Bedfordshire Hospitals
NHS Foundation Trust

Quality Account

2023/24

CONTENTS

ONE: What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an **annual Quality Account**. This is a report that informs the public about the quality of the services that we deliver. They are published annually and are available to the public.

Quality Accounts aim to increase public accountability and drive quality improvement. They do this by requiring organisations to review their performance over the previous year, publish their performance and identify areas for improvement. Quality accounts will also inform you about how an organisation will make those improvements and how they will be measured.

A review of our quality of services for 2023/24 is included in this account alongside our priorities and goals for quality improvement in 2024/25 and how we intend to achieve them.

How the 'quality' of the services provided is defined?
We have measured the quality of the services we provide by looking at:

- Patient safety
- The effectiveness of treatments that patients receive
- How patients experience the care they receive

About our Quality Account

This report is divided into sections.

- A statement on quality from the Chief Executive and sets out our corporate objectives for the coming year.

- Our performance in 2023/24 against the priorities that we set for patient safety, clinical effectiveness and patient experience.

- Our quality priorities and goals for 2024/25 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.

- Statements related to the quality of services that we have provided and includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.

- Our quality performance and includes performance against national priorities and local indicators. It also provides examples of how we have improved services for patients.

- A statement of Directors' responsibility in respect of the quality account.

- Comments from our external stakeholders.

PERFORMANCE ANALYSIS

Principal activities of the Trust

Bedfordshire Hospitals NHS Foundation Trust is a large general hospital across two sites, Luton and Dunstable University Hospital and Bedford Hospital.

The Trust has approximately 1,100 overnight inpatient beds (excluding contingency beds, Labour/Delivery wards/Day wards) across the two sites and provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 190,000 (including day cases) admitted patients, over 794,000 outpatient attendances and over 188,000 Type 1 Emergency Department attendees (over 285,000 including Type 3 attendances) and we delivered 8,000 babies.

All inpatient services and most outpatient services are provided on the Luton and Dunstable Hospital and Bedford Hospital sites. The Trust provides community musculo-skeletal services (MSK) at three locations across the catchment area, including our Orthopaedic Centre situated further along Dunstable Road and chronic obstructive pulmonary disease (COPD) and Diabetes services for South Bedfordshire. Outreach clinics for phlebotomy and therapies are also sited at the North Wing site in Bedford.

We serve a diverse population across Luton, Central Bedfordshire and Bedford Borough. This year, information from the 2021 Census is available across all three boroughs:

Luton

- The population of Luton is 225,300, which is an increase of 22,200 people since the last Census. This is an 11 per cent increase in population. Nationally the population increased by 6 per cent over the last decade.
- Luton has a younger than average population.
- There are 78,900 households in Luton, an increase of 6 per cent between 2011 and 2021. In comparison population growth was 11 per cent indicating that Luton is becoming more overcrowded.
- The population of Luton now has a non-white majority with 54.8 per cent of the population being non-white.
- Luton is one of four authorities outside of London with the majority of the population being from ethnic minority groups. Slough has the largest non-white population at 64.1 per cent with Leicester at 59.1 per cent, Birmingham also having an ethnic minority majority of 51.4 per cent of the population.
- White British make up 31.8 per cent of the population of Luton compared with 74.4 per cent nationally.
- The percentage of people with English as their first language in Luton is 76.5 per cent, which is one of the smallest proportions in the country.
- Of the population of Luton, 74.9 per cent have a UK identity compared with 88 per cent nationally.
- The number of people reporting as Christian is still the largest group in Luton but the number of Christians fell by 11.4 per cent from 96,271 in 2011 to 85,297 in 2021.
- The numbers of Muslims increased from 49,991 to 74,191 in the last decade, an increase of 48.4 per cent.

Central Bedfordshire

- The population size has increased by 15.7% to 294,200 in 2021. This is higher than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.
- The average (median) age of Central Bedfordshire increased by one year, from 40 to 41 years of age.

