>82% (best)*</td>
<td>76%</td>
</tr>
<tr>
<td>Staff receiving training and development in the last 12 months</td>
<td>82%</td>
<td>86% (best)*</td>
<td>82%</td>
</tr>
<tr>
<td>Staff able to contribute to improvements at work</td>
<td>65%</td>
<td>76% (best)*</td>
<td>68%</td>
</tr>
<tr>
<td>Staff job satisfaction</td>
<td>3.54</td>
<td>3.78</td>
<td>3.61 (summary scale)</td>
</tr>
<tr>
<td>Staff recommendation of the Trust as a place to work or receive treatment</td>
<td>3.50</td>
<td>3.76</td>
<td>3.58</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>3.92</td>
<td>3.98 (best)*</td>
<td>3.82</td>
</tr>
<tr>
<td>Staff reporting good communication between senior management and staff</td>
<td>35%</td>
<td>46% (best)*</td>
<td>28%</td>
</tr>
<tr>
<td>Staff receiving an appraisal</td>
<td>85%</td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>Fairness and effectiveness of incident reporting procedures</td>
<td>3.57</td>
<td>3.69</td>
<td>3.54</td>
</tr>
</tbody>
</table>

*(best) - This means that our score was the best score nationally when compared to other community health services.
Recruitment and Retention

Although there were a few occasions when it was difficult to recruit staff we had no major recruitment issues in 2012/13, despite the year being one of organisational uncertainty. We were able to reduce the use of temporary and agency staff in the clinical areas, which saved us money as well as ensuring a good quality service for patients. As our staff turnover rate increased during the year (average 14%) we carried out a review of those leaving the organisation and as a result have made some improvements to the way we capture information. There is now an online ‘exit’ process that is offered to staff in addition to face to face interviews. This is facilitated by the Human Resources department rather than individual services.

Sickness absence rates have risen slightly during the year, reflecting pressures that staff are under, but we have put in place additional targeted support and the absence rate now shows signs of reducing. Our average sickness absence rate is 4.3%. Additional coaching with managers is in place to equip them to manage sickness absence effectively.

All new staff are subject to employment checks on commencing employment, which continues to ensure a safe and effective workforce.

Clinical effectiveness: Safety thermometer

The NHS Safety Thermometer is a national tool which MKCHS used to support delivery of the ‘harm free care’ programme. The programme has an overarching ambition to deliver harm free care, defined by the absence of four key harms - pressure ulcers, harm from falls, catheter acquired urinary tract infections (CA-UTI) and venous thromboembolism (VTE - blood clots) in 95% of our patients. The Safety Thermometer was used to measure the rate of patient harm occurring from 3 of the 4 harms through a survey carried out on those patients receiving care in the organisation on a given day every month. The VTE element was not measured in MKCHS, however a roll out programme to implement this element starting at Windsor Intermediate Care Unit from May 2013 is in place.

The tool looks at the whole patient pathway and as such may have captured harm which happened before the patient was admitted to our services as well as harm that happened whilst they were receiving care from our services.

Why was this area a priority?

Previously, scrutiny of ‘harm’ had concentrated on the individual harm itself and had not looked for links between them. This new approach provided a richer picture of organisational safety and quality. It also allowed us to be clear about what we meant by ‘harm free care’, as shown by the example in the table below.

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>Pressure Uo</th>
<th>VTE</th>
<th>CA-UTI</th>
<th>Fall</th>
<th>Audit results</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Patient 2</td>
<td>X</td>
<td>☑</td>
<td></td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Patient 3</td>
<td>☑</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Patient 4</td>
<td>☑</td>
<td>X</td>
<td></td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All or none</th>
<th>X</th>
<th>X</th>
</tr>
</thead>
</table>

| Percentage | 75% | 75% | 50% | 46% |

| Only 1 patient (25%) got harm free care |

Key:
X = Harm-free care
☑ = Harm occurred

In this example only 1 patient (patient 3) received harm free care.
**What are the outcomes from the work developed?**

Milton Keynes Community Health Services collected data from four service areas - HMP Woodhill in-patient area, Windsor Intermediate Care Unit, The Older People’s Assessment Service and all of the District Nursing teams. Each month, approximately 320 patients were included in the assessment.

From April 2013, additional teams will formally collect data: Early Stroke Rehabilitation Team, Rapid Access and Intervention Team and the Home to Stay Team.

Results over the last year demonstrate a steady and continuous decrease in harm from pressure ulcers and falls. The focus for the coming year is to maintain this trend and to share improvements in practice and learning across the services and teams that are participating in the programme.

Table 1 shows the number of patients per month who developed ‘new’ harms. These were categorised as harm that the patient had experienced whilst in our care.

**Table 1 - New ‘harms’**

![Table 1 - New ‘harms’](image)

When looking at Table 2, we can see the gradual but continuous improvement in relation to numbers of all ‘harm.

**Table 2 – All ‘harms’**

![Table 2 – All ‘harms’](image)
Perhaps the most significant data is shown in Table 3. This identifies that the number of patients per month that were ‘harm free’, gradually rose from 84.4% in March 2012 to 95.5% in March 2013.

**Table 3 – Harm Free**

![Graph showing the trend of harm-free patients from March 2012 to March 2013.]

Over the next 12 months we will use this data in a meaningful way to continue to improve practice and provide safer care to our patients. We will use this data to complement other methods of measurement used within the organisation to ensure that trends are analysed to inform improvement work.

**Patient experience**

Our aim for 2012/13 was to embed our Patient Experience Strategy ensuring our patient experience campaigns prioritised the needs of our most vulnerable service users, including people with characteristics protected under equality and diversity law, mental health service users, those who access our children’s services and people with learning disabilities. We worked with the services to ensure they were using a range of methods to engage with their service users, were providing feedback to them and were making improvements.

Through the Patient Experience Steering Group, services were invited to submit campaign ideas that would improve the patient experience. Group members were asked to take into account national initiatives and/or local areas of concern, including complaints and incidents, to decide which campaigns to support. The campaigns chosen for 2012/13 were:

- The introduction of the friends and family questionnaire.
- Mental health service transformation – engagement during transition.
- Pressure ulcers – how does it feel to be a patient?
- Achieving consistent, directorate wide feedback in children’s services.
- Access to podiatry clinics.
- Collecting user experience feedback from people with learning disabilities.

Each campaign has made considerable progress in 2012/13 which has significantly contributed to the patient experience agenda.
Campaign 1: The introduction of the friends and family questionnaire

Background

This year’s patient experience agenda was heavily influenced by a local quality (CQUIN) target which required Milton Keynes Community Health Services to:

- Establish the friends and family question and ensure it was used within all local patient experience/satisfaction surveys.
- Establish a system for collating patient stories.
- Establish a baseline score (for the question) for each service/directorate report quarterly to the Board and Commissioner at organisational, speciality and service level, including how patient experience and stories had impacted or will impact on changes to services.
- Achieve a ten point improvement in the score (for the question) from quarter one to quarter four.

The friends and family question was developed to measure the local population’s perception of the health care they received. It asked how likely a service user would be to recommend the service to friends and family with the responses ranging from extremely likely to not at all. The campaign’s aim was to ensure that every service undertook a survey which included the friends and family question to get baseline results. The results were discussed and fed back to patients and the Board and there was a commitment to achieve a ten point improvement in the score within the year. The campaign also included establishing a system for collecting patient stories.

What happened?

The friends and family test question was rolled out as standard across all services, along with seven additional questions to measure experience. Services had the choice of using the original or an easy read version of the questionnaire. They could use a variety of methods for collecting the results, including patient experience trackers, paper based surveys, postcards and the more recent addition of an online survey. The results were collated by the patient experience team on a monthly basis and fed back to services to share with their teams and service users.

The process of implementation was a challenge for some of our services, particularly those who did not have an existing survey in place. However, the organisation’s response rate increased substantially over the three quarters from 185 respondents in quarter one to 1,641 respondents in quarter three. Services made changes based on the feedback they received and provided feedback about these changes to service users using ‘You said, we did’ posters. The changes included:
More visible name badges for the health visiting team.
Better patient information within the district nursing service.
The introduction of a quiz afternoon and ‘Film Friday’ at Windsor Intermediate Care Unit.
Additional speech and language therapists at ‘drop in’ clinics to reduce waiting times and to reduce the need for additional follow up appointments.

In addition, the qualitative feedback was available on the homepage of our website so that staff and service users could see what people using our services thought of us.

Raising the profile of the patient experience delivered another major benefit, a subtle change in culture. Although we saw a drop in our friends and family test score, the number of responses increased.

Our quality (CQUIN) target also required us to develop a system for collecting patient stories. We did this through the friends and family questionnaire, focus groups and the complaints process.

Five patient stories were collected from district nursing, Windsor Intermediate Care Unit, mental health and the health visiting team. The stories were filmed and presented to the Board and Patient Experience Steering Group. Following consent, they were also placed on the home page of our website.

The patient stories had a big impact on staff. Where actions were identified, follow up work was undertaken and completed. Additionally, staff watching the films reported taking the lessons away and applying them to their own areas of work. Services also used them as part of their staff training programmes.

**What next?**

The friends and family question is not a national requirement for community health services in 2013/14, however it has been set as a local quality (CQUIN) target.

Irrespective of the target, as an organisation, we will continue with the process of surveying our service users and will adapt the questions accordingly. We may consider surveying discharged patients in line with the national target and taking a different approach for our services that do not frequently discharge patients.

**Campaign 2: Mental health service transformation - engagement during transition**

**Background**

The Mental Health Joint Services campaign aimed to establish a strong service user and carer feedback process to support the mental health service change (transformation) programme.

**What happened?**

The feedback process was developed through a series of informal service user and carer
forums, which were widely advertised. The forums covered patients’ experiences of the Assessment and Short Term Intervention (ASTI) service, dementia and care planning. Although the number of attendees varied, we gained valuable insight into how it felt to be a patient. Following each forum, a summary of the meeting and associated actions were distributed to all service users who attended. A few months later this was followed up with an update of the changes that had taken place as a result of the feedback.

Changes that took place at the ASTI service included an increase in the number of customer liaison officers, improved call handling equipment and longer opening hours.

What next?

The forums were successful so they will continue throughout 2013/14. We have received feedback from service users, carers and LINk:MK on the planning, timing and topics for this year’s programme. Taking this feedback, national targets, local initiatives and any areas of concern into account, this year’s forums will be based on:

- Planning care, understanding the care planning approach.
- Support for carers.
- Meeting the needs of young people.
- Dementia care.
- Support during recovery.

Campaign 3: Pressure ulcers – how does it feel to be a patient?

Background

Research has shown that a patient’s experience of the care they receive can be negatively impacted upon if they also have a pressure ulcer.

The pressure ulcer campaign aimed to eliminate avoidable grade two, three and four pressure ulcers by December 2012. The key elements of the campaign included the development of supporting information for patients and carers on pressure ulcer prevention and early detection, involving patients in selection of pressure relieving equipment and patient feedback on living with a pressure ulcer.

What happened?

A patient information leaflet was developed, printed and distributed. It is being translated into an easy read version with the support of the learning disabilities team and the ‘Check it out’ service user group.

A month’s trial of pressure relieving mattresses took place at Windsor Intermediate Care Unit. Patients were asked to provide feedback on them taking into account noise, comfort and if they found themselves more prone to slipping. The mattress that was most popular was purchased and all 19 of our mattresses were replaced. This was also complemented by the installation of new beds.

Two patient stories relating to pressure ulcers were filmed and one was used for a dedicated staff training day on pressure ulcers.
To ensure up to date and evidence based approaches to pressure ulcer prevention and management, two levels of pressure ulcer training, designated as ‘Essential to Role’, were introduced and all relevant staff received this training, either yearly or two yearly, dependant on role.

We continued to improve the quality of our incident reporting to ensure accurate and robust data which allowed us to track progress and clearly identify whether a pressure ulcer was avoidable or unavoidable. We began reporting on this data from October 2012 and identified that during the latter six months of 2012/13 we had 9 grade two, three or four pressure ulcers that could have been avoided.

**What next?**

Due to the occurrence of these 9 avoidable pressure ulcers our campaign did not fully meet its objective, however, we continue to work hard to improve this. We are developing ways of ensuring that key learning is shared across the organisation, we continue to use the videos for staff training and the impact of the pressure ulcer leaflet will be evaluated at the end of the year.

**Campaign 4: Achieving consistent, directorate wide feedback in children’s services**

**Background**

The objective of the campaign was to develop a more consistent approach across the directorate to securing feedback from children and young people, and their parents and carers about their experiences of using our services. It was recognised that some teams had good mechanisms in place to do this and others did not.

**What happened?**

In June 2012, service leads undertook a mapping exercise, agreed the next steps for the campaign and developed an implementation plan.

In August 2012, a set of standard questions for use in the Directorate were agreed and an easy read version was developed for use with younger service users. A LINk:MK representative was identified to support the campaign, though most services identified service representatives suitable for their specific service areas too. The use of electronic trackers to collect patient feedback in line with national guidance was trialled and a number of services found these beneficial.

Feedback from service users was largely positive and where improvements were identified action has been taken. Examples include:

- The purchase of clearer name badges (in addition to identity badges) where service users reported that they did not know the member of staff treating them.
- The development of ‘You said, we did’ posters which have also been put on a Facebook page for children’s speech and language therapy service users.
• The piloting of a post diagnostic parent support group in the community paediatric service commencing January 2013. This was to support parents who reported long waits to access the parent training programme. The parent training programme has been amended to facilitate and allow more time for discussion.
• The facility for parents to return assessment questionnaires directly to the service, rather than via the GP practice. A stamped addressed envelope was provided to enable this.

What next?

The main objective for this campaign was achieved as each service now takes part in monthly feedback. Next steps are to ensure all services consistently provide feedback to their service users in an appropriate way. In 2013, the Directorate will review the feedback twice a year to be aware of, and address, common themes.

Campaign 5: Access to podiatry clinics

Background

The aim of the campaign was to explore the access issues service users faced when they attended podiatry clinics in Milton Keynes. Concerns had been raised both internally and via LINk:MK about the lack of reception staff to greet or to book in with when they attend appointments, poor lighting and signage, and inadequate facilities to support service users with sensory impairments.

Three podiatry clinics were identified (Eaglestone Health Centre, Neath Hill Health Centre and Bletchley Therapy Unit) and a working group was established in conjunction with LINk:MK to discuss with service users the problems faced by them when attending these sites and what improvements could be made.

What happened?

A survey was developed and conducted from 20 November 2012 to 30 November 2012. It asked questions about the information in appointment letters, internal and external signage, designated drop off points and disabled parking bays, getting to the clinic, presence of podiatry reception desks and receptionists, and accessibility to the clinic room. A total of 80 responses were collected across all three clinics.

Discussion with service users found they reported apprehension and frustration but also praise for the service and staff. All routine patients (including patients with sensory impairment) have “got used to” the process and procedures of the service and know their route; whereas, new patients cited difficulties in accessing the service at the beginning of their care pathway and found the signage inadequate. The survey and discussions highlighted a number of areas for improvement which resulted in the following actions:

• New patient information leaflets (a different one for each of our six clinics) were introduced. They provided information on what to expect at the first appointment,
what to wear and bring with you, a map, and what to do on arrival at the clinic.

- The need for improvements to physical signage and maintenance of clinics was referred to our Estates and Facilities department. Some of the actions identified were beyond our capacity and remit to change as MKCHS does not own the facilities it uses.

**What next?**

The action plan and recommendations will be monitored by podiatry team leads. They will provide feedback on progress to the Patient Experience Strategy Group and Patient Experience Team.

Outcomes will be fed back to staff at team meetings, and service users through “You said, we did” posters. The work supports the findings of a similar project undertaken by our Communications Department to improve access to buildings across all our services.

**Campaign 6: Collecting user experience feedback from people with learning disabilities**

**Background**

The aim of the campaign was to establish a way of collecting user experience feedback from people with learning disabilities.

People with a learning disability in Milton Keynes need to be able to access health services and have their needs effectively met. The Health Action Team (within the community team for adults) has done a lot of work to improve access for this client group and to help address health inequalities. However, there had been limited feedback from people with a learning disability.

**What happened?**

An easy read questionnaire, suitable for the client group to understand, was developed in an electronic format. The ten questions were primarily about health appointments and how adults with a learning disability found their experience when attending their appointment. The survey covered attendance by this client group at one of eight different services we offer. The feedback for this project was collected at the ‘Big Health Day’ in May 2012. In total, 61 people took part in the survey.

The results of people’s experiences were then converted into easy read bar charts for the client group to understand. The results were discussed at the ‘Check it out’ subgroup, a subgroup of the Learning Disability Partnership Board. The overall feedback response indicated that our services were rated as ‘good’.

**What next?**

The ‘Check it out’ subgroup felt that GPs and pharmacies were the most important people to send the information to and feedback gained from the survey as they were the first point of
contact with the health service for many people. The group offered to do some training with them to show them how to use an easy read version of the tracker. They also asked for the survey to be circulated to all our senior managers so best practice could be shared across the organisation. The team aims to repeat the survey in 2013 and will collect carers’ views this year too.

**Summary**

In 2012/13 all campaigns achieved their aims to involve service users and to improve their experience of our services.

The implementation of the friends and family questionnaire brought about real change for our service users and led to a change in staff attitudes and increased morale for many services.

We have been able to show our service users that we are listening to their experiences at every level from the Board to the ward using the patient stories. This will continue to be a powerful training tool for the coming year.

Our work with our mental health service users as part of our change programme provided us with valuable insight into how it feels to be a service user and a carer both in our inpatient units and in the community. We also had the opportunity to provide feedback to those who took the time to tell us about their experience, informing them of changes that have been made as a direct result of their input.

Working with our learning disability service users and their carers highlighted the importance of taking the time to engage with those service users whose voice is often not heard. Learning from this work is being shared across the organisation in a variety of areas from children’s services to patient transport.

We have been able to show that we are acting on local concerns with our access campaign. The feedback will be considered when we are planning changes to some of our buildings, and a change to our patient information has provided service users with the information they have asked for prior to their appointments.

Developing a systematic approach to gathering feedback from our younger service users and their carers has enabled us to better plan the services we offer in line with what they need.

Our aim for 2013/14 will be to build on this year’s success. We will continue to look for new ways to engage with our service users, particularly those whose voices are not often heard. We will also continue to ensure that feedback from service users is used to develop and improve our services and that we respond with news of changes we have made quickly and effectively.
**Our priorities for quality improvement during 2013/14**

In this section in our Quality Accounts we now look forward and identify Bedford Hospital's quality priorities for 2013/14.

**Please note:** MKCHS quality priorities are purposely not included as they are not being hosted by Bedford Hospital NHS Trust for 2013/14.

**Developing our Quality Priorities**

Bedford Hospital has used information that patients and staff have shared with us over the last year to develop a number of possible quality improvement priorities for 2013/14.

This process has included:

1. Engagement with our external partners, such as Healthwatch and listening to what patients are telling us about their care by analysing themes from complaints and concerns raised with us. The top three themes identified from complaints in the last 12 months have related to lack of information, staff attitude and pain relief.
2. We have also analysed satisfaction and feedback from our patients and their relatives/carers. This has included analysis of the results from the Patient Experience Survey and Friends and Family Test.
3. Hearing the views of our staff through forums such as our staff council, feedback at meetings or feedback to individual members of staff.
4. Involvement in, and audit of national priorities and initiatives, such as the Safety Thermometer, responding to feedback from reports, audits and inspections and learning from the analysis of what may have caused incidents.

We have looked at this information alongside what we know about our performance and what we know about regional and national priorities.

We then developed a list of nine possible priorities for improvement and consulted with patients and staff to help us identify three priority areas where we need to improve the quality of services during 2013/14.

**Patient safety: Reducing infections**

Prevention and control of infection has always been taken seriously at Bedford Hospital and we have an annual work programme in place to reduce infections across the hospital. However, our staff have identified that they believe we should strengthen the work we have undertaken over the last years and have identified that reducing infections should be our patient safety quality priority for this year.

Our Patient Council has also told us they would like us to make reducing infections a priority for 2013/14.

The following table demonstrates Bedford Hospital Quality Indicator Performance for *Clostridium difficile*. The full indicator table can be found on page 64.
NHS Outcomes Framework Domain

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of <em>Clostridium difficile</em> infection reported within the trust amongst patients aged 2 or over during the reporting period.</td>
<td>2011/12 - 27 cases of <em>Clostridium difficile</em>&lt;br&gt; <em>22.6 per 100,000 bed days</em>&lt;br&gt; 2012/13 - 17 cases of <em>Clostridium difficile</em>&lt;br&gt; <em>14.1 per 100,000 bed days</em>&lt;br&gt; <em>internal data</em></td>
<td>2011/12 National Average: 21.8&lt;br&gt; Lowest: 0&lt;br&gt; Highest: 51.6</td>
</tr>
</tbody>
</table>

Aim

Our aim for 2013/14 is that no preventable infection is allowed to develop in patients who are in our care.

Targets for 2013/14

We have set a maximum threshold for this year to further reduce the following healthcare associated infection rates:

- Reduce MRSA Bacteraemia to 0 cases.
- Reduce *Clostridium difficile* to less than 15 cases.
- Achieve 80% ‘time to isolate’ for patients with suspected infectious diarrhoea within two hours.

We explain each of these thresholds in more detail below:

Reduce MRSA Blood Stream Infection (Bacteraemia) to 0 cases

- In 2012/13, only 1 patient developed an MRSA blood stream infection, which is the same as the previous year (2011/12).

MRSA (Meticillin-resistant *Staphylococcus aureus*) is a well-known healthcare associated infection. It is estimated that 3% of the overall population carry MRSA harmlessly on their skin. The risk for hospital patients may be increased due to wounds or invasive treatments, which make them more vulnerable. Serious MRSA may result in blood stream infection (bacteraemia).
Areas of Improvement that have been introduced in 2012/13

- Medical devices that penetrate the body either through a body orifice or through the body surface (invasive devices) were monitored daily. Audits were undertaken on a monthly basis and we started reporting our achievements of this on our infection control dashboard.
- We strengthened infection control practices by introducing staff competencies within the hospital in the Aseptic Non Touch Technique (ANTT), and many staff are trained and have been assessed as being competent with this practice.
- A training programme was put in place which supports staff to use the correct technique when they take blood cultures.
- MRSA screening took place for patients who were admitted as an emergency or as a planned admission.

The following graph below shows how we have reduced our MRSA blood stream infections over an eight-year period:

Areas of Improvement planned for 2013/14

- Implement a new approach to monitoring hand hygiene that meets the Infection Prevention Society (IPS) guidelines with monthly monitoring via a dashboard and monthly reporting to the Quality Board.
- Implement a new way of monitoring and reporting our achievements of important infection control measures on our infection control dashboard. (A dashboard is a tool used to provide monthly measures of quality of infection control practices).
- Continue with MRSA screening for patients who are admitted as an emergency or as a planned admission and treat patients appropriately according to guidelines to minimise the risk of infection.
- Continue to train and update staff in infection control practices relating to Aseptic Non Touch Technique (ANTT).
- Continue to train staff in the process of taking blood cultures.
Reduce Clostridium difficile to less than 15 cases

- In 2012/13, 17 Clostridium difficile infections were identified against a maximum threshold of 19.

Clostridium difficile is a common cause of hospital acquired diarrhoea. It is a bacteria that is present in the bowel of 3-5% of healthy adults, and up to 30% of elderly patients. When certain antibiotics disturb the balance of bacteria of the gut, Clostridium difficile can multiply rapidly and produce toxins which cause diarrhoea and illness.

Areas of Improvement that have been introduced in 2012/13

- A multidisciplinary Clostridium difficile working party was formed in September 2012 to formulate actions to reduce Clostridium difficile cases further at the Trust.
- Root cause analysis has been undertaken for all cases of Clostridium difficile so that learning about the cause of the infection can help us prevent infections in the future. This process was undertaken by a multi-disciplinary team.
- A new antibiotic policy has been developed to restrict the use of certain antibiotics which could contribute to Clostridium difficile infections.

The following graph shows how we have reduced Clostridium difficile in our hospital over a six year period:

Areas of Improvement planned for 2013/14

- Implement a new approach to monitoring hand hygiene that meets the Infection Prevention Society (IPS) guidelines with monthly compliance monitoring.
- Fully implement the revised antibiotic policy.
- Weekly visits and reviews of Clostridium difficile cases by the consultant infection control microbiologist, infection control team, antibiotic pharmacist and appointed consultant.
• Continue with robust root cause analysis for each *Clostridium difficile* case, including multidisciplinary face to face meetings.

**Isolate 80% of patients with suspected infectious diarrhoea within two hours**

Bedford Hospital realised that, in order comply with The *Health and Social Care Act 2008* (the Hygiene Code), the management and use of isolation facilities needed to improve.

In 2012/13 our 2 hour time to isolate was 22.13%, however, it was identified that there was limited evidence and assurance data available to ensure our information was accurate and up to date prior to the introduction of time to isolate target of 80% for the year 2013/14.

The Infection Prevention and Control team identified that a robust data collection and information sharing system was needed. A project group has been set up to address time to isolate and are developing systems to determine the most appropriate approach. An electronic tool to capture data is currently under development to collect analyse, share and provide most accurate and up to date information around time to isolate.

**Areas of Improvement that have been introduced in 2012/13**

• A multidisciplinary *Clostridium difficile* working party was formed in September 2012 to formulate actions to reduce *Clostridium difficile* cases further at the Trust.
• *Clostridium difficile* root cause analysis was traditionally undertaken in isolation by the Infection control team but an altered focus has been adopted and a shared approach involving a dedicated multidisciplinary team was implemented, involving full face to face meetings for each case.
• The antibiotic policy underwent a full review to restrict the use of certain antibiotics which could contribute to *Clostridium difficile* infection.

**Areas of Improvement planned for 2013/14**

• Implement a new way of capturing information on the time a patient with suspected infectious diarrhoea has been isolated. This will include an escalation procedure if isolation is not achieved within two hours.
• Introduce a new flow chart for prioritising patients for isolation.
• Implement training for bed managers and staff on using the new information capturing system.
• Include monitoring and reporting within the infection control dashboard, this will be reported monthly to Quality Board.

**How we will measure and monitor our performance**

Every month we will measure our performance against each of the three infection control targets. In particular:

• The Infection Control Dashboard which will be reviewed at the monthly Hospital Infection Prevention Committee (HIPCC). This committee monitors incidence of infections and monitors the quality of infection control practices. It is chaired by the
Director of Nursing and Patient Services, who is also the Director of Infection Prevention and Control (DIPC).

- A quarterly progress and assurance report will be submitted to the Trust’s Quality Committee (sub-committee of the Board).

**Patient experience: Achieving improvements in areas of most concern to patients**

Our priorities for improving patient experience have been identified by listening to what patients are telling us about their hospital experience, through a number of feedback mechanisms.

By focusing on these key areas, we believe that improvements can be delivered that are meaningful for patients, family and carers. In turn, we think that patients will be more likely to choose to have their care and treatment at Bedford Hospital in the future and recommend the hospital services to family and friends.

**Aim**

Our aim for 2013/14 is to increase the number of patients who say that they would be likely to recommend Bedford Hospital to a friend or family member based on their own experience.

**Targets for 2013/14**

- 2.5 point increase in the following personal needs inpatient survey questions:
  - Did a member of staff tell you about medication side effects to watch for when you went home?
  - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- Increase Friends and Family Test score response rate by 10 points to 70, so that the Trust can capture patient feedback to enable improvements on its quality and services.
- Achieve improvements in the areas of most concern to patients - noise at night, the discharge process.

**Areas of Improvement that have been introduced in 2012/13**

- Bedford Hospital’s 4th floor has been transformed to become our ‘complex’ elderly care unit - where clinical teams come together to better manage health and social care needs of elderly, vulnerable patients.
- Dementia care is being developed through working partnerships with other providers, including mental health services, voluntary organisations (Alzheimer’s Society, Age UK) and carer involvement.
- A Carers Lounge has been successfully introduced within the hospital, supported by Bedford Borough Council. Personal advice and support is available on a range of issues and this service has received very positive feedback.
- More car parking spaces have been introduced for disabled patients/visitors, and a service user with disability is currently working with the Estates team to advise on
future developments, for example site access and ward improvements such as washroom refurbishments.

Further information on the ‘Trust’s responsiveness to the personal needs of its patients’ can be found in the Quality Indicator table on page 62.

Areas of Improvement planned for 2013/14

- There will be a significant drive throughout 2013/14 to engage with patients and the public to further improve hospital services. National programmes, such as Patient Led Assessment of Care Environments (PLACE, formerly PEAT) require inspection teams to include 50% patient/public representatives. This requires planning and engagement and work is already underway in preparation for this.
- Projects will be launched to reduce the noise that patients experience at night and to further improve the discharge process.
- The Patient Council Sub-groups will continue to develop work programmes to support improvements in patient experience.
- Engagement with Healthwatch, community groups and voluntary services will be strengthened to further develop our services and build confidence in our community.

How we will measure and monitor our performance

Our Clinical Business Units will review and act upon the Friends and Family Test scores on a monthly basis. These actions will be reported to and monitored through the Trust’s Quality Board.

Clinical Business Units will also consider numbers and types of complaints on a monthly basis and will report trends and actions to the monthly Quality Board, where actions will be monitored.

On a quarterly basis, the Director of Nursing and Patient Services will provide assurance to the Trust’s Quality Committee that the necessary actions are being taken in each of these areas.

Clinical effectiveness: Preventing avoidable deaths

The Summary Hospital-level Mortality Indicator (SHMI) reports mortality at trust level across the NHS in England using standard and transparent methodology. The Department of Health is now committed to implementing the SHMI as the single hospital-level indicator.

The figure below shows the Trust’s mortality indicator (SHMI) which is published nationally. Bedford Hospital SHMI value (Oct 2011 – Sept 2012) was reported as being ‘as expected’ with a SHMI of 1.06.
Although the Trust’s SHMI was reported as being ‘as expected’, we know that there is work that we can do to further improve our performance.

When we asked staff and patients whether we should make reducing avoidable deaths a priority, they agreed that this should be one of our priorities.

The table below demonstrates Bedford Hospital Quality Indicator Performance in 2011/12 and 2012/13. The full indicator table can be found on page 59.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Quality Indicator</th>
<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
</tr>
</thead>
</table>
| Domain 1: Preventing People from dying prematurely. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to— (a) the value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | July 2011 - June 2012  
1.06  
Band 2  
‘as expected’.
Oct 2011 – Sept 2012  
1.06  
Band 2  
‘as expected’.
July 2011 - June 2012  
26.24%  
Oct 2011 – Sept 2012  
23.15% | July 2011 – June 2012  
Best: 0.71 Band 3  
Worst: 1.26 Band 1  
Oct 2011- Sept 2012:  
Best: 0.6849 Band 3  
Worst: 1.2107 Band 1  
July 2011 - June 2012  
Not available  
Oct 2011 – Sept 2012  
Best: 0.2%  
Worst: 43.3% |
| Domain 2: Enhancing quality of life for people with long-term conditions. | | | |

**Aim**

Our aim for 2013/14 is to achieve a mortality rate less than 1 with the Trust being defined as ‘better than expected’.

**Targets for 2013/14**

- Reduce hospital wide mortality.
- Reduce mortality rates per speciality.
- Regularly review specialty level quality indicators.

**Areas of improvement that have been introduced in 2012/13**

During 2012/13 the Trust identified the requirement to deliver safer care seven days a week. Improving access for our patients both out of the traditional Monday to Friday 9-5 services and also across the weekend and bank holiday periods was implemented to prevent delays in treatment and improve clinical outcomes.

To achieve this, the Trust has carried out the following:
Introduced 7-day matron cover, 7-day consultant working in medicine, a 24-hour critical care outreach service and enhanced pharmacy services.

Introduced an improved medical handover on the Acute Assessment Unit to ensure continuity of care.

Introduced a mortality and morbidity review of unexpected deaths within priority Clinical Business Units.

**Areas of Improvement planned for 2013/14**

The range of actions planned for the coming year to further improve mortality includes:

- 7-day working and cover across all clinical areas, particularly to support emergency areas, to eliminate variation in care.
- Mortality and morbidity reviews of all unexpected deaths within each Clinical Business Unit.
- Review of all expected patient deaths within each Clinical Business Unit to identify common themes and learning.
- Improved patient pathways with colleagues in primary and community care to support patients who wish to have their end of life care in their normal place of residence.
- Introduction of an IT supported, enhanced handover of care model to all clinical areas.
- Introduction of care bundles in Complex Elderly Medicine. These care bundles will formalise key components of care for elderly, non elective, medical admissions.
- Continued review of the workforce and skill mix in line with best practice models with maximised use of e-rostering.
- Documentation redesign to facilitate safe care.
- Appointment of additional matrons and heads of nursing within each Clinical Business Unit to support seven day working and improvements in quality of care at ward level.
- Implement an internal trigger tool to identify avoidable deaths. An avoidable death is death caused by certain conditions, for which effective public health and medical interventions are available.
- Analysis of the accuracy and depth of clinical coding to ensure that any improvements that can be made are introduced. Coding will be clinically focussed with consultant engagement and clinical sign-off.

**How progress will be monitored and measured**

Each Clinical Business Unit will review mortality figures and where these do not meet the required level the Associate Medical Directors will instigate the necessary actions using the SHMI Mortality Review Template.

Clinical Business Units will report monthly to the Trust’s Quality Board on all actions being taken to reduce mortality.

The Medical Director will provide assurance to the Trust’s Quality Committee on a quarterly basis that the necessary actions are being taken to monitor the Trust’s mortality rate and to take the necessary actions to reduce the mortality rate.
Statement of assurance from the Board about the quality of NHS services provided at Bedford Hospital NHS Trust

Review of Services

During 2012/13 Bedford Hospital provided 43 relevant health services and sub-contracted 11 relevant health services. These are listed in Annex 1.

Bedford Hospital has reviewed all the data available to them on the quality of care in 52 of these services during the year through external review reports, national clinical audit, local clinical audit, patient surveys and performance reports. The data reviewed by Bedford Hospital on the quality of care provided by its relevant health services has included all three dimensions of quality – patient safety, clinical effectiveness and patient experience. Sufficient data was available to complete these reviews apart from our Retinal Screening service which did not participate in a quality review last year and our audiology service which participated in a patient experience review only. Both these services have quality reviews planned in 2013/14.

The income generated by the relevant services reviewed in 2012/13 represents 100% of the total income generated from the provision of relevant health services by Bedford Hospital for 2012/13.