- Around 254,700 Central Bedfordshire residents said they were born in England.
- 42.8% of Central Bedfordshire residents reported having "No religion", up from 28.4% in 2011
- 47.9% of people in Central Bedfordshire described themselves as Christian (down from 62.2%)
- 49.4% of Central Bedfordshire residents described their health as "very good", increasing from 47.2% in 2011
- 5.8% of Central Bedfordshire residents were identified as being disabled. This figure decreased from 6.9% in 2011.
- 90.2% of people in Central Bedfordshire identified their ethnic group within the "White" category (compared with 93.8% in 2011)

Bedford Borough

- The population of Bedford increased by 17.6%, from around 157,500 in 2011 to around 185,200 in 2021.
- This means Bedford's population saw the largest percentage increase in the East of England. The population of the East of England increased by 8.3%, while the population of England rose by 6.6%.
- Bedford was home to around 2.8 people per football pitch-sized piece of land, compared with 2.4 in 2011. This area was among the lowest 40% for population density across English local authority areas at the last census.
- The average (median) age remained 39 years in Bedford between the last two censuses.
- The percentage who were employed rose from 58.1% in 2011 to 59.7% in 2021.
- 34.1% of Bedford residents reported having "No religion", up from 23.6% in 2011.
- 47.6% of people in Bedford described themselves as Christian (down from 59.3%), while 7.1% described themselves as Muslim (up from 5.5% the decade before).
- 12.8% of Bedford residents did not identify with any national identity associated with the UK. This figure increased from 11.2% in 2011.
- 6.6% of Bedford residents were identified as being disabled and limited a lot. This figure decreased from 7.9% in 2011.
- 74% of people in Central Bedfordshire identified their ethnic group within the "White" category (compared with 93.8% in 2011).

The Trust has developed a range of specialist services including cancer, obesity, neurophysiology and oral maxillofacial (jaw) surgery. We have the responsibility for treating the most premature and critically ill newborn babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

Specialties	
Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine Respiratory Medicine Diabetes and Endocrinology Gastroenterology	Cardiology Dermatology Heptology Neurology Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
General Surgery - Colorectal - Upper Gastrointestinal - Vascular	Plastic Surgery ENT Cancer Services Medical Oncology

Specialties	
- Bariatric Surgery	Ophthalmology
Urology	Oral & Maxillofacial Surgery
Paediatric Surgery Trauma & Orthopaedic Hospital at Home Critical Care	Anaesthetics Pain Management Orthodontics Audiology
Obstetrics Community Midwifery Early Pregnancy General Gynaecology Gynae-oncology	Paediatrics Fertility Neonatal Intensive Care Unit Uro-gynaecology Ambulatory Gynaecology
Pathology Services - Blood Sciences - Cellular Pathology - Microbiology - Phlebotomy Haematology Care Pharmacy Physiotherapy and Occupational Therapy	Imaging Musculoskeletal Services Dietetics Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2023/24 the Clinical Service Line Clinical Directors, General Managers and Lead Nurses and Executive Directors met in the Executive Review Meetings to maintain clinical accountability at specialty level. The Chief Nurse met with Care Units to oversee ward quality and performance.

A suite of oversight cross cutting boards are in place to ensure that there is development and learning across service lines when required.

Statement on Quality from the Chief Executive

Welcome to Bedfordshire Hospital NHS Foundation Trust's quality account for 2023/24.

The quality account gives us the opportunity to review what we have been doing to improve the quality of care we provide. Within this document, we set out our priorities for improvement in 2024/25 and review our progress against the priorities we set out in the 2023/24 quality account.

Within our Quality Account, you can read all about some of the improvements staff have made and those we are yet to make, and I hope this captures the caring spirit of the staff at Bedfordshire Hospitals and their ongoing commitment to quality improvement.

Last year we had an ambitious set of Quality Initiatives and I am particularly proud of the work that has taken place across many of our staff groups.

One of the most significant changes has been the implementation of the Patient Safety Incident Response Framework in line with the National Patient Safety Strategy. This initiative is seeing a substantial change in the way the Trust deals with those incidents where things have not gone as well as we hoped.

Use of the framework has allowed a deeper understanding of areas across the Trust where we can make improvements as well as providing a clear focus on learning opportunities and ensuring a positive culture and a wider system analysis in reviewing safety events.

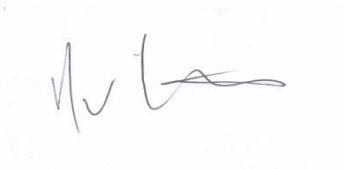
Looking forward to 2024/25 we look to maintain this focus on improvement and learning and in doing so have employed Patient Safety Partners to work alongside Trust staff to ensure that in doing so the voice of the patient is central to this activity.

We also continue the work started in previous years to support the health and wellbeing of our staff. As part of this we will have a focus on Equality and Diversity throughout the year and to support this have strengthened our resource to support and enhance the work underway.

Operational performance still remains, as for many Trusts, an ongoing challenge in several key areas of Trust activity. I was however very proud of the commitment and diligence of our staff in their efforts to support reduction of our long waits within cancer services, reducing the 62 day pathway backlog and improving Faster Diagnosis standards in December 2023 which led to recognition by the national NHS Cancer Programme.

We head into 2024/25 in a challenging operational and financial national context, but take significant optimism from the progress we made in 2023/24 and the strength of our partnerships, with our system colleagues, external partners, and with our local community.

In conclusion I want to express my thanks to all our staff, volunteers, patients and our stakeholders: thank you for everything you do. Your commitment and compassion has helped us deliver the very best care and services we can to our patients and I am extremely proud of all that we have achieved together and look forward to working collaboratively in the coming year.



David Carter
Chief Executive Officer

Corporate Objectives 2024/25

The Trust's Strategy is underpinned by a set of annual Corporate Objectives and supported by principles so that each objective has:

- Targets and deliverables
- Oversight through the current governance structures
- Risks to achievement are reviewed through the Board Assurance Framework
- Taken account of three golden threads of ***Quality and Patient Experience, Sustainability, Equality/Health Inequalities***

The Board has an agreed delivery framework to oversee the objectives, targets and deliverables associated with the strategic pillars.

The Trust's Strategic and Operational Plans are underpinned by 10 Corporate Objectives - below:

Objective 2024/25	Overview	Strategic Priority / Delivery Work stream
1. To strengthen the capacity, capabilities and health and wellbeing of our workforce to lead the organisation, to deliver high quality, cost-effective services and to play an impactful role in improving the health of the populations we serve	To establish the conditions and to create and maintain the culture, that attracts people, especially those from our local communities, to become, and to remain, valued respected and impactful employees and/or volunteers of our Trust. Health and wellbeing, integration, education and training and engaging with the workforce of the future through work experience and the Health Care Academy will continue to be a priority. This will also further embed the THRIVE values throughout the Trust.	Workforce and Culture Workforce/ Attractiveness
2. To bring about a step improvement in the condition, functionality and sustainability of the physical facilities from which we deliver our services, thereby also significantly reducing the risk that the poor condition of some of our existing facilities undermines our ability to provide high quality services	To sustainably create the physical conditions that enable our services and the staff that deliver these services to maximise their individual and collective potential. There is recognition of the need to be agile to be able to respond to the centre when capital becomes available. The site planning will have close links to the Clinical Strategy. Backlog maintenance is an increasing risk and a prioritisation exercise will the undertaken to develop an investment strategy.	Infrastructure One Health Estate Redevelopment Board/ Finance and Investment Performance Committee
3. To bring about a step-improvement in the digital capabilities that support our workforce	To sustainably create the digital conditions that enable our services and the staff that deliver these services to maximise their individual and collective potential	Infrastructure Digital

Objective 2024/25	Overview	Strategic Priority / Delivery Work stream
and which enable our patients, our service users, our service delivery partners and our wider populations to engage effectively with the Trust and its services	Digital underpins all elements of the Trust's objectives. The aim is to deliver the Digital Strategy, so that the Trust benefits from improved resilience, greater levels of digital maturity and integration.	
4. To operate productively and cost-effectively so that we achieve our financial plans	To sustainably create the financial conditions that enable our services and the staff that deliver these services to maximise their individual and collective potential. The Trust has a challenging financial agenda and this objective includes budget reviews, CDEL limits, oversight of the redevelopment costs and ongoing financial position.	All Current governance Service Lines, Finance and Investment Performance Committee
5. To recover service performance standards, as a minimum so they meet national standards, following the debilitating effects of the pandemic and industrial action	To provide clinical services that are demonstrably excellent and which are highly valued by well-engaged users/patients This will focus on the targets and priorities outlined in the 2024/25 operational planning guidance and the Trust Quality Priorities 2024/25. Work will also be undertaken to review the current data sets and information provision to work towards an integrated performance dashboard for service lines and reporting up to the Board. The Trust is also required to implement the National Patient Safety Strategy.	All Current governance Service Lines, Clinical Quality Operational Board, Quality Committee
6. To further integrate services we deliver by building on the individual and collective clinical strengths of both of our hospitals and our associated facilities	To provide clinical services that are demonstrably excellent and which are highly valued by well-engaged users/patients A programme of work is being undertaken to track the delivery of the Clinical Service Line Strategies, further develop integration and inform transformation projects.	Our portfolio of hospital services Directions Programme
7. To play a leading role to integrate care at the sub-system Bedfordshire Care Alliance (BCA) level	This will focus on the health inequalities agenda, primary care, community, and social and mental health care provision and how best the Trust can integrate. It includes vertical integration, community outpatients and diagnostics and supporting patient flow through community bed provision.	Community and primary care Greater integration within Bedfordshire