Milton Keynes Community Health Services provided and/or sub-contracted 55 relevant health services. These are listed in Annex 1.

Milton Keynes Community Health Services has reviewed all the data available to them on the quality of care in 55 of these relevant health NHS services. The data reviewed by Milton Keynes Community Health Services on the quality of care provided by all its relevant health services has included all three dimensions of quality – patient safety, clinical effectiveness and patient experience. Sufficient data was available to complete this review.

The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by Milton Keynes Community Health Services for 2012/13.

Participation in clinical audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. National clinical audit is designed to improve patient outcomes across a wide range of health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Confidential enquiries/inquiries are not in themselves audits, although they have audit like features. The purpose of a national confidential enquiry is to detect areas of deficiency in clinical practice and devise recommendations to resolve them. Enquiries can also make suggestions for future research programmes.

This section will be split into two parts. The first will discuss the participation in clinical audit and national confidential enquiries at Bedford Hospital and the second will discuss the
participation in clinical audit and national confidential inquiries at Milton Keynes Community Health Services.

**Clinical Audit Bedford Hospital**

During 2012/13, 35 national clinical audits and 3 national confidential enquiries covered the relevant health services that Bedford Hospital provides.

During 2012/13 Bedford Hospital participated in 83% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Bedford Hospital did not participate in 100% of the national clinical audits as the organisation assessed that it had no patients relevant to the specific audit criteria.

The national clinical audits that Bedford Hospital was eligible to participate in during 2012/13 are as follows:

- National Vascular Database
- Multicentre Appendicectomy Audit
- Oesophago-gastric Cancer (National O-G Cancer Audit)
- National Hip Fracture Database
- Epilepsy 12 (Childhood Epilepsy)
- Diabetes (Paediatric)
- Cardiac Arrest (National Cardiac Arrest Audit)
- Fever in Children (College of Emergency Medicine)
- Stroke National Audit Programme (combined Sentinel and SINAP)
- Acute Myocardial Infarction and other ACS (MINAP)
- Non Invasive Ventilation (British Thoracic Society)
- National Joint Registry
- Cardiac Arrhythmia
- National Diabetes Inpatient Audit
- Head and Neck Oncology
- Renal Colic (College of Emergency Medicine)
- Bowel Cancer (National Bowel Cancer Audit Programme)
- Bronchiectasis (British Thoracic Society)
- UK Carotid Endarterectomy Audit
- National Emergency Laparotomy Audit (NELA)
- Severe Trauma (Trauma Audit and Research Network)
- Paediatric Asthma
- Heavy Menstrual Bleeding
- ICNARC National Audit
- National Audit of Dementia
- Fractured Neck of Femur (College of Emergency Medicine)
- Chronic Obstructive Pulmonary Disease (COPD) and Community Acquired Pneumonia Care Bundle
- Adult Community Acquired Pneumonia (British Thoracic Society)
- Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)
• Heart Failure (National Heart Failure Audit)
• Inflammatory Bowel Disease (IBD)
• Lung Cancer (National Lung Cancer Audit)
• Adult Asthma (British Thoracic Society)
• National Review of Asthma Deaths (NRAD)
• Emergency Use of Oxygen (British Thoracic Society)

National Confidential Enquiries

The national confidential enquiries that Bedford Hospital was eligible to participate in during 2012/13 are as follows:

• Alcohol Related Liver Disease
• Tracheostomy Care Study
• Subarachnoid Haemorrhage Study

The national clinical audits and national confidential enquiries that Bedford Hospital participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Title</th>
<th>Percentage participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Audits</td>
<td></td>
</tr>
<tr>
<td>National Vascular Database</td>
<td>On-going</td>
</tr>
<tr>
<td>UK Carotid Endarterectomy Audit</td>
<td>On-going</td>
</tr>
<tr>
<td>Multicentre Appendicectomy Audit</td>
<td>On-going</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>On-going</td>
</tr>
<tr>
<td>National Joint Registry</td>
<td>On-going</td>
</tr>
<tr>
<td>Severe Trauma (Trauma Audit and Research Network)</td>
<td>On-going</td>
</tr>
<tr>
<td>National Hip Fracture Database</td>
<td>On-going</td>
</tr>
<tr>
<td>Paediatric Asthma</td>
<td>100%</td>
</tr>
<tr>
<td>Epilepsy 12 (Childhood Epilepsy)</td>
<td>100%</td>
</tr>
<tr>
<td>Heavy Menstrual Bleeding</td>
<td>On-going</td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
<td>100%</td>
</tr>
<tr>
<td>ICNARC National Audit</td>
<td>On-going</td>
</tr>
<tr>
<td>Cardiac Arrest (National Cardiac Arrest Audit)</td>
<td>On-going</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>98%</td>
</tr>
<tr>
<td>Fever in Children (College of Emergency Medicine)</td>
<td>100%</td>
</tr>
<tr>
<td>Fractured Neck of Femur (College of Emergency Medicine)</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke National Audit Programme (combined Sentinel and SINAP)</td>
<td>On-going</td>
</tr>
<tr>
<td>National Review of Asthma Deaths (NRAD)</td>
<td>On-going</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) and Community Acquired Pneumonia (CAP) Care Bundle</td>
<td>On-going</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>On-going</td>
</tr>
<tr>
<td>Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)</td>
<td>On-going</td>
</tr>
<tr>
<td>Acute Myocardial Infarction and other ACS (MINAP)</td>
<td>On-going</td>
</tr>
<tr>
<td>Heart Failure (National Heart Failure Audit)</td>
<td>On-going</td>
</tr>
<tr>
<td>Cardiac Arrhythmia</td>
<td>On-going</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD)</td>
<td>On-going</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit</td>
<td>100%</td>
</tr>
</tbody>
</table>
Title | Percentage participation
---|---
Bowel Cancer (National Bowel Cancer Audit Programme) | On-going
Oesophago-gastric Cancer (National O-G Cancer Audit) | On-going
Head and Neck Oncology | On-going
**National Confidential Enquiries**
Alcohol Related Liver Disease | 100%
Subarachnoid Haemorrhage Study | 100%
Tracheostomy Care Study | On-going

The reports of one national clinical audit and one national confidential enquiry were reviewed by the provider in 2012/13 and Bedford Hospital intends to take the following actions to improve the quality of healthcare provided:

### National Audit

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Care of the Dying Audit – Round 3</td>
</tr>
<tr>
<td>- Mandatory on-going training and education for all healthcare workers caring for dying patients and relatives/carers (DH 2009)</td>
</tr>
<tr>
<td>- Implementation of Liverpool Care Pathway e-learning programme</td>
</tr>
<tr>
<td>- Dissemination of findings to Matrons and Ward Managers and results to be discussed at Clinical Governance Meetings</td>
</tr>
</tbody>
</table>

### National Confidential Enquiry

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD report “Time to intervene”</td>
</tr>
<tr>
<td>- Implement recommendations from national report including strengthening initial assessment and use of early warning triggers; setting a local goal for reduction in cardiac arrests leading to resuscitation attempts and implementing a programme of work to achieve this.</td>
</tr>
</tbody>
</table>

The reports of 29 local clinical audits were reviewed by Bedford Hospital in 2012/13 and we intend to take the following action to improve the quality of care provided:

### Local Clinical Audit

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-audit of Pre-Cardiac Arrest Management</td>
</tr>
<tr>
<td>- Further develop the training provided on recognising and managing a patient that is deteriorating</td>
</tr>
<tr>
<td>TIA Referral Documentation</td>
</tr>
<tr>
<td>- Consultant and registrar to be actively involved in the referral of patients</td>
</tr>
<tr>
<td>- Increase the training of junior doctors to ensure more accurate completion of referral documentation</td>
</tr>
<tr>
<td>Readmissions of Patients with Urinary Tract Infections (UTI)</td>
</tr>
<tr>
<td>- Implementation of the Nottingham University urinary tract infection care pathway to improve diagnosis and treatment</td>
</tr>
<tr>
<td>Drug Histories on Admission</td>
</tr>
<tr>
<td>- Closer liaison with GPs at point of admission to ensure all regular medications are prescribed</td>
</tr>
<tr>
<td>- Patient information relating to medication to be improved</td>
</tr>
<tr>
<td>- Review the process of assessing patients medication history</td>
</tr>
</tbody>
</table>
| - Closer liaison with GPs on patient discharge to
<table>
<thead>
<tr>
<th>Local Clinical Audit</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ensure medication history is updated.</td>
<td></td>
</tr>
<tr>
<td>PAR Scoring</td>
<td>• Review the tools used for identifying early deterioration of a patient</td>
</tr>
<tr>
<td>Re-audit of the Early Management of Oncology Patients with Febrile Neutropenia</td>
<td>• Review antibiotic prescribing guidelines</td>
</tr>
<tr>
<td>Community Acquired Pneumonia Management (CAP)</td>
<td>• Review antibiotic prescribing policy • Review the use of diagnostic blood tests</td>
</tr>
<tr>
<td>Chest Drain Insertion Audit</td>
<td>• Introduction of procedure checklist • Appointment of a lead physician with responsibility for setting and monitoring standards and ensuring adequate training of junior doctors • Provide thoracic ultrasound training for registrars and introduce the use of ultrasound to assist the insertion of a chest drain</td>
</tr>
<tr>
<td>Antibiotic Prescribing Point Prevalence Audit</td>
<td>• Strengthening of prescription guidelines to incorporate a 48 hour review of all prescribed antibiotics • Increase the advisory role of the consultant microbiologist</td>
</tr>
<tr>
<td>Prophylactic Antibiotic Use for Diagnostic Flexible Cystoscopy</td>
<td>• Introduce antibiotic prophylaxis for diagnostic flexible cystoscopies</td>
</tr>
<tr>
<td>Re audit of Abdominal Aortic Aneurysm</td>
<td>• Use of cardiac output monitoring • Increase use of cell-saver for emergency cases where possible</td>
</tr>
<tr>
<td>Audit of Term Babies Admission to the Neonatal Unit (NNU)</td>
<td>• Participation in the East of England programme 'Keeping the Newborn Baby Pink, Warm and Sweet' • Implement an improved care pathway for new-born babies incorporating standardised monitoring and protocols for discharge</td>
</tr>
<tr>
<td>Network Parenteral Nutrition (PN) Practice – a Pre-Implementation Audit</td>
<td>• New East of England TPN guidelines have been implemented</td>
</tr>
<tr>
<td>Epidural Analgesia in Labour</td>
<td>• Review of analgesia used during Labour • Review patient information leaflet on pain relief during labour</td>
</tr>
<tr>
<td>Bladder Care Audit</td>
<td>• All women experiencing urinary incontinence or urinary retention are referred to a Consultant Obstetrician and a plan of care documented</td>
</tr>
<tr>
<td>Induction of Labour</td>
<td>• Documentation to be improved • Training session for vacuum delivery for registrars</td>
</tr>
<tr>
<td>Management of Diabetes Mellitus</td>
<td>• Improvement in risk factor identification especially high-risk ethnic groups • Improve Folic Acid and Vitamin D supplementation</td>
</tr>
<tr>
<td>Induction of Labour</td>
<td>• Review reduced fetal movements’ policy to include fetal wellbeing assessment</td>
</tr>
</tbody>
</table>
**Clinical Audit Milton Keynes Community Health Services**

During 2012/13 six national clinical audits and one national confidential inquiry covered the relevant health services that Milton Keynes Community Health Services provides.

During 2012/13 Milton Keynes Community Health Services participated in 16.7% national clinical audits and 100% national confidential inquiries which it was eligible to participate in.

The national clinical audits that Milton Keynes Community Health Services was eligible to participate in during 2012/13 are as follows:

- Epilepsy 12 (childhood epilepsy).
- Falls and Bone Health.
- Parkinson's Disease.
- Psychological Therapies.
- Prescribing Observatory for Mental Health.
- Schizophrenia.

The national confidential inquiries that Milton Keynes Community Health Services was eligible to participate in during 2012/13 are as follows:

- Suicide and Homicide by People with Mental Illness.

The national clinical audits and national confidential enquiries that Milton Keynes Community Health Services participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Title</th>
<th>Cases included</th>
<th>Reason for non participation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Audits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy 12 (childhood epilepsy)</td>
<td>50</td>
<td>Data not collected during the year.</td>
</tr>
<tr>
<td>Falls and Bone Health</td>
<td>0</td>
<td>Data not collected during the year.</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>0</td>
<td>Not completed due to national recommendations that services take part every other year to give time for them to respond to findings.</td>
</tr>
<tr>
<td>Psychological Therapies</td>
<td>0</td>
<td>Data not collected during the year.</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health</td>
<td>0</td>
<td>Staff shortage and an inability to recruit.</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0</td>
<td>Data not collected during the year.</td>
</tr>
<tr>
<td><strong>National Confidential Enquiries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide and Homicide by People with Mental Illness</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>
**Reviewing reports of national clinical audits**

The report of 1 national clinical audit was reviewed by the provider in 2012/13:

Epilepsy 12 – In 2009, the Healthcare Quality Improvement Partnership (HQIP) and Health Improvement Scotland (HIS) funded the Royal College of Paediatrics and Child Health (RCPCH) to establish Epilepsy12 - the United Kingdom collaborative clinical audit of health care for children and young people with suspected epileptic seizures. The ‘12’ refers to the design of 12 meaningful and pragmatic measures of quality applied to the first 12 months of care after first paediatric assessment. The key aims of Epilepsy12 are:

- To facilitate health providers and commissioners to measure and improve quality of care for children and young people with seizures and epilepsies.
- To contribute to the continuing improvement of outcomes for those children, young people and their families.

The results of the audit were mainly positive with positive comment regarding the role of the epilepsy Specialist Nurse. We agreed that our Epilepsy Specialist Nurse does an excellent job in supporting families and liaising with tertiary centres.

Milton Keynes Community Health Services intends to take the following actions to improve the quality of care provided:

- Adopt the proforma for assessing a child with first paroxysmal events from the PET2 (Paediatric Epilepsy Training) course.
- Review documentation and assessments in case notes and re-audit.
- Deliver a dedicated teaching programme on epilepsies.
- The general paediatricians with expertise in epilepsy will keep up to date with epilepsy courses.
- Review the prescribing of Carbamazepine to ensure it is appropriate.

**Annual clinical audit plan**

The annual clinical audit plan reflects local and national priorities for service improvement and there is an expectation for all services to engage fully in the audit process to ensure continual review of current practice against specific objectives.

All services complete an audit of their record keeping practice each year to demonstrate that adequate information is recorded for each patient to ensure safe and effective treatment and care. Health and safety audits, security audits, hand hygiene and infection prevention audits are also carried out in all services annually and are of great value in terms of ensuring safety of patients and staff and minimising the spread of infection.

The reports of 94 local audits were reviewed by Milton Keynes Community Health Services in 2012/13 and MKCHS intends to take actions to improve the quality of healthcare provided.

As part of our audit cycle, clinical services undertake a consent audit every three years. This measures how our services involve service users and, where relevant, their families or carers in making decisions about all aspects of their care and treatment.
implementation of the consent audit has delivered noticeable improvements in practice.

We have highlighted two examples of good practice from consent audits this year, below:

The Early Stroke Rehabilitation Team (ESRT), established in April 2010, works across the acute, community, health and social care settings to provide intensive rehabilitation and support to stroke survivors being discharged home from the Acute Stroke Unit (ASU), Milton Keynes Foundation Trust Hospital. The aim of the ESRT is to facilitate earlier discharge from hospital and to provide home based assessment, rehabilitation and support, for those who have suffered a recent stroke.

During the audit, the auditor identified several examples of good practice relating to ensuring informed consent to treatment. These included:

- The development of laminated cards which act as visual aids to communication with patients in support of the consent process.
- Regular multi-disciplinary meetings where a patient’s capacity to consent is discussed. The social worker is highly involved in these discussions and in undertaking capacity assessments. An independent Mental Capacity Advocate (IMCA) is also involved.
- Assurance regarding staff being trained in supported conversation techniques with patients, and repeat visits to patients at which previously held conversations are reiterated with time lapses in-between these visits in support of the patient’s decision-making processes.

The ESRT Speech and Language Therapists were pivotal in the language choice and design of the ESRT Information Leaflet, alongside stroke survivors themselves.

Milton Keynes Priority Dental Services provides specialist dental services within Milton Keynes and is responsible for the provision of dental care to patients who have difficulty accessing that care from a general dental practitioner due to their special needs. These needs include physical disability, learning disability, mental health problems, severe anxiety/phobia or a complex medical history. Looked-after children and HMP Woodhill also receive dental care from this service.

Within the Milton Keynes Priority Dental Service, ‘Consent’ relates to engaging the service user and relevant family members or carers as fully as possible in care-planning and making decisions about all aspects of dental health and welfare.

During the audit clinical notes were reviewed which covered four aspects of consent. These areas were:

- Cases involving sedation or anaesthesia of an adult.
- Cases involving parental consent for the sedation or anaesthesia of a child.
- Cases involving adults who were unable to consent to their own treatment.
- Cases involving no requirement for formal consent.

The audit found clear evidence that the service users’ ability to give informed consent was part of a routine process of assessment leading either to formal or informal consent to
treatment. In all cases, it was apparent that where mental capacity was deemed to be missing or where the service user was not adult, relevant steps were taken to gain appropriate levels of consent.

The process of decision-making appeared to be so well understood and applied that there was no evidence of any implied consent. All consent was either formal or verbal (or otherwise specifically indicated), and was well evidenced in the records in both cases. The attendance of the service user for an appointment, for example, was not taken as implied consent for going ahead with treatment. What was seen and described on the day of the review indicated a high level of service user involvement and a commitment to engagement.

**Participation in clinical research:**

**Bedford Hospital**

The number of patients receiving health services provided or sub-contracted by Bedford Hospital in 2012/13, which were recruited during that period to participate in research approved by a Research Ethics Committee, was 486. This was an increase from 431 the previous year.

Participation in clinical research demonstrates Bedford Hospital’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During 2012/13 Bedford Hospital was involved in conducting 85 clinical research projects in medical oncology, cardiology, stroke, elderly care, ophthalmology neurology, emergency medicine, critical care, gastroenterology, dermatology, respiratory medicine, diabetes, rheumatology, genito-urinary medicine and oral and maxillofacial surgery. The improvement in health outcomes at Bedford Hospital is supported by clinical research.

Over 100 clinical staff participated in research approved by ethical committees at Bedford Hospital in 2012/13. These staff participated in research across 15 medical specialties.

In the last three years, 131 publications have resulted from our involvement in National Institute for Health Research, which shows our commitment to transparency and desire to improve patient outcomes across the NHS. Our engagement with clinical research also demonstrates Bedford Hospital’s commitment to testing and offering the latest medical treatments and techniques.

**Milton Keynes Community Health Services**

We recognise the value of participation in research as an activity which drives up standards of care. It is therefore embedded in our Innovation Strategy.

MKCHS is a member of the Thames Valley Comprehensive Local Research Network and participates in high-quality research and development in order to promote best practice. We are compliant with the Research Governance Framework, which ensures all research studies are conducted safely.
Over the past 12 months we have agreed to participate in 11 local and national research projects, working in partnership with staff, the Research Network and universities.

The following table gives an overview of the research studies we have been involved with in the last 12 months.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child health (recruitment to vaccination studies)</td>
<td>4</td>
</tr>
<tr>
<td>Child and adolescent mental health</td>
<td>2</td>
</tr>
<tr>
<td>Health visiting</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2</td>
</tr>
<tr>
<td>Psychology</td>
<td>2</td>
</tr>
</tbody>
</table>

The number of patients receiving relevant health services provided or sub-contracted by Milton Keynes Community Health Services in 2012/13 is not able to be provided as these figures are collected for all Thames Valley primary and community settings as a group; however, the Thames Valley Research Network Board reported a good level of recruitment from the partner organisations.
Quality improvement goals we agreed with our commissioners

Use of the CQUIN framework

A proportion of Bedford Hospital NHS Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Bedford Hospital NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment Framework.


Bedford Hospital

In 2011/12, Bedford Hospital achieved full CQUIN payment of £1.8m. The income for 2012/13, conditional upon achieving the agreed quality improvement and innovation goals, was £2.9m. At the time of this report the associated payment for 2012/13 CQUIN was £1.92m. This amounted to 66%. The final settlement figure will be agreed between our finance team and Commissioning body.

Milton Keynes Community Health Services

In 2011/12 MKCHS achieved full CQUIN payment of £449,000 and in 2012/13 full payment was again achieved which amounted to £461,840.
Care Quality Commission

Bedford Hospital

Bedford Hospital is required to register with the Care Quality Commission (CQC) and its current registration status is with no conditions.

The Care Quality Commission has not taken enforcement action against Bedford Hospital during 2012/13.

Bedford Hospital has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Care Quality Commission conducted a routine inspection visit during July 2012. During this visit Bedford Hospital NHS Trust was assessed as compliant in the following essential standards of quality and safety:

**Outcome 1:** People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.

**Outcome 2:** Before people are given any examination, care, treatment or support, they should be asked if they agree to it.

**Outcome 7:** People should be protected from abuse and staff should respect their human rights.

**Outcome 9:** People should be given the medicines they need when they need them, and in a safe way.

**Outcome 13:** There should be enough members of staff to keep people safe and meet their health and welfare needs.

**Outcome 16:** The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

**Outcome 21:** People's personal records, including medical records, should be accurate and kept safe and confidential.

During the same visit, Bedford Hospital was assessed as non-compliant in the following essential standards of quality and safety:

**Outcome 04:** People should get safe and appropriate care that meets their needs and supports their rights.

**Outcome 05:** Food and drink should meet people's individual dietary needs.
**Outcome 20:** The service must tell us about important events that affect people's wellbeing, health and safety.

A subsequent assessment by the Care Quality Commission on 27 December 2012, identified non-compliance in the following essential standards of quality and safety:

**Outcome 04:** People should get safe and appropriate care that meets their needs and supports their rights.

**Outcome 16:** The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

In response, a robust action plan was developed and submitted to the Care Quality Commission - with target dates for completion within three months.

The Care Quality Commission conducted an unannounced re-inspection on 13 March, 2013, and deemed full compliance against all of these outcomes.

Work will continue to embed the significant progress made, with continuing assurance through the Trust’s Ward Level Quality Review Programme and the Nursing and Midwifery Quality Indicators Dashboard.

**Milton Keynes Community Health Services**

Milton Keynes Community Health Services are required to register with the Care Quality Commission and its current registration status is ‘Unconditional Registration’.

The Care Quality Commission has not taken enforcement action against Milton Keynes Community Health Services during 2012/13.

Milton Keynes Community Health Services has not participated in any special reviews or investigations by the Care Quality Commission in the reporting period.

The Care Quality Commission conducted a routine inspection visit during 2012/13. The inspection took place at the Campbell Centre, which is an acute adult mental health inpatient unit. The outcome of the inspection showed compliance with Care Quality Commission standards, however moderate concerns in relation to six areas were raised against the following outcomes:

**Outcome 1:** Respecting and involving people who use the service.

**Outcome 4:** Care and welfare of people who use the service.

**Outcome 7:** Safeguarding people who use services from abuse.

**Outcome 10:** Safety and suitability of premises.

**Outcome 13:** Staffing.

**Outcome 16:** Assessing and monitoring the quality of the service.
Improvement actions were identified and these were progressed. The Care Quality Commission re-inspected the Campbell Centre on 21st March and 2nd April 2013 against the above outcomes along with two additional ones - Outcome 2: Consent to care and treatment and Outcome 9: Medicines management. The Care Quality Commission found that action was required for all 8 Outcomes before MKCHS could be deemed compliant.

The CQC also completed Mental Health Act compliance assessments which are carried out annually. These reviews took place at the following sites:

- The Older People’s Assessment Service (TOPAS), older people’s mental health.
- The Campbell Centre, acute adult mental health service.
- The Linden Unit, adult mental health rehabilitation unit.

This highlighted some areas for improvement at the Campbell Centre which are presently being addressed.

An OFSTED and CQC Inspection of safeguarding and looked after children services was completed between 9th and 20th July 2012. The CQC provided its own report that included findings from the overall inspection report with more detailed evidence and feedback on the findings from the CQC component of the inspection. Within the report there were no recommendations relating specifically to MKCHS safeguarding children arrangements, however, there were three recommendations requiring action by MKCHS. Two related to children in care. The other recommendation related to ensuring provision of equipment for children with disabilities and life limiting conditions does not impede their discharge from hospital and that a comprehensive maintenance programme is in place. Milton Keynes Clinical Commissioning Group has overall responsibility for the plan.

**Data quality**

**Bedford Hospital**

Bedford Hospital monitors and reviews all elements of data quality, which includes completeness, validity and quality of its clinical and business data. Specific data quality work streams have been developed during 2012/13 which relate to improving data processes and reviewing critical systems in relation to data capture, including the roll out of a data quality training programme across the Trust. The Internal Data Quality Group monitors progress against all data quality work streams and meets monthly. The Data Quality Group reports to the Information Governance Board. Bedford Hospital has made significant improvements during 2012/13 specifically in relation to key data items, i.e. NHS Number, GP Practice, A&E treatment, investigation coding and consultant, speciality attribution.

**Milton Keynes Community Health Services**

‘Milton Keynes Community Health Services made considerable progress in 2012/13 to enable the internal and external reporting of performance data required as a result of increased contractual requirements. We achieved this by continuing our implementation and enhancement of the RiO system (Rivers of Information - a clinical records data collection system) and through the introduction of various data collection tools across services including an enhanced reporting portfolio and the Business Intelligence system. This is a
comprehensive health application platform which provides daily information to enable managers to monitor and drive up quality of care. We have also increased the capacity and capability of staff within services with regard to data recording, reporting and analysis through regular partnership meetings where data is reviewed and education around information management provided.

**NHS Number and General Medical Practice Code Validity**

**Bedford Hospital**

Bedford Hospital submitted records during 2012/13 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS Number was:
  
  99.56% for admitted patient care;
  99.83% for outpatient care; and
  96.70% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:
  
  100% for admitted patient care;
  100% for outpatient care; and
  100% for accident and emergency care.

**Milton Keynes Community Health Services**

Milton Keynes Community Health Services submitted records during 2012/13 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS Number was:
  
  100% for admitted care;
  99.8% for outpatient care.

- which included the patient's valid General Practitioner Registration Code was:
  
  100% for admitted care;
  100% for outpatient care.
**Information Governance Toolkit - attainment levels**

Bedford Hospital NHS Trust's Information Governance Assessment Report overall score for 2012/13 was 70% and was graded green. The Trust achieved a minimum of Level 2 on all requirements.

**Clinical Coding Accuracy**

**Bedford Hospital**

Bedford Hospital was subject to the Payment by Results (PBR) clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect 30%
- Secondary Diagnoses Incorrect 20%
- Primary Procedures Incorrect 15.2%
- Secondary Procedures Incorrect 75.0%

It is important to note the focus for this audit was only on 43 spells covering Skin HRG JC15Z predominately within the dermatology minor operations unit. The spells in the sample had a higher error rate in all areas. Many of the errors were due to proformas being used as the coding source for laser or minor operations instead of the full case-notes. There has been a recent review of procedures being undertaken in the laser and minor operations unit where the Trust records these as day cases and it is recognised that a high proportion of these should now be recorded as outpatients.

The Trust had a further audit of clinical coding undertaken by a NHS Classifications Service approved clinical coding auditor in March 2013.

The results of this audit show coding error rates as follows:

- Primary Diagnoses Incorrect 7.5%
- Secondary Diagnoses Incorrect 4.92%
- Primary Procedures Incorrect 3.48%
- Secondary Procedures Incorrect 1.95%

The Trust achieved the accuracy percentage scores required for level 3 of the Information Governance Toolkit Assessment.

Bedford Hospital will be taking the following actions to improve data quality:

- Developing guidance for Doctors to help them understand the complexities of coding.
- Introduce a sign-off mechanism for all hospital deaths (started 1st April 2013).
- Clinicians playing a part in checking clinician/specialty attribution on inpatients (started from December 2012).
- Review of all outpatient areas where procedures take place – specialty specific outcome sheets.
- Retrospective review of coded episodes where histology's are issued – ensuring primary diagnosis reflects histology result.
- Development of online report to enable coding to be more visible for auditing in relation to the coding rules and conventions.
- Reduction and review of the use of signs and symptoms codes.
- Diagnosis checklist on discharge.
- Specialty specific coding workshops planned for 2013/14 – Orthopaedic – Vascular – Chemotherapy.
- Continue development of clinical coders to enable achievement of ACC qualification.
- Typed operation sheets - recommendation for future development.

*Milton Keynes Community Health Services*

Milton Keynes Community Health Services was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The Trust has recently reviewed its Information Governance Board and subgroups and has introduced new subgroups from 2013/14 to further strengthen the assurance provided. The Trust is also appointing a Deputy Senior Risk Officer to improve and strengthen the information risk assurance processes.
National Quality Indicators

In February 2012 the Department of Health published new Quality Account reporting requirements for 2012/13. In the past, local flexibility in the content of the Quality Account gave a strong local ownership to the document which allowed reflection of local priorities and circumstances. However this meant that comparable performance with other organisations was not always possible. The new mandatory sections have been introduced in order for the local population to assess if an organisation's performance is good or poor against other NHS Organisations. This section will be separated into two sections to identify Bedford Hospital’s performance against the quality indicators and then that of Milton Keynes Community Health Services.

National Quality Indicators - Bedford Hospital

Of the 15 indicators, 8 are relevant to Bedford Hospital. These are as follows:

- Summary Hospital-level Mortality Indicator (SHMI)
  - SHMI banding
  - Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care
- Patient Reported Outcome Measures Scores (PROMS) for:
  - groin hernia surgery
  - varicose vein surgery
  - hip replacement surgery
  - knee replacement surgery
- Emergency re-admissions to hospital within 28 days of discharge.
- Responsiveness to inpatients’ needs.
- Percentage of staff who would recommend the Trust to friends or family needing care.
- Percentage of admitted patients risk assessed for venous thromboembolism (VTE).
- Rate of Clostridium difficile.
- Rate of patient safety incidents and the percentage resulting in severe harm or death.

Bedford Hospital aims to meet all national targets and priorities. In the table below we have provided Bedford Hospital's performance against the quality indicators that we are required to report in our annual Quality Account. Although we may have referred to these elsewhere we have included the full table for completeness. The performance indicator figures have been taken from The Health and Social Care Information Centre (HSCIC) but where the most up to date information is not available, this is taken from the Trust's own internal data and labelled as such. Similarly, in some cases, information on national averages cannot be obtained in a meaningful way from the HSCIC portal and in such instances has not been stated.
<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Quality Indicator</th>
<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
<th>Supporting Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Preventing People from dying prematurely.</td>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to—</td>
<td>July 2011 - June 2012</td>
<td>July 2011 – June 2012</td>
<td>SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.</td>
</tr>
</tbody>
</table>
| | (a) the value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period; and | 1.06  
Band 2  
'as expected'. | Best: 0.71 Band 3  
Worst: 1.26 Band 1 | The SHMI is an index where 1 is the norm ('as expected'). |
| | (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | Oct 2011 – Sept 2012 | Oct 2011- Sept 2012: | Where the value is below 1, mortality is better than expected (band 3), and above 1, mortality is higher than expected (band 1). |
| | | 1.06  
Band 2  
'as expected’ | Best: 0.6849 Band 3  
Worst: 1.2107 Band 1 | Bedford Hospital considers that this data is as described for the following reasons: |
| | | July 2011 - June 2012  
26.24% | July 2011 - June 2012  
Not available | * Processes are in place to review all deaths.  
* Lessons are learnt through the review process.  
* Early Warning Scores are present in general wards, maternity and paediatrics. |
| | | Oct 2011 – Sept 2012  
23.15% | Oct 2011 – Sept 2012  
Best: 0.2%  
Worst: 43.3% | Bedford Hospital has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by: |
| | | | | * Undertaking an audit to review mortality data.  
* Establishing a new process for clinicians to review each patient death. |
<p>| | | | | PROMs measure a patient’s health status or health-related quality of life from the patient’s perspective, typically based on information gathered from a questionnaire that patients complete before and after surgery. |
| Domain 2: Enhancing quality of life for people with long-term conditions. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust’s patient reported outcome measures scores | | | |
| Domain 3: Helping people to recover from episodes of ill health or following injury. | | | | |</p>
<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Quality Indicator</th>
<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
<th>Supporting Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 3: Helping people to recover from episodes of ill health</td>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care 2011/2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apr 2011 – Mar 2012</td>
<td>Apr 2011 – Mar 2012</td>
<td>Bedford Hospital considers that the outcome scores are as described for the following reasons:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• We undertake a higher than average number of laparoscopic hernia repairs.</td>
</tr>
<tr>
<td></td>
<td>for—</td>
<td></td>
<td></td>
<td>• We undertake less invasive treatments for varicose veins.</td>
</tr>
<tr>
<td></td>
<td>(i) groin hernia surgery</td>
<td></td>
<td></td>
<td>• The sample size for varicose vein surgery was in low numbers for April 2012 - December 2012.</td>
</tr>
<tr>
<td></td>
<td>(ii) varicose vein surgery</td>
<td></td>
<td></td>
<td>Bedford Hospital has taken the following actions to improve this score, and so the quality of its services, by:</td>
</tr>
<tr>
<td></td>
<td>(iii) hip replacement surgery</td>
<td></td>
<td></td>
<td>• Improving our same day admission pathways.</td>
</tr>
<tr>
<td></td>
<td>(iv) knee replacement surgery</td>
<td></td>
<td></td>
<td>• Offering a range of open and laparoscopic techniques for groin hernia surgery.</td>
</tr>
<tr>
<td></td>
<td>during the reporting period.</td>
<td></td>
<td></td>
<td>• Delivering a higher percentage of radio-frequency ablation treatments and ultra-sound guided injections rather than invasive surgery requiring a general anaesthetic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgery</td>
<td>EQ-5D</td>
<td>Surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Groin hernia</td>
<td>0.103</td>
<td>Groin hernia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Varicose vein</td>
<td>0.077</td>
<td>Varicose vein</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hip replacement</td>
<td>0.442</td>
<td>Hip replacement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knee replacement</td>
<td>0.298</td>
<td>Knee replacement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Groin hernia</td>
<td>0.077</td>
<td>Groin hernia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Varicose vein</td>
<td>N/A</td>
<td>Varicose vein</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hip replacement</td>
<td>0.497</td>
<td>Hip replacement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knee replacement</td>
<td>N/A</td>
<td>Knee replacement</td>
</tr>
</tbody>
</table>

EQ-5D: A standardised calculation based on 5 key questions relating to general health that a patient is asked before and after their surgery. It is scored between 0 and 1 where 1 is the best.
<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Quality Indicator</th>
<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
<th>Supporting Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>health or following injury.</td>
<td>Information Centre with regard to the percentage of patients aged— &lt;br&gt; (i) 0 to 14 &lt;br&gt; (ii) 15 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.</td>
<td>(0-15) 7.16%* &lt;br&gt; (16+) 10.19* &lt;br&gt; *internal data</td>
<td>2012/2013 &lt;br&gt; (0-14) 9.6%* &lt;br&gt; (15 or over) 10.8%* &lt;br&gt; *provisional internal data</td>
<td>could potentially be avoided through ensuring the delivery of optimal treatment according to each patient’s needs, careful planning and support for self-care. Bedford Hospital considers that this data is as described for the following reasons:&lt;br&gt; - We have worked closely with primary care and social services throughout the year.&lt;br&gt; Bedford Hospital has taken the following actions to improve these percentages, and so the quality of its services, by:&lt;br&gt; - Introducing post-discharge follow up phone calls.&lt;br&gt; - Improving our management of complex discharges by joint working with other agencies and meeting to discuss discharges every day.&lt;br&gt; - Introducing a complex needs assessment tool for all frail elderly patients who are admitted to our hospital.&lt;br&gt; - Introducing Consultant rounds every day for all medical frail elderly patients.</td>
</tr>
</tbody>
</table>
### NHS Outcomes Framework Domain

#### Domain 4: Ensuring that people have a positive experience of care.

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust’s responsiveness to the personal needs of its patients during the reporting period. This score is based on the average of five questions in the inpatient survey:

1. **Were you involved as much as you wanted to be in decisions about your care?**
   - **2012/13**: 70%
   - **2011/12**: 68%

2. **Did you find someone on the hospital staff to talk to about your worries and fears?**
   - **2012/13**: 54%
   - **2011/12**: Not available

3. **Were you given enough privacy when discussing your condition or treatment?**
   - **2012/13**: 80%
   - **2011/12**: 92%

4. **Did a member of staff tell you about medication side effects to watch for when you went home?**
   - **2012/13**: 44%
   - **2011/12**: 49%

---

**Bedford Hospital Score**

- Patient experience is a key measure of the quality of care.
- Bedford Hospital considers that this data is as described for the following reasons:
  - Improvement work was slow to embed.