Objective 2024/25	Overview	Strategic Priority / Delivery Work stream
8. To further develop our role as an Anchor Institution in Bedfordshire and to use our resources to improve the wider determinants of health and wellbeing of local people.	To make a significant and measurable contribution to our communities and to the lives of local people, by being an active engaged and responsible corporate citizen This will focus on how the Trust uses its leverage as a major local employer which is committed to improve the prosperity, health and wellbeing of residents taking in to account the health inequalities agenda linked to Objective 7.	Wider determinants of health Health and Wellbeing Boards Workforce Committee / Strategy Committee
9. To work with our partners to implement the recommendations of the Denny Review and in particular, to remove barriers that arise due to a lack of "cultural competency" on our part and which reduce or prevent timely access to the Trust's services.	To improve health and wellbeing of the populations we serve, whilst at the same time, reducing the health inequalities they experience	Wider determinants of health
10. Develop and embed the Equality, Diversity and Inclusion (EDI) Strategy	The Trust is committed to promoting equality, diversity and inclusion (EDI) across all aspects of the organisation. The strategy aims to foster a culture where everyone feels valued, respected and supported. Through the development and embedding of the strategy, the Trust is committing to creating a fair, inclusive and supportive environment for staff, patients and communities. The Trust strives to deliver high-quality healthcare services that meet the diverse needs of everyone we serve.	Equality Diversity and Human Rights meeting Trust Board

TWO: 2.1 Achievements In Quality Improvement Priorities 2023/24

Priority 1: Improve Patient Safety

1.1 Flu vaccinations for frontline healthcare workers

Why was this a priority?

This priority was published as a CQUIN for 2022/23 and was carried forward to 2023/24. Frontline health care workers are more likely to be exposed to the influenza virus. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season - this is a much higher incidence than expected in the general population. Influenza is also a highly infectious illness, which spreads rapidly and patients in hospital are more vulnerable to the severe effects and complications of flu.
Staff flu vaccinations are critical in reducing the spread of flu during winter months when flu activity is higher. Flu vaccinations can protect those in clinical risk groups and reduce the risk of contracting both flu and COVID-19 at the same time (along with the associated poorer outcomes) in addition to increased staff absence and the risk for the overall safe running of NHS services.
It is recommended that health care workers with patient contact are vaccinated annually to reduce transmission of flu to protect themselves, their families and patients from getting flu and it is supported by best practice guidance (NICE, NG103).

The CQUIN target aimed to achieve 80% uptake of flu vaccinations by frontline staff with patient contact.

What did we do?

- The Trust's occupational health teams led on this priority, and a working group was set up with representation from the Trust departments of human resources, infection control, and the communications team.

- A Trust-wide communications campaign was put in place to actively encourage staff to have the flu vaccine.

- Senior nursing and allied health professional staff and Medical Directors supported the flu campaign and actively participated in the working group.

- Vaccination clinics were set up at each hospital site. Opening times, how to book an appointment using the online system ('Vaccination track') and available appointments were promoted in regular communications.

- Staff were able to drop in to the Occupational Health Departments and were administered the vaccination where possible.

- Roving vaccinators have been visiting designated areas, nearer to clinical departments to enable staff to access more easily.

- ‘Vaccination track’ created an automated invitation letter which was sent to staff via email every seven days, encouraging them to either book an appointment, decline the vaccine or inform the Trust if they had received their vaccination elsewhere.

How did we perform?