Bedford Hospital has taken the following actions to improve this data, and so the quality of its services by:

- Identifying this as a quality priority for 2013/14.
- Implementing patient information leaflets for patients on discharge, which inform them about their medicines.
- Telephone patients 24 hours after discharge to understand if they have any concerns.
<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Quality Indicator</th>
<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
<th>Supporting Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?</td>
<td>72%</td>
<td>2011/12 Weighted average score 66.8%</td>
<td>How members of staff rate the care that their employer organisation provides can be a meaningful indication of the quality of care and a helpful measure of improvement over time. Bedford Hospital considers that this percentage is as described for the following reasons: <strong>We had a programme of staff engagement in place which ran regularly throughout the year and was supplemented by weekly communications from the Chief Executive as well as regular Chief Executive Roadshows.</strong> Bedford Hospital has taken the following actions to improve this percentage, and so the quality of its services, by: <strong>Introducing a staff council to enable staff to influence the way we develop our services.</strong> <strong>Implementing a Trust Code of Conduct for all staff.</strong></td>
</tr>
<tr>
<td>Domain 4: Ensuring that people have a positive experience of care.</td>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.</td>
<td>2011 Trust 71%</td>
<td>2011 National: 62% Best: 89% Worst: 33%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2012 Trust: 60%*</td>
<td>2012 National: 60%*</td>
<td><strong>Data from Picker Institute</strong></td>
<td><strong>Data from Picker Institute</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Data from Picker Institute</strong></td>
</tr>
<tr>
<td>NHS Outcomes Framework Domain</td>
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<td>Trust Performance</td>
<td>National comparisons: Average, best and worst (where available)</td>
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</tr>
</tbody>
</table>
| Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. | 2012/13 %  
Q1 95.10  
Q2 94.60  
Q3 97.10  
Q4 95.80  
2011/12 %  
Q1 89.27  
Q2 93.36  
Q3 93.05  
Q4 94.34 | 2012/13  
Highest %  
Q1 100  
Q2 100  
Q3 100  
Q4 Not av.  
2011/12  
Not av.  
Not av.  
Not av. | VTE (deep vein thrombosis and pulmonary embolism) can cause death and long term morbidity, but many case of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis.  
Bedford Hospital considers that this data is as described for the following reasons:  
- Improvement programme led by Associate Medical Director who also chaired the Trust VTE Committee.  
- Close monitoring and feedback was in place to support improvement work.  
Bedford Hospital has taken the following actions to improve this score, and so the quality of its services, by:  
- Introducing a programme of raising awareness.  
- Supporting junior doctors by providing daily information on completed and uncompleted assessments. |
| Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of *Clostridium difficile* infection reported within the trust amongst patients aged 2 or over during the reporting period. | 2010/11  
25.1 per 100,000 bed days  
2011/12 27 cases of *Clostridium difficile*.  
22.6 per 100,000 bed days.  
2012/13 17 cases of *Clostridium difficile*. | 2010/11  
National average: 29.6  
Lowest: 0  
Highest: 71.8  
2011/12  
National average: 21.8  
Lowest: 0  
Highest: 51.6  
2012/13 No national data available. | *Clostridium difficile* can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel, but hospital associated *Clostridium difficile* can be preventable.  
This data represents the number of *Clostridium difficile* infections during the year where the Trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to the Trust (where the day of admission is day one). A
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.</strong></td>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, <strong>rate of patient safety incidents</strong> reported within the trust during the</td>
<td>Oct 2011 to March 2012 809 incidents reported  Incidents reported per 100 admissions: 3.36  Percentage resulting in severe harm or death: 0.49%</td>
<td>National average for severe harm or death 1.00% Lowest 0% / Highest 3.50%</td>
<td>An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. This indicator is expressed as a percentage of patient safety incidents reported to the National Reporting and Learning Service (NRLS) that have resulted in severe harm or death.</td>
</tr>
</tbody>
</table>

14.1 per 100,000 bed days*  
*internal data
<table>
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</thead>
<tbody>
<tr>
<td></td>
<td>reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</td>
<td>April to Sept 2012: 1172 incidents reported</td>
<td>April to Sept 2012: Incidents reported per 100 admissions: 4.7</td>
<td>A patient safety incident is defined as ‘any unintended or unexpected incident(s) that could or did lead to harm for one of more person(s) receiving NHS funded healthcare’.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage resulting in severe harm or death: 0.26%</td>
<td>Percentage resulting in severe harm or death: 0.9%</td>
<td>The ‘degree of harm’ for patient safety incidents is defined as follows: ‘severe’ – the patient has been permanently harmed as a result of the incident; and ‘death’ – the incident has resulted in the death of the patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Numbers of Harm: None 852 Low 220 Mod 97 Severe 0 Death 3</td>
<td>Oct 2012 to Mar 2013*: 1363 incidents reported</td>
<td>Bedford Hospital considers that this data is as described for the following reasons:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage resulting in severe harm or death: 1.47%</td>
<td>Percentage resulting in severe harm or death - not yet available.</td>
<td>The number of incidents uploaded to the National Reporting and Learning System (NRLS) have been audited and validated. At year end our internal records identified that for the reporting period Apr 2012-Sep 2012 our severe harm/death rate was 10.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Numbers of Harm: None 1004 Low 276 Mod 63 Severe 13 Death 7</td>
<td></td>
<td>The 7 events that were not captured in the NRLS feedback report can be explained as a result of the Trusts recategorisation of fractured neck of femurs resulting from an inpatient fall (n=6). All 6 events were upgraded from moderate harm to severe harm following a thematic review.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total for 2012/13 - 2535 incidents reported, 23 resulting in severe harm or death = 0.91%.</td>
<td></td>
<td>One additional incident was also upgraded after further investigation. The case involved a patient with a rare and complex clinical condition, identified as a failure to diagnose, and this was upgraded to patient death.</td>
</tr>
</tbody>
</table>

This increased the number of severe harm/death
<table>
<thead>
<tr>
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<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
<th>Supporting Commentary</th>
</tr>
</thead>
</table>
|                               |                   |                   | *internal data retrieved from Datix Incident Reporting System. | figures to 10 for the reporting period but this data had not been available in time for NRLS publication. Bedford Hospital has taken the following actions to improve this score, and so the quality of its services, by:  
  - Setting a standard for investigating incidents that are reported.  
  - Reporting incident reporting rates to our Quality Board on a monthly basis.  
  - Employing a Patient Safety Coordinator to lead improvement work in incident reporting and management. |
National Quality Indicators - Milton Keynes Community Health Services

Out of the 15 indicators 8 are relevant to MKCHS. These are as follows:

- Percentage of patients on Care Programme Approach followed up within 7 days after discharge.
- Percentage of admissions to acute wards for which the Crisis Resolution Home Team acted as a gatekeeper.
- Percentage of patients readmitted in 28 days.
- Percentage of staff who would recommend the organisation to friends and family needing care.
- Patient experience of community mental health services.
- Percentage of admitted patients risk assessed for venous thromboembolism (blood clots).
- Rate of Clostridium difficile infection.
- Rate of patient safety incidents and percentages resulting in severe harm or death.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
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<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
<th>Supporting Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Preventing People from dying prematurely.</td>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.</td>
<td>Trust</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>96.43</td>
<td>97.43</td>
<td>100</td>
<td>92.23</td>
</tr>
<tr>
<td>Q1</td>
<td>96.40</td>
<td>97.50</td>
<td>100</td>
<td>94.90</td>
</tr>
<tr>
<td>Q2</td>
<td>96.70</td>
<td>97.20</td>
<td>100</td>
<td>89.80</td>
</tr>
<tr>
<td>Q3</td>
<td>96.20</td>
<td>97.60</td>
<td>100</td>
<td>92.00</td>
</tr>
<tr>
<td>2011/12</td>
<td>95.43</td>
<td>97.25</td>
<td>100</td>
<td>80.28</td>
</tr>
<tr>
<td>Q1</td>
<td>92.60</td>
<td>96.70</td>
<td>100</td>
<td>78.40</td>
</tr>
<tr>
<td>Q2</td>
<td>98.30</td>
<td>97.30</td>
<td>100</td>
<td>90.30</td>
</tr>
<tr>
<td>Q3</td>
<td>97.00</td>
<td>97.40</td>
<td>100</td>
<td>60.00</td>
</tr>
<tr>
<td>Q4</td>
<td>93.80</td>
<td>97.60</td>
<td>100</td>
<td>92.40</td>
</tr>
</tbody>
</table>

Care Programme Approach and Non Care Programme Approach figures are included as data was not separated until April 2013.

MKCHS considers that this data is as described for the following reasons:
- An improvement programme was in place involving implementing best practice approaches.

MKCHS has taken the following actions to improve this score, and so the quality of its services: The target was fully achieved and work will continue to maintain good performance through 2013/14.
### NHS Outcomes Framework Domain

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Trust Performance</th>
<th>National comparisons: Average, best and worst (where available)</th>
<th>Supporting Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2: Enhancing quality of life for people with long-term conditions.</strong></td>
<td><strong>Trust Performance</strong></td>
<td><strong>National comparisons:</strong> Average, best and worst (where available)</td>
<td>MKCHS considers that this data is as described for the following reasons:</td>
</tr>
<tr>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.</td>
<td>Trust</td>
<td>Nat. Av. %</td>
<td>Highest %</td>
</tr>
<tr>
<td></td>
<td>2012/13</td>
<td>90.33</td>
<td>98.17</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>83.00</td>
<td>98.00</td>
</tr>
<tr>
<td></td>
<td>Q2</td>
<td>89.80</td>
<td>98.10</td>
</tr>
<tr>
<td></td>
<td>Q3</td>
<td>98.20</td>
<td>98.40</td>
</tr>
<tr>
<td></td>
<td>2011/12</td>
<td>63.40</td>
<td>97.43</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>37.20</td>
<td>97.00</td>
</tr>
<tr>
<td></td>
<td>Q2</td>
<td>29.80</td>
<td>97.30</td>
</tr>
<tr>
<td></td>
<td>Q3</td>
<td>91.90</td>
<td>97.70</td>
</tr>
<tr>
<td></td>
<td>Q4</td>
<td>94.70</td>
<td>97.70</td>
</tr>
</tbody>
</table>

MKCHS has taken the following actions to improve this score, and so the quality of its services, by:

- Data collection improvement work was underway to support better performance.

| **3: Helping people to recover from episodes of ill health or following injury.** | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged—(i) 0 to 14; and (ii) 15 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. | During 2012/13 the readmission percentage for the Campbell Centre was at 14% and for TOPAS 7%.* | No national data available. | MKCHS considers that this data is as described for the following reasons: |
| | | | | MKCHS has taken the following actions to improve this score, and so the quality of its services. |
| | | | | - This information was collected during 2012/13 for the first time. It will be used for future improvement work. |
| | | | | - Reconfiguration of community mental health teams ensuring reduced numbers of inappropriate referrals. |
| | | | | - Increased consultant input on site at units with direct work to improve quality of discharges, therefore reducing likelihood of readmissions. |

### Domain 4: Ensuring that people have a positive experience of care.

| The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre | 2011/12 | 2011/12 | MKCHS considers that this data is as described for the following reasons: |
| | Trust – 56% | National average – 65% | Highest – 77% | MKCHS has taken the following actions to improve this score, and so the quality of its services. |

MKCHS has taken the following actions to improve this score, and so the quality of its services by:

- Identifying this as specific improvement priority for 2013/14. As such we have improved staff awareness and monitoring processes.
<table>
<thead>
<tr>
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</thead>
</table>
|                              | Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. | 2012/13 Trust - 67%* | Lowest 56% | improvement on staff communication and engagement.  
- A series of workshops were held with senior managers and roadshows were regularly run.  
MKCHS has taken the following actions to improve this score, and so the quality of its services, by:  
- Prioritising its focus on staff engagement throughout the year. |
| Domain 2: Enhancing quality of life for people with long-term conditions. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust’s “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period. | Results published on an annual basis with 5 indicators relevant under Health and Social Care Workers.  
All 5 indicators showed MKCHS performance within the lower bracket of average performing trusts. Score – 8.2. | ‘About the same’ as other Trusts  
Lowest national score = 8.2  
Highest national score = 9.1 | MKCHS considers that this data is as described for the following reasons:  
- An improvement programme has been in place linked to our organisational service user engagement work.  
MKCHS intends to take the following actions to improve this score, and so the quality of its services, by:  
- Improving communication, and increasing user involvement. This is monitored within CPA audits.  
- A full action plan was presented to MKCHS Board and is monitored through the Quality Committee. |
| Domain 4: Ensuring that people have a positive experience of care. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who | During 2012/13 no risk assessments were carried out for VTE. | 2012/13  
| | | | Q1 | 100 | 80.80 |
| | | | Q2 | 100 | 80.90 |
| | | | Q3 | 100 | 84.60 |
| Domain 5: Treating and caring for people in a safe environment and protecting them from harm. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who | | MKCHS considers that this data is as described for the following reasons: No data available.  
MKCHS intends to take the following actions to improve this score, and so the quality of its services, by: |
<table>
<thead>
<tr>
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</table>
| Domain 5: Treating and caring for people in a safe environment and protecting them from harm. | were risk assessed for venous thromboembolism during the reporting period. | 2011/12 Highest % Lowest % | - Ensuring that NICE guidance will be fully implemented at the Windsor Intermediate Care Unit, our community in-patient unit, before the end of May 2013.  
- A review of our other in-patient units will be conducted later in 2013/14. |
| | | Q3 100 32.40 Q4 100 70.00 | | |
| | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of Clostridium difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. | In 2012/13 there have been no Clostridium difficile cases in any of our in-patient settings.* |
| | | | *internal data |
| | | 2010/11 National average: 29.6 Lowest: 0 Highest: 71.8 | |
| | | 2011/12 National average: 21.8 Lowest: 0 Highest: 51.6 | At MKCHS we have three inpatient settings, with only one that this indicator would be appropriate to.  
Clostridium difficile can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel, but hospital associated Clostridium difficile can be preventable.

This data represents the number of Clostridium difficile infections during the year where the Trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to the Trust (where the day of admission is day one). A positive laboratory test result for Clostridium difficile is recognised as a case according to the Trust's diagnostic.