In 2023/24, the levels of influenza rates locally were less than the previous year in 2022/23, which had seen an increase in the level of influenza infection compared to the previous year as social contact and activity increased as the COVID pandemic restrictions eased. Evidence suggests the vaccines matched closely to the circulating strains.
Although uptake for the flu vaccine by frontline staff with patient contact for 2023/24 remained lower than hoped, even with plenty of booking appointments available for vaccinations, 52.8% (number = 4,062) of frontline healthcare workers with patient contact received the flu vaccination. Whilst the vaccination was actively declined by 1,072 frontline staff, there was an increase in overall uptake compared to 2022/23.

The uptake of flu vaccination remains important for the health and well-being of both our staff and patients and the Trust has kept this as a quality priority for the coming year, 2024/25.

1.2 Recording of and appropriate response to NEWS2 score for unplanned critical care admissions

Why was this a priority?

This key priority was published as a CQUIN for 2022/3. The National Early Warning System (NEWS2) protocol is the Royal College of Physicians (RCP) and NHS-endorsed best practice for spotting the signs of deterioration and ensuring a timely response. This priority aims to ensure adherence to evidence-based practice in the identification, recording and timely escalation and response to deterioration, which reduces the rate of preventable deaths and Intensive Care Unit (ICU) admissions.

This quality priority, based on a national CQUIN, aims for 30% of unplanned critical care admission from non-critical care wards to have a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in the clinical notes.

What did we do?

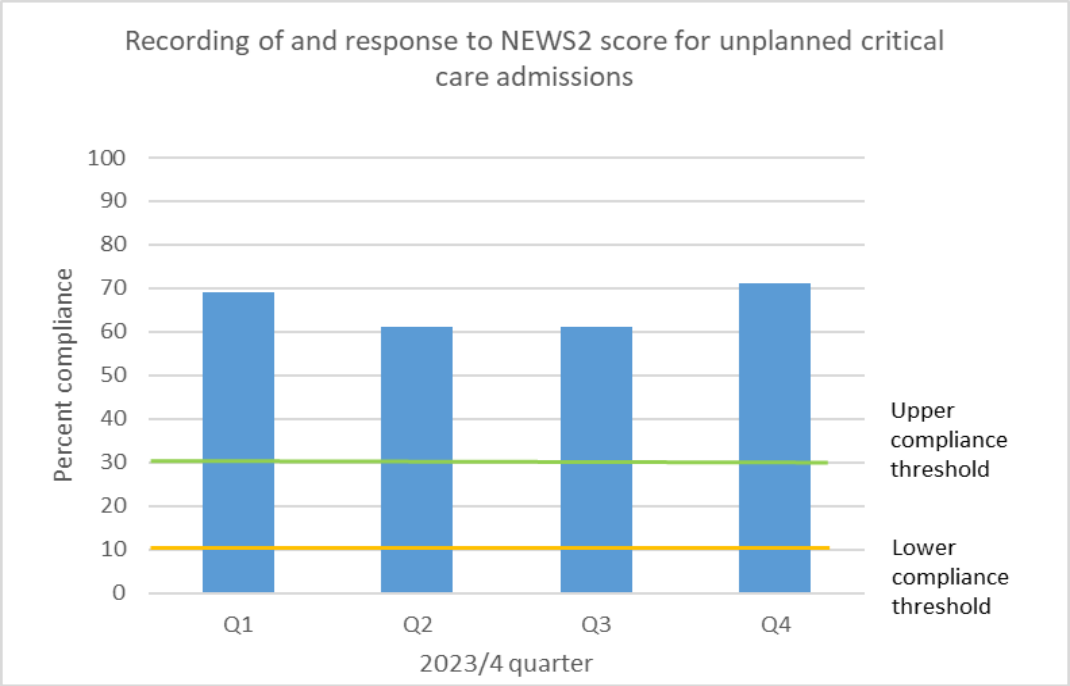
- We worked with the Digital Team to update the NEWS2 scoring system on NerveCentre so that it aligns with the latest RCP guidance. (NerveCentre is an electronic system, which allows staff to document clinical observations and gives guidance on escalation if a patient’s observations are deteriorating).

- We aligned practice and introduced a Medical Emergency Team call (MET) at Bedford Hospital. Staff can activate a call to the Medical Emergency Team by calling 2222 and stating ‘medical emergency’ for instances when an anaesthetist is not required.

- We reviewed and updated the Trust guideline on Recognition and Management of the Deteriorating Patient to ensure alignment with the latest RCP guidance and the MET call process at Bedford.

- Training for health care support workers, nursing and medical staff