Only patients aged 2 or more are included. Positive results on the same patient more than 28 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or |
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</thead>
</table>
| Domain 5: Treating and caring for people in a safe environment and protecting them from harm. | The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. | **April to Sept 2012**:  
1034 incidents reported  
Percentage resulting in severe harm or death: 0.68%  
**Numbers of Harm:**  
None 454  
Low 452  
Mod 121  
Severe 1  
Death 6 | Incidents resulting in severe harm or death (mental health):  
**April to Sept 2012**  
National average: 1.60%  
Lowest: 0%  
Highest: 9.40% | MKCHS considers that this data is as described for the following reasons:  
- Robust systems are in place to ensure all staff are aware of Infection Control risks in relation to overuse of antibiotics and links with *Clostridium difficile*.  
- High level of compliance with mandatory training and hand hygiene.  
MKCHS has taken the following actions to improve this score, and so the quality of its services, by:  
- Proactive engagement with GPs who have high levels of antibiotic prescribing.  
- Dedicated antibiotic pharmacist leading improvement work.  
This indicator is expressed as a percentage of patient safety incidents reported to the National Reporting and Learning Service (NRLS) that have resulted in severe harm or death.  
A patient safety incident is defined as ‘any unintended or unexpected incident(s) that could or did lead to harm for one of more person(s) receiving NHS funded healthcare’.  
The ‘degree of harm’ for patient safety incidents is defined as follows: ‘severe’ – the patient has been permanently harmed as a result of the incident; and ‘death’ – the incident has resulted in the death of the patient.  
Because MKCHS were unable to use Bedford’s... |
<table>
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</thead>
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<tr>
<td>Oct 2012 to Mar 2013*: 808 incidents reported</td>
<td>Oct 2012 to Mar 2013: Data not yet available.</td>
<td></td>
<td>organisational code in 2012/13 they retained ‘5CQ’ which meant that MKCHS’ data was included with MK PCT’s in NRLS feedback reports.</td>
<td></td>
</tr>
<tr>
<td>Percentage resulting in severe harm or death: 1.1%</td>
<td></td>
<td></td>
<td>MKCHS are therefore unable to report on the required information for the rate of patient safety incidents per 100 admissions.</td>
<td></td>
</tr>
<tr>
<td>Numbers of Harm:</td>
<td></td>
<td></td>
<td>MKCHS considers this data is as described:-</td>
<td></td>
</tr>
<tr>
<td>None 344</td>
<td></td>
<td></td>
<td>The 16 incidents that resulted in death or severe harm (extensive injury) of our service users between April 2012 and March 2013 were reported and investigated as Serious Incidents.</td>
<td></td>
</tr>
<tr>
<td>Low 348</td>
<td></td>
<td></td>
<td>The reporting data has been audited and validated. The outcome of the investigations into patient death identified that 10 service users receiving outpatient mental health services, and 1 receiving in-patient mental health services, died following self-harm. One patient died whilst receiving in-patient mental health services and it was identified that increased observation and monitoring may have led to a better outcome.</td>
<td></td>
</tr>
<tr>
<td>Mod 107</td>
<td></td>
<td></td>
<td>MKCHS has taken action to improve this score, and so the quality of its services by:</td>
<td></td>
</tr>
<tr>
<td>Severe 3</td>
<td></td>
<td></td>
<td>Ensuring that in 2013/14 staff will continue to receive training to ensure they remain alert to the need to report incidents. This is considered very positive by the National Reporting and Learning System (NRLS) and the Care Quality Commission as it demonstrates vigilance and transparency.</td>
<td></td>
</tr>
<tr>
<td>Death 6</td>
<td></td>
<td></td>
<td>All serious incidents are thoroughly investigated</td>
<td></td>
</tr>
<tr>
<td>Total for 2012/13 - 1842 incidents, 16 resulting in severe harm or death = 0.87%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Internal data retrieved from Safeguard Incident Reporting System.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Outcomes Framework Domain</td>
<td>Quality Indicator</td>
<td>Trust Performance</td>
<td>National comparisons: Average, best and worst (where available)</td>
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</tbody>
</table>

(Using root-cause analysis methodology) and all recommendations are included on an action-plan which is implemented by the service. Implementation of the action plan is monitored at commissioner-led review meetings and learning points are shared with our services and with partner organisations in this forum.
Every year, the Department of Health produce an Operating Framework for NHS England. In our report we refer to a number of the national indicators, the following table identifies six indicators for Bedford Hospital which have not been referred to elsewhere in our Quality Accounts:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Plan 2012/13</th>
<th>Achievement</th>
<th>End of Year Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>All types of cancers: 2 week wait from referral to the first date seen by the Trust</td>
<td>&gt;93%</td>
<td>94.76%</td>
<td>G</td>
</tr>
<tr>
<td>All types of cancers: 31 day wait from diagnosis to first treatment</td>
<td>&gt;98%</td>
<td>99.63%</td>
<td>G</td>
</tr>
<tr>
<td>All types of cancers: 62 day wait for first treatment from GP referral</td>
<td>&gt;85%</td>
<td>87.49%</td>
<td>G</td>
</tr>
<tr>
<td>Percentage of patients who were admitted to hospital and <strong>waited less than 18 weeks</strong> for their treatment</td>
<td>&gt;90%</td>
<td>93.83%</td>
<td>G</td>
</tr>
<tr>
<td>Percentage of patients who were not admitted to hospital and <strong>waited less than 18 weeks</strong> for their treatment</td>
<td>&gt;95%</td>
<td>98.28%</td>
<td>G</td>
</tr>
<tr>
<td>A&amp;E: Maximum wait time of 4 hours from arrival to admission/transfer/discharge</td>
<td>&gt;95%</td>
<td>95.01%</td>
<td>G</td>
</tr>
</tbody>
</table>

- Green = Planned performance met

The Trust met all key access criteria in 2012/13.

**What did this actually mean for our patients?**

The hospital ensured there was appropriate service provision for patients to access our clinics, emergency department and inpatient beds as set out in the national standards. For patients on cancer pathways, it meant that they waited a minimum amount of time from when potential cancer concerns were noticed by their General Practitioner or Screening Service to when they received their first treatment. For patients who required planned care, it meant that most patients waited no more than 18 weeks from referral to treatment. For emergency patients it meant that most were treated, admitted or discharged from the hospital within four hours of arrival in our accident and emergency department.
Complaints – Bedford Hospital

Bedford Hospital is committed to resolving complaints to the satisfaction of the complainant, to learn from what has happened and, where appropriate, make demonstrable improvements to services.

Our Complaints Team manage the Complaints Procedure and work with our Clinical Business Units to improve the quality of investigations and responses. The Team provides guidance and support to staff handling complaints, staff against which complaints have been raised, as well as to complainants.

Our Complaints Team also provides the interface between the hospital and the Ombudsman and any other relevant organisations regarding complaints.

Each formal complaint received by Bedford Hospital is registered, managed and monitored through our Datix Management System.

The Chief Executive is the “Responsible Person” under the National Health Service Complaints (England) Regulations 2009 and reviews weekly complaint summaries of complaints received. The Chief Executive is also the signatory to all written responses.

During 2012/13 Bedford Hospital received 228 formal complaints. The top 3 concerns of our patients related to information, staff attitude and pain relief.

Of the 228 complaints 93% were acknowledged within 3 working days however only 12% received their response letter within 45 working days which we have acknowledged as a priority area for improvement in 2013/14. The number of complaints is a useful tool for us to understand and act upon to improve the quality of care we provide.

Our Complaints Department has recently undergone an independent external review and we are awaiting the final report which will help to steer our improvements in 2013/14. An action plan will be developed from the recommendations in the report which will be presented and monitored by our Quality Committee. Additionally, we have also increased the personnel in the Complaints Department and introduced new processes. We have also agreed the following recommendations:

- Our Datix system will be fully utilised to improve reporting and compliance monitoring.
- We will provide an aggregated analysis of complaints, legal claims and incidents which will be reported to the Quality Board quarterly, with learning identified in the report.
- Our response rates to complaints will be monitored monthly. An improved response rate will be achieved, with all complaints being acknowledged within 3 working days and above 85% of all complaints being responded to within 45 working days.
## Annex 1 – Health Services provided during 2012/13

### Bedford Hospital

<table>
<thead>
<tr>
<th>Service Description</th>
<th><strong>Speciality Support Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Podiatry (Diabetic Outpatients)****</td>
</tr>
<tr>
<td>Critical Care Medicine (ITU)</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Thoracic Medicine</td>
</tr>
<tr>
<td>Tunable Dye Laser Treatment</td>
<td>Genito-Urinary Medicine/Sexual Health</td>
</tr>
<tr>
<td>Diabetic Medicine</td>
<td>Trauma and Orthopaedics</td>
</tr>
<tr>
<td>Elderly Care</td>
<td>Urology</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>General Pathology ***</td>
</tr>
<tr>
<td>Ear Nose and Throat (ENT)</td>
<td>Blood Transfusion</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Chemical Pathology ***</td>
</tr>
<tr>
<td>General Medicine</td>
<td>Haematology ***</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Histopathology ***</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>Immunopathology ***</td>
</tr>
<tr>
<td>Upper Gastro-intestinal</td>
<td>Microbiology ***</td>
</tr>
<tr>
<td>Lower Gastro-intestinal</td>
<td>Radiology (includes MRI/CT/Ultrasound)</td>
</tr>
<tr>
<td>Vascular</td>
<td><strong>Speciality Support Services</strong></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Audiology</td>
</tr>
<tr>
<td>Midwifery</td>
<td>Dietetics</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Nephrology*</td>
<td>Orthotics*****</td>
</tr>
<tr>
<td>Neurology</td>
<td>Retinal Screening</td>
</tr>
<tr>
<td>Neonatal</td>
<td><strong>Service Departments</strong></td>
</tr>
<tr>
<td>Obstetrics</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Ophthalmology**</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Oral Maxillo Facial</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Speech and Language Therapy****</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Theatres</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Acute Admissions Unit</td>
</tr>
</tbody>
</table>

* indicates a service provided by Lister Hospital - East and North Hertfordshire NHS Trust  
** indicates a service provided by Moorfields Eye Hospital NHS Foundation Trust  
*** indicates a laboratory service provided by Guy’s and St Thomas’ NHS Foundation Trust  
**** indicates a service provided by South Essex Partnership Trust (SEPT)  
***** indicates a service provided by Patterson Healthcare
# Milton Keynes Community Health Services

<table>
<thead>
<tr>
<th>Service/Team</th>
<th>Brief description</th>
<th>Joint Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding and Children in Care Team</td>
<td>Provides support to staff across the organisation with regard to safeguarding children responsibilities and promotes health of children in care.</td>
<td></td>
</tr>
<tr>
<td>Children with Complex Needs</td>
<td>Provides healthcare interventions to support the needs of children with complex or palliative care needs. Promotes the health and wellbeing of children and young people with specialist needs for example sickle cell disease or epilepsy.</td>
<td></td>
</tr>
<tr>
<td>Paediatric Occupational Therapy</td>
<td>Works with children and families to promote independent functioning.</td>
<td></td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>Provides specialist medical care for children with a range of neuro-developmental needs/disorders.</td>
<td></td>
</tr>
<tr>
<td>Children’s Speech and Language Therapy Services (SALT)</td>
<td>Assesses and treats people with communication and swallowing/eating difficulties.</td>
<td></td>
</tr>
<tr>
<td>Child Health Information Service</td>
<td>Provides management of specific health information to support universal children's services including health visiting and primary care.</td>
<td></td>
</tr>
<tr>
<td>Adult Hearing Service</td>
<td>Assesses the hearing impaired and offers hearing aids.</td>
<td></td>
</tr>
<tr>
<td>Health Visiting</td>
<td>Provides a core universal service and a targeted and prioritised service according to identified needs.</td>
<td></td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td>Provides a preventative, intensive and structured home visiting programme for young, first time mothers – from early pregnancy until the child is two.</td>
<td></td>
</tr>
<tr>
<td>School Nursing</td>
<td>Provides a core universal service to school children.</td>
<td></td>
</tr>
<tr>
<td>Integrated Specialist Child and Adolescent Mental Health Service (CAMHS)</td>
<td>Promotes emotional wellbeing for children young people and their families by offering advice, support and specialist mental health therapeutic interventions.</td>
<td>Some council Social Workers seconded from children’s services</td>
</tr>
<tr>
<td>Healthcare – HMP Woodhill</td>
<td>Provides a comprehensive range of primary care and mental health services to the local category A male prison for 820 prisoners.</td>
<td></td>
</tr>
<tr>
<td>Community Team</td>
<td>Provides short-term intensive support and longer-term re-enablement.</td>
<td>Jointly managed service with MK Council – no section 75</td>
</tr>
<tr>
<td>Intermediate Care Beds</td>
<td>Windsor Intermediate Care Unit – 19 bedded unit for short, intensive rehabilitation and re-enablement. Orchard House – 18 re-enablement flats within sheltered housing.</td>
<td></td>
</tr>
<tr>
<td>Rapid Access Intervention Team (RAIT)</td>
<td>Provides nurse and therapy led rapid support</td>
<td></td>
</tr>
<tr>
<td>Home to Stay Team</td>
<td>A community facing hospital based transition team, overseeing and supporting complex transfer of care for up to 30 days post discharge.</td>
<td></td>
</tr>
<tr>
<td>Adult Speech and Language Therapy Services (SALT)</td>
<td>Assesses and treats adults with communication and swallowing/eating difficulties.</td>
<td></td>
</tr>
<tr>
<td>Service/Team</td>
<td>Brief description</td>
<td>Joint Service</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Adult Neurological Rehabilitation Team and Unit</td>
<td>Supports people with neurological conditions or multiple diagnoses related to ageing to achieve their functional and wellbeing potential.</td>
<td></td>
</tr>
<tr>
<td>Neuro-specialist team — Multiple Sclerosis, Parkinsons Disease, Brain Injury</td>
<td>Provides in-depth knowledge and expertise in the delivery of a specialist service.</td>
<td></td>
</tr>
<tr>
<td>Falls Service</td>
<td>Provides advice and support to those at risk of or with history of falls.</td>
<td></td>
</tr>
<tr>
<td>Wheelchair Service</td>
<td>Provides the framework to clinically assess, and then provides appropriate wheelchairs with associated equipment to clients with a long-term mobility need.</td>
<td></td>
</tr>
<tr>
<td>Early Stroke Rehabilitation Team</td>
<td>Provides specialist early supported discharge support and 6 weeks post discharge active input.</td>
<td></td>
</tr>
<tr>
<td>Community Occupational Therapy</td>
<td>Supports and promotes patient mobility and safety within their environment and discharge from hospital.</td>
<td></td>
</tr>
<tr>
<td>Integrated Community Equipment Service</td>
<td>Provides the equipment needed to facilitate rehabilitation and the promotion of independence.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>District Nursing Service</td>
<td>Promotes independent living and provides clinical support to the housebound.</td>
<td></td>
</tr>
<tr>
<td>Community Matron Service</td>
<td>Provides advice and support towards self-management of long-term conditions.</td>
<td></td>
</tr>
<tr>
<td>Specialist Nurses—Dermatology, Continence, Tissue Viability, Epilepsy, Pulmonary Rehabilitation,</td>
<td>Provides in-depth specialist support, expertise and complex management for a number of specific conditions.</td>
<td></td>
</tr>
<tr>
<td>Diabetes Nurse Specialist</td>
<td>Provides specialist support for insulin initiation and complex management of diabetes in the community.</td>
<td></td>
</tr>
<tr>
<td>EoL Specialist Community Team</td>
<td>Provides psychological intervention to individuals and families. Provides training and supervision for clinical staff. Leads on policy development and implementation.</td>
<td></td>
</tr>
<tr>
<td>IAPT Team</td>
<td>Provides psychological intervention, support and guidance to individuals and carers.</td>
<td></td>
</tr>
<tr>
<td>Acute Home Treatment Team (AHTT)</td>
<td>Provides home treatment and crisis intervention.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Mental Health Assessment Service</td>
<td>Provides the single point of access and assessment for secondary mental health care.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Early Intervention and Psychosis Team</td>
<td>Provides early identification and treatment for young people experiencing first episode psychosis.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Assertive Outreach Team</td>
<td>Provides support to those that struggle to engage with services.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Recovery Teams</td>
<td>Provides recovery focussed community based support and psychological interventions.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Service/Team</td>
<td>Brief description</td>
<td>Joint Service</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Complex Needs Service</td>
<td>Provides assessment and treatment to those with personality disorders.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Acute In-patient Care</td>
<td>Campbell Centre – acute mental health care for adults on 38-bedded unit.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Rehabilitation Unit</td>
<td>Linden – longer term rehabilitation in a nurse led, 8-bedded unit.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Dementia Care</td>
<td>TOPAS – an acute in-patient 20 bedded facility for older people.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Memory Assessment Service</td>
<td>Provides an ageless memory assessment service.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Community Dementia Team</td>
<td>Provides assessment and commissioned care packages for people with dementia.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Day Care Services</td>
<td>Redwood – day care service for older people.</td>
<td>Budget – MK Council Managed – MKCHS</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Provides a service that consists of assessment, diagnosis and treatment of foot and lower limb disorders.</td>
<td></td>
</tr>
<tr>
<td>Musculo Skeletal Assessment Service (MSAS)</td>
<td>Provides a specialist multi-disciplinary service consisting of assessment, diagnosis and treatment for musculo-skeletal conditions.</td>
<td></td>
</tr>
<tr>
<td>Priority Dental Service</td>
<td>Provides care to vulnerable groups across county struggling to access treatment.</td>
<td></td>
</tr>
<tr>
<td>Out of Hours</td>
<td>Provides emergency care in evenings, weekends and bank-holidays.</td>
<td></td>
</tr>
<tr>
<td>Oral Health Promotion</td>
<td>Provides a public health service for children and adults.</td>
<td></td>
</tr>
<tr>
<td>Secure Settings</td>
<td>Provides dental services to HMP Woodhill.</td>
<td></td>
</tr>
<tr>
<td>Acute Occupational Therapy</td>
<td>Provides Occupational Therapy to Milton Keynes NHS Hospital Foundation Trust.</td>
<td></td>
</tr>
<tr>
<td>Community Teams</td>
<td>Provides a service which supports adults with a learning disability to remain in the community.</td>
<td>Integrated service with MK Council – section 75</td>
</tr>
<tr>
<td>Residential Unit</td>
<td>Oakwood – 6 beds for dual diagnosis mental health and learning disability medium to long term interventions.</td>
<td></td>
</tr>
<tr>
<td>Supporting People Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Breaks Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Support Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Achievement</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>1. Patient Revolution – NET Promoter Score. <strong>Indicator Weighting = 10% (£309,429).</strong></td>
<td>Partly Achieved</td>
<td></td>
</tr>
<tr>
<td>2. NHS Safety Thermometer. <strong>Indicator Weighting (based on three quarters) = 10% (£309,429).</strong></td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>3. Venous Thromboembolism (VTE). <strong>Indicator Weighting = 10% (£309,429).</strong></td>
<td>Partly achieved</td>
<td></td>
</tr>
<tr>
<td>4. National goal to improve responsiveness to the personal needs of patients. <strong>Indicator Weighting = 10% (£309,429).</strong></td>
<td>Not achieved</td>
<td></td>
</tr>
<tr>
<td>5. % of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening question. <strong>Indicator Weighting for 5a, 5b and 5c = 10% (£309,429).</strong></td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>6. Early implementation of e-prescribing. <strong>Indicator Weighting = 20% (£154,714).</strong></td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>7. Reducing Alcohol Related Admissions. <strong>Indicator Weighting = 11.25% (£87,027).</strong> 10% reduction in admissions. <strong>Indicator Weighting = 3.75% (£116,036).</strong></td>
<td>Partly achieved</td>
<td></td>
</tr>
<tr>
<td>8. Enhanced Discharge Pathway. <strong>Indicator Weighting = 15% (£464,143).</strong></td>
<td>Partly achieved</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Patient Outcome</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 1. Patient Experience        | • Friends and Family Test – roll out.  
   • Increase response rate to at least 15%.  
   • Improved Performance on the Staff Friends and Family Test. | • Rollout to A&E attendees from April 2013 and Maternity from October 2013.  
   • Increase Trust response rate from inpatients and A&E attendees.  
   • To survey Trust staff. | To capture patient feedback to enable Bedford Hospital to improve on its quality and services.                                                     |
| 2. NHS Safety Thermometer (ST) | • Data collection.  
   • Reduction in prevalence of pressure ulcers and harm from falls. | • To collect the data on the three elements of ST – Pressure ulcers, falls and urinary tract infection in patients with catheters.  
   • To reduce the prevalence of pressure ulcers by 50% from baseline and harm from falls by 10% from baseline. | To increase the proportion of patients receiving harm free care.                                                                                                                                           |
| 3. Dementia                   | • FAIR (find, assess, investigate and refer).  
   • Clinical leadership and training  
   • Supporting carers of people with dementia. | • To FAIR patients aged 75 and over following emergency admission lasting >72 hours.  
   • To have in place a named clinician for Dementia and to deliver a training programme to all Bedford Hospital staff throughout 2013/14.  
   • A monthly audit of carers of people with dementia to test whether they feel supported. | To improve the appropriate management of patients by significantly improving the quality of care for both patients and carers.                               |
| 4. Venous Thromboembolism (VTE) | • 95% risk assessments completed per month.  
   • Root Cause Analysis (RCA) on hospital-acquired VTE assessment of all adults on admission to hospital. | • VTE assessment of all adults on admission to hospital.  
   • To report through RCA on all patients who have | To reduce avoidable death, disability and chronic ill health from venous thromboembolism.                                                      |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Patient Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>thrombosis (HAT).</td>
<td>a HAT within 90 days of discharge.</td>
<td></td>
</tr>
<tr>
<td>5. Enhanced Recovery (ER)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting on the ER database.</td>
<td>● To record comprehensive information about ER patients on the national database.</td>
<td>ER programme is an evidence-based approach involving a selected number of interventions which, when implemented, demonstrate a greater impact on outcomes. It optimises the patient pre-operatively, intra-operatively and maximises post-operative care resulting in improvements in patient experience, clinical outcomes and MDT working.</td>
</tr>
<tr>
<td>Surgery performed on day of admission.</td>
<td>● Specific criteria of patients to be admitted on day of surgery.</td>
<td></td>
</tr>
<tr>
<td>Goal directed fluid therapy (GDFT)</td>
<td>● The majority of patients to receive GDFT.</td>
<td></td>
</tr>
<tr>
<td>Reduce length of stay.</td>
<td>● To reduce the length of stay within the specific criteria.</td>
<td></td>
</tr>
<tr>
<td>6. E-prescribing – 2nd year of implementation.</td>
<td>Implementation throughout the Trust for 2013/14.</td>
<td>This system can support the whole medicine use process, enabling medications to be managed electronically and will assist in the reduction of medication errors, therefore reducing the risk to patients and improving outcomes.</td>
</tr>
<tr>
<td>Paediatric Patient Experience – Implement the Friends and Family Test and achieve a 10% footfall.</td>
<td>To achieve a 10 point improvement in the Net Promoter score from 1st month’s baseline, whilst maintaining a 10% footfall throughout the year.</td>
<td>To capture timely, granular feedback from patients about their experience. Through capturing the Net Promoter score paediatrics can maintain and build on the improvements identified.</td>
</tr>
<tr>
<td>8. Improving stroke care - 90% of stroke patients spend 90% of time on Stroke Ward.</td>
<td>90% of patients at the point of a primary diagnosis of stroke to be cared for on an acute stroke unit for 90% of their stay each month.</td>
<td>By making sure a stroke patient will spend 90% of the time on a stroke unit 90% of their stay, therefore improving their access to the best possible care at all times.</td>
</tr>
<tr>
<td>9. End of Life Care.</td>
<td>Identification and utilisation of the Partnership for Excellence in Palliative Support (PEPS) service at End of Life.</td>
<td>Integrated working for all end of life care services in the area to enable patients to receive care in their place of choice.</td>
</tr>
</tbody>
</table>
Milton Keynes Community Health Services – 2012/13

Milton Keynes Community Health Services had 8 CQUINS that were set under 2 headings - Community and Mental Health.

4 of the CQUINS related to our Community Services and 4 to our Mental Health Services:

- 3 CQUINS covered both Community Services and Mental Health Services.
  - Safety Thermometer.
  - High Impact Innovations.
  - Patient Revolution - Net Promoter.
- The Community CQUIN was Long Term Conditions.
- The Mental Health CQUIN was Dementia Prescribing.

MKCHS achieved all 8 CQUINS.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Safety Thermometer</strong></td>
<td>We commenced data collection using the Patient Safety Thermometer tool in February 2012 for three areas – The Windsor Intermediate Care Unit, The Older People’s Assessment Service, and our District Nursing Service, with HMP Woodhill being included from September 2012 onwards. Our main goal in the last year has been to develop robust systems for data collection.</td>
</tr>
<tr>
<td>Data collection in relation to pressure ulcers, harm from falls, urinary tract infections in those patients with a catheter and venous thromboembolism.</td>
<td></td>
</tr>
<tr>
<td><strong>High Impact Innovations</strong></td>
<td>A steering group was established in January 2013 to oversee innovation across the organisation and this will progress the implementation of this CQUIN going forward.</td>
</tr>
<tr>
<td>During 2012/13 providers should have developed and agreed with Commissioners a plan for the implementation of the High Impact Innovations as set out in ‘Innovation, Health and Wealth’. MKCHS were required to demonstrate implementation of the High Impact Innovations relevant to them as a provider set out in ‘Innovation, Health and Wealth’.</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Revolution – Net Promoter</strong></td>
<td>The net promoter (friends and family) question has been established across all service areas and collected on a quarterly basis. The 10 point achievement was not achieved, however, due to the significant improvements in collecting the FFT data by Q4, our commissioners decided that this outweighed the 10 point improvement target set for Q1 and full payment was received for the CQUIN.</td>
</tr>
<tr>
<td>To establish a ‘net promoter (friends and family) question’ and ensure that it is used within all local patient experience / satisfaction surveys.</td>
<td></td>
</tr>
<tr>
<td>To establish a system for collating patient stories.</td>
<td></td>
</tr>
<tr>
<td>To establish a baseline net promoter (friends and family) score for each service/directorate.</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>2012/13 Achievement</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>To report quarterly to Board and Commissioner at specialty and service level, including how patient experience and stories have impacted/will impact on changes to service.</td>
<td>Achieve a 10 point improvement in net promoter (friends and family) score from quarter 1 to quarter 4.</td>
</tr>
<tr>
<td><strong>Patients with long-term conditions are identified and receive care in the most appropriate place dependent on clinical care</strong></td>
<td>Community matrons have been providing case management for over 300 patients with long term conditions who had been identified as at high risk of requiring hospital admission due to their condition.</td>
</tr>
<tr>
<td>To identify those patients with long term conditions most at risk of hospital admission. To personalise and improve the care, safety and experience for people with defined long term conditions through the use of case management and joint working across health and social care, leading to a reduction in emergency admission and readmission of patients with long term conditions.</td>
<td>A new self care plan was introduced and rolled out during the year. The aim was for all patients to have a personalised self-care plan in place by the end of quarter 4 and this was achieved in advance of the end of the quarter.</td>
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<tr>
<td></td>
<td>The target was to have no more than 225 patients on the community matron’s caseload admitted to hospital as an emergency by the end of March 2013. At the end of quarter three, 169 patients had been admitted to hospital.</td>
</tr>
<tr>
<td></td>
<td>In addition, the target for attendances at A&amp;E for patients on the community matron caseload was no more than 137. At the end of quarter 3 this was 103.</td>
</tr>
<tr>
<td></td>
<td>These have been challenging targets and achievement has been supported through a range of activity within the service such as reviewing oxygen requirement and provision, checking inhaler techniques, medication reviews, use of telehealth to monitor and respond during an acute exacerbation of a condition, linking with other services and agencies to ensure the right level of support is provided to address individual needs and concerns.</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td><strong>Prescribing Guidance:</strong> Guarantee appropriate prescribing of antipsychotic medication for people with dementia and behavioural and</td>
</tr>
<tr>
<td></td>
<td>Developed and gained approval for antipsychotic medication process in line with national guidelines for use in the treatment of dementia and BPSD.</td>
</tr>
<tr>
<td></td>
<td>All new prescribing is in accordance with</td>
</tr>
<tr>
<td>Indicator</td>
<td>2012/13 Achievement</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>psychological symptoms of dementia (BPSD) through the development and</td>
<td>new guidance.</td>
</tr>
<tr>
<td>implementation of best practice prescribing guidance.</td>
<td>An initial checklist is completed for all patients.</td>
</tr>
<tr>
<td><strong>Discharge Planning:</strong></td>
<td>All patients who are prescribed antipsychotic medication are reviewed on a</td>
</tr>
<tr>
<td>Embed good practice in the discharge of patients with dementia and BPSD</td>
<td>12 weekly timeframe.</td>
</tr>
<tr>
<td>who are prescribed antipsychotic medication through the development and</td>
<td>Patients prescribing audit was completed and submitted within the requested</td>
</tr>
<tr>
<td>implementation of discharge processes that lead to routine/timely review</td>
<td>timeframe.</td>
</tr>
<tr>
<td>of antipsychotic medications.</td>
<td></td>
</tr>
<tr>
<td>Prescribing review 1 – Review all current prescribing of antipsychotic</td>
<td></td>
</tr>
<tr>
<td>medications in patients with dementia and BPSD.</td>
<td></td>
</tr>
<tr>
<td>Prescribing review 2 – Review antipsychotic prescribing patterns within</td>
<td></td>
</tr>
<tr>
<td>older people’s mental health unit in patients with dementia and BPSD.</td>
<td></td>
</tr>
</tbody>
</table>
### Annex 3 - Glossary

<table>
<thead>
<tr>
<th><strong>Adverse event</strong></th>
<th>An event that is not anticipated or not known to be related to the person's condition or the intervention being used. Adverse events include near misses.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTT</strong></td>
<td>Aseptic Non-Touch Technique is a practice framework with a clear infection prevention aim of asepsis for all invasive clinical procedures.</td>
</tr>
<tr>
<td><strong>ASCAT</strong></td>
<td>Adult Social Care Access Team - a local team that deals with Safeguarding Adults Alerts.</td>
</tr>
<tr>
<td><strong>ASTI</strong></td>
<td>The Assessment and Short Term Intervention Team (ASTI) is a community based assessment and short-term intervention team which supports individuals aged 18 and over, who have a presentation of severe and/or enduring mental illness. The ASTI service provides an ageless single point of access to the mental health service.</td>
</tr>
<tr>
<td><strong>Clostridium difficile</strong></td>
<td><em>Clostridium difficile</em> (C. difficile) is a bacterium (germ). It lives harmlessly in the gut of many people. Infection with Clostridium difficile most commonly occurs in people who have recently had a course of antibiotics and are in hospital. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel. No treatment may be needed in mild cases except drinking plenty of fluids. However, treatment with specific antibiotics is needed in more severe cases.</td>
</tr>
<tr>
<td><strong>Complaint</strong></td>
<td>An expression of dissatisfaction with something. This can relate to any aspect of a person’s care, treatment or support and can be expressed orally or in writing.</td>
</tr>
<tr>
<td><strong>CQC</strong></td>
<td>The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes. Part of the Commission's remit is protecting the interests of people whose rights have been restricted under the Mental Health Act.</td>
</tr>
<tr>
<td><strong>CQUIN</strong></td>
<td>Commissioning for Quality and Innovation (CQUIN) payment framework. The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion everywhere.</td>
</tr>
<tr>
<td><strong>Discharge</strong></td>
<td>The point at which a patient leaves hospital to return home or be transferred to another service or formal conclusion of a service provided to a person who uses the service.</td>
</tr>
<tr>
<td><strong>End of life</strong></td>
<td>The last phase of a person’s life, when a judgement has been made by an appropriately qualified person that the person has an advanced, progressive, incurable illness, or that the person's death is imminent.</td>
</tr>
<tr>
<td><strong>End of life care</strong> covers the management of pain and other symptoms, and the provision of psychological, social, spiritual and practical support, and support for the family into bereavement.</td>
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</tr>
<tr>
<td><strong>FAIR</strong></td>
<td>A systematic pathway to identify patients with dementia and cognitive impairment which gives an opportunity for better management. It has 3 parts - Find, Assess and Investigate, Refer.</td>
</tr>
<tr>
<td><strong>FFT</strong></td>
<td>The Friends and Family Test: Patients are asked a simple question to identify if they would recommend a particular A&amp;E department or ward to their friends and family. The results of this friends and family test are used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback.</td>
</tr>
<tr>
<td><strong>HCAI</strong></td>
<td>Healthcare Acquired Infection: An infection that is acquired as a result of a healthcare intervention.</td>
</tr>
<tr>
<td><strong>IPS</strong></td>
<td>The Infection Prevention Society whose mission is to inform promote and sustain expert infection prevention policy and practice in the pursuit of patient or service user and staff safety wherever care is delivered.</td>
</tr>
<tr>
<td><strong>MCA</strong></td>
<td>The Mental Capacity Act 2005 (MCA) creates a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. The MCA came into force on 1 October 2007. It is supported by a Code of Practice.</td>
</tr>
<tr>
<td><strong>MRSA</strong></td>
<td>Meticillin Resistant <em>Staphylococcus Aureus</em>: There are many strains of this bacteria, but it is shorthand for any strain of <em>S. aureus</em> that is resistant to one or more conventional antibiotics. MRSA is one example of the Staphylococcus family of common bacteria. Many people naturally carry it in their throat or nose and on their skin, and it can cause a mild infection such as pimples and impetigo in a healthy patient. Occasionally, Staphylococcus can get through the skin and cause serious infection elsewhere in the body such as sepsis (blood infection), pneumonia and endocarditis.</td>
</tr>
<tr>
<td><strong>MUST</strong></td>
<td>Malnutrition Universal Screening Tool: ‘MUST’ is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.</td>
</tr>
<tr>
<td><strong>NICE</strong></td>
<td>National Institute for Health and Clinical Excellence. NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.</td>
</tr>
<tr>
<td><strong>PAR</strong></td>
<td>A ‘Patient At Risk’ score is a calculated ‘Early Warning Score’ based on the patient’s observations. Our specialist ‘Patient At Risk’ team can be called to provide specialist care for patients with high PAR scores.</td>
</tr>
</tbody>
</table>
Pressure ulcers

Pressure ulcers are also known as pressure sores, or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases, the underlying muscle and bone can also be damaged. People who are unable to move some or all of their body due to illness, paralysis or advanced age often develop pressure ulcers.

PROMs

Patient Reported Outcome Measures assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. The four procedures are:

- groin hernia
- varicose veins
- hip replacements
- knee replacements

PROMs have been collected by all providers of NHS-funded care since April 2009. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires.

RAIT

Rapid Assessment and Intervention Team is an integrated multi-disciplinary community team providing a rapid assessment service at the interface between home and hospital.

SAAF

Safeguarding Adults self-assessment and Assurance Framework supports health services to meet safeguarding adults responsibilities and achieve improved outcomes.

SAAG

The Safeguarding Adults Advisory Group, which includes stakeholders from health and social care professionals and providers from both public and independent sectors, provides advice and feedback on adult safeguarding policy.

SHMI

Summary Hospital-level Mortality Index measures whether the hospitals death rate was in line with expectations.

Stroke

A stroke is a brain injury caused by sudden interruption of blood flow. A stroke is what happens when the blood supply to part of the brain is cut off. Blood carries essential nutrients and oxygen to the brain. Without a blood supply, brain cells can be damaged or destroyed and won’t be able to do their job.

TPN

Total Parenteral Nutrition is a way of supplying all the nutritional needs of the body by bypassing the digestive system and giving the nutrient solution directly into a vein.

UTI

Urinary Tract Infection which develops when part of the urinary tract becomes infected, usually by bacteria.

Venous Thromboembolism

A venous thromboembolism is a blood clot that forms in a vein. Venous thromboembolism is the one of the commonest cause of avoidable death in our hospitals.

WanderGuard

An alert system providing easy-to-use and effective protection for vulnerable, wandering patients.
This section will provide statements in two parts. The first set of statements will relate to Bedford Hospital the second set of statements will relate to Milton Keynes Community Health Services.

Annex 4 - Statements from Clinical Commissioning Groups, Local Healthwatch Organisations and the Overview and Scrutiny Committee for Bedford Hospital
Statement from Bedfordshire Clinical Commissioning Group to Bedford Hospital NHS Trust Quality Account 2012 – 2013

Bedfordshire Clinical Commissioning Group has received the Quality Account 2012/2013 from Bedford Hospital NHS Trust. The Quality Account was shared with Bedford Clinical Commissioning Group, Non-executives, Executive Directors, Performance, Quality and Safety Team and reviewed at the Patient Safety and Quality Committee as part of developing our assurance statement.

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account which was submitted as part of the Trust's contractual obligation. All data provided corresponds with data used as part of the on-going contract monitoring process.

Bedford Hospital is required to include Trust performance against national quality indicators. The Trust has included this data. Improvements are required in some areas such as the Friends and Family Test (Net Promoter score) and the rate of patient safety incidents per 100 admissions. Bedford Hospital NHS Trust have stated that they aim to increase the Friends and Family Test by 2.5 points. Bedfordshire Clinical Commissioning Group are disappointed that the Trust have not considered improving this to a higher level. The rate of patient safety incidents for March 2013 is 4.7 (rate of patient safety incidents per 100 admissions) and this is in the lowest quartile of similar hospitals, but is an improvement from March 2012 which was 4.2. We will continue to monitor progress in 2013/14 as significant improvements are still required to achieve an acceptable standard.

Bedfordshire Commissioning Group acknowledges the intended improvements to the care of patients in the first 24 hours mentioned in the account but would like to see information about sustained improvements to the patient emergency pathway. We note there is no description around stroke care; we look forward to working with the Trust to improve the quality of stroke services.

Bedfordshire Commissioning Group note that Bedford Hospital Trust achieved only 66% of 2012/13 CQUIN (Commissioning for Quality and Innovation). Significant improvements were made in relation to Dementia screening of their patients and onward referral, but further work is required in 2013/14 to improve patient experience feedback.

It is recognised that the national inpatient survey identifies some areas for improvement which have been included within the quality account and will be monitored closely via the regular clinical quality review meetings.

We welcome the Trust's commitment to participation in national and local audits and we will continue to support the Trust to ensure that their services use the outcomes of these audits to drive further quality improvements. We would support inclusion of audits to assess achievement against the performance of 2013/14 priority reduction in variation in clinical care.

better care, better value, better health
Annex 4.2 - Statement from Healthwatch Organisation

Healthwatch Bedford Borough

The Board of Health watch Bedford Borough have considered the draft QA and have no specific comments to add.

Healthwatch Central Bedfordshire

Healthwatch Central Bedfordshire Response to the Bedford Hospital NHS Trust Quality Account 2012/13 16 May 2013

Firstly, Healthwatch Central Bedfordshire would like to thank Bedford Hospital NHS Trust for giving us the opportunity to comment on its Quality Account document.

It is important to point out that Healthwatch is a newly established independent consumer champion which came into being on 1st April 2013. We are therefore basing our comments on the legacy work of our predecessors, Bedfordshire Local Involvement Network (LINk) (covering Central Bedfordshire) who held office until 31st March 2013.

The Account for the Hospital is a well presented and a very readable document. For the lay reader, the document would benefit from a glossary of acronyms and an explanation of the clinical terms used.

Our focus and experience is from the perspective of the patients' and public's experience of the care they receive from the Trust, so can only comment on this aspect. It is heartening to read that the three outcomes to improve patient experience, patient safety and clinical effectiveness is progressing successfully and that there is continuous monitoring of these areas. In terms of information held from the LINk legacy, the hospital has been complimented on its attention to the hydration and nutrition of patients, so we commend the Hospital on this aspect.

The safe discharge of patients from hospital has been a particular and enduring concern of our predecessor organisation, and we are pleased to read under Part 3 of your Review of Quality Performance 2012/13 that a focus is being made on a co-ordinated discharge pathway and a check made on patients 24 hours after discharge to check that everything is as planned.

There are some excellent initiatives underway or proposed in this section of the Quality Account, in particular with regard to creating a positive patient and carer experience. The Carers Lounge at the Bedford Hospital has been particularly welcomed by patients and carers, and we look forward to similar provision at other hospitals used by Central Bedfordshire residents.

In conclusion, Healthwatch Central Bedfordshire is aware of the huge pressure being placed on the health service in general to make savings, but it is pleasing to see and hear about the continuous improvements being made at Bedford Hospital.

Ruth Featherstone
Chair, Healthwatch Central Bedfordshire
Annex 4.3 - Statement from Bedford Overview and Scrutiny Committee

That the Committee makes the following comment for the Bedford Hospital Quality Account 2012/13:

During 2012/13 the Bedford Borough Council Adult Services and Health Overview and Scrutiny Committee invited Bedford Hospital to two meetings to discuss:

- Hospital processes for discharging patients,
- Foundation Trust status.

At the Committee’s meeting of 16th April 2013, the Committee considered Bedford Hospital’s Draft Quality Account for 2012/13. The Committee agreed that the Hospital’s priorities matched those of the public and that no major issues had been omitted. The Committee was also satisfied that the Hospital had involved patients and the public in producing the Quality Account.

In addition, the Committee asked that in future the Quality Account should look more fully at the patient’s whole care pathway from first contact with health services, such as when an ambulance arrives before taking a patient to hospital.

The Committee also praised the success in dementia care, the introduction of 7-day cover by matrons, processes for good nutrition and hydration, and measures to ensure dignity at the end of life.

The Chair thanked the NHS representatives for their attendance and participation in the discussion.

"Bedford Borough Council - Working with our partners to make the borough a better place to live, work and visit."
Annex 4.4 - Statement from Central Beds Health Scrutiny Committee

No comments received from the Committee.
Annex 5 - Statements from Clinical Commissioning Groups, Local Healthwatch Organisations and the Overview and Scrutiny Committee for Milton Keynes Community Health Services
Annex 5.1 - Statement from Milton Keynes Clinical Commissioning Group

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MK3 6RT

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Fax: 01908 278663
Jill.Wilkinson1@miltonkeynes.nhs.uk
www.miltonkeynesccg.nhs.uk

22 May 2013

Cathy Walker
Managing Director
Milton Keynes Community Health Services
Hospital Campus
Standing Way
Eaglestone
Milton Keynes
MK6 5NG

Dear Cathy

Thank you for forwarding a copy of the Quality Account for Milton Keynes Community Health Services (MKCHS) to the Milton Keynes CCG.

The CCG can confirm that the information in the Quality Account is accurate and fairly interpreted, and that the range of services described is representative.

The document describes achievements in 2012/13 including:

1. Improvements in transfer of care to support people to stay and home or for those admitted to hospital to be transferred home as quickly as possible. Successful initiatives include establishment of a home to stay team, development of the Rapid Access and Intervention Team, support for intravenous treatment, support for end of life care, diabetic specialist team and community matrons and telecare;
2. Improvement in infection prevention and control resulting in an overall cleanliness score of 91.6% against a target of 88.6%;
3. PEAT scores in the Campbell centre, the Older Peoples Assessment Service and the Windsor Intermediate Care Unit in line with national average comparators. The dignity and privacy score remained excellent across all three sites;
4. Improvements in safeguarding adults arrangement including training and incident monitoring;
5. Strengthening of advice available for staff in relation to safeguarding children;
6. Above average staff survey results with overall staff engagement score being one of the best in the country;
7. The roll out of the patient thermometer tool across all relevant community services resulting in a steady and continuous decrease of harm from pressure ulcers and falls;

All CQUIN’s were achieved and details of participation in national and local clinical audits included. The hard work and commitment this achievement represents is to be commended.

The CCG fully supports the priorities for improvement for 2103/14 including:

1. Improving patient safety through ensuring safe transfer of care by working in partnership with local health and social care providers to reduce the number of care incidents and the potential for preventable harm;
2. Improving clinical effectiveness through achievement of zero avoidable pressure ulcers;
3. Improving patient experience by prioritising responsiveness to patient’s needs. The impact will be measured by exceeding the national average score on the CQC national inpatient survey for the MKCHS Mental Health Services; achieving the friends and family test across all services and achieving a year end position within the top 50% of the national result; and improving on the 2012 national staff survey result.

The CCG welcomes the opportunity to work collaboratively with MKCHS and further strengthen the relationship to support continuous improvement in quality of care provided to patients. We are confident that MKCHS will continue to deliver improvements in quality for all patients who access services.

Yours sincerely

[Signature]

Jill Wilkinson
Director of Quality and Safeguarding
Milton Keynes Clinical Commissioning Group
3. Milton Keynes Community Health Service

Ruth Weetman, Operational Director Patient Safety and Standards/DIPC at Milton Keynes Community Health Service, attended the meeting and was able to clarify or comment upon some of the issues raised by the Panel.

Ms Weetman advised the Panel that the draft Quality Account was currently out for consultation. A full glossary had not been included in the draft but would be included in the final version.

She was also aware of some presentation issues which would be tidied up before the final version was published.

Having scrutinised the Account, the Panel then commented specifically on the following points:

- On page 7 reference was made to the Milton Keynes Safeguarding Adults Board. The Panel felt that the Account needed to be clear that the Safeguarding Adults Board did not adopt strategy itself, but was there to advise other organisations on how to develop their own strategies;

- The Panel thought that for clarity, more information on the transfer to the Central North West London (CNWL) NHS Foundation Trust would have been helpful but acknowledged the Quality Account covered the period prior to the transfer on 1 April 2013 and that there would be more information about the transfer in the 2013-14 Account;

- The Community Health Service saw the Transfer of Care as the start of a journey. It was a big issue in Milton Keynes and had been for a number of years. Due to the large remit it covered it continued to be a priority for the Community Health Service and included a current discussion of community based care and the use of personal health budgets;

- The Healthwatch representative commented that Healthwatch received a lot of queries about the transfer of care and the priority given to it by the hospital. Ms Weetman agreed that the transfer of care process was not as good as it should be in Milton Keynes and that hopefully, by treating this as a priority issue, a marked improvement would be seen by the end of the year;
The Panel noted what appeared to be a lack of involvement in clinical audits during 2012-13. Ms Weetman agreed that the Community Health Service had struggled with these in the past year although it should be noted that clinical audits did not have to be carried out every year. She acknowledged that they had not done as many during the year as they would have liked and will ensure that the issue is addressed in the future;

- The Panel noted with approval that the spend on home based care was rising whilst the spend on hospital based care was going down. It was hoped that there would be a sustained investment in home care across the health service in the future;

- The Panel expressed concern as to whether the Community Health Service was in a strong enough position to deal with mental health issues in Milton Keynes and whether enough was known about the services provided at the Campbell Centre. Ms Weetman felt that following the transfer to CNWL the Community Health Service was now in a very good position to deal effectively with the provision of mental health care in Milton Keynes;

- The Panel recommended that the Director included a brief statement about the work being done / services provided by the Campbell Centre in her introduction in order to re-assure the general reader;

- In the Director’s introduction “the Health And Community Wellbeing Select Committee” should be changed to read “the Health and Adult Social Care Select Committee”;

- Once again the section in the Quality Account dealing with the patient experience was deemed to be excellent.

The Panel’s final assessment was that based on last year’s successful format, this was a very thorough account which contained all the information about the Milton Keynes Community Health Service anyone was likely to need. It was a readable Account which would be understood and appreciated by the general reader.
Annex 5.3 – Statement from Healthwatch Organisation

Healthwatch Milton Keynes (formerly LINK:MK) welcomes the opportunity to review and comment on the Milton Keynes Community Health Services Quality Accounts for 2012/13.

We would like to acknowledge the efforts of Milton Keynes Community Health Service in producing a comprehensive, open and wide ranging report on Quality Accounts as well as take this opportunity to thank them for involving LINK:MK and its members in its work for that year. The document is clear and comprehensive, but may have benefitted from the inclusion of information on how Central North West London will bring expertise that will enhance the efforts of MKCHS in the coming year, particularly as LINK:MK Executive Committee Members had involvement in the tendering and procurement process.

LINK:MK enabled the voice of the patients and the public to be heard and taken into account in the design and delivery of health and social care services and will continue to do so as Healthwatch Milton Keynes, the new independent consumer champion for health and social care. We are pleased to note that Patient Experience once again been prioritised by MKCHS, relying on feedback from service users to help make service improvements and patient satisfaction. We are also pleased to note the inclusion of Transfer of Care, underlining a commitment to multi-agency working to improve an area that has been of concern to Healthwatch Milton Keynes, which we have worked on throughout the previous year with MKCHS.

Healthwatch Milton Keynes wishes to congratulate MKCHS on the “Access to Services” project undertaken in a number of services last year as a result of LINK:MK issues, and for involving LINK:MK members in the practical part of that project. Healthwatch Milton Keynes would have liked to have seen this included in the Quality Accounts.

MKCHS Quality Accounts shows dedication in involving patients and the public in the design, development and delivery of health and social care services including continuous efforts in making service improvements. We are equally committed in extending our help and support to MKCHS in the future to enable the citizens of Milton Keynes to participate and influence the commissioning and delivery pathways across all of their services and look forward to receiving and reviewing a local report next year.

May 2013

www.healthwatchmiltonkeynes.co.uk
INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF
THE BEDFORD HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are engaged by the Audit Commission to perform an independent assurance engagement in respect of Bedford Hospital NHS Trust’s Quality Account for the year ended 31 March 2013 (“the Quality Account”) and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (“the Act”). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death (pages 66 to 67 and 72 to 74); and
- Rate of Clostridium Difficile infections (pages 64 and 71).

We refer to these two indicators collectively as “the specified indicators”.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.
The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the information requirements prescribed in the Schedule referred to in Section four of the Regulations (“the Schedule”);
- the Quality Account is not consistent in all material respects with the sources specified below; and
- the specified indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account have not been prepared in all material respects in accordance with Section 10c of the NHS (Quality Accounts) Amendment Regulations 2012 and the six dimensions of data quality set out in the NHS Quality Accounts - Auditor Guidance 2012/13 issued by the Audit Commission in April 2013 (“the Guidance”).

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 and up to the date of signing the limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period;
- Feedback from Bedfordshire Clinical Commissioning Group received 21 May;
- Feedback from Milton Keynes Clinical Commissioning Group dated May 2013 and received 19 May 2013;
- Feedback from local Healthwatch organisations Healthwatch Bedford Borough and Healthwatch Central Bedfordshire both dated 16 May 2013;
- Feedback from Healthwatch Milton Keynes dated May 2013 and received 29 May 2013;
- Feedback from Bedford Borough Council Overview and Scrutiny Committee at its meeting held 16 April 2013;
- Feedback from Milton Keynes Council, Health and Adult Care Select Committee at its meeting 7 May 2013;
- Complaints annual update presented to the Quality Board on 13 May 2013;
- Milton Keynes Community Health Services, Annual Complaints Report 2012/13;
- Care Quality Commission (CQC) Patient Survey report 2012 - Survey of adult inpatients, Bedford Hospital NHS Trust, published April 2013;
- CQC Accident and Emergency survey report 2012 - Bedford Hospital NHS Trust, published December 2012;
- CQC Community Mental Health Survey 2012 - Milton Keynes PCT;
- 2012 National NHS Staff Survey - Results from Bedford Hospital NHS Trust;
• 2012 National NHS Staff Survey - Brief summary of results from Milton Keynes Community Health Services;

• Annual Governance Statement (AGS);


• Internal Audit Annual Report, year ended 31 March 2013 (encompassing the Head of Internal Audit’s opinion over the NHS Trust’s control environment), presented to the Audit Committee on 28 May 2013;

• Milton Keynes Community Health Services, Internal Audit Annual Report - Year ended 31 March 2013, presented to the Audit Committee meeting of May 2013;


• CQC Inspection Report on the Campbell Centre published 9 November 2012; and


We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Bedford Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Bedford Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with the Guidance. Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

• making enquiries of management;

• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

• comparing the content of the Quality Account to the requirements of the Regulations; and

• reading the documents.
A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the Schedule set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Bedford Hospital NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the requirements of the Regulations and the prescribed information in the Schedule;
- the Quality Account is not consistent in all material respects with the sources specified above; and
- the specified indicators in the Quality Account subject to limited assurance have not been prepared in all material respects in accordance with the Section 10c of the NHS (Quality Accounts) Amendment Regulations 2012 and the six dimensions of data quality set out in the Guidance.

PricewaterhouseCoopers LLP Chartered Accountants
St Albans
26 June 2013
Annex 7 - Statement of Directors’ responsibilities in respect of the quality account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012)).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chair

Date 25 June 2013

Chief Executive

Date 25th June 2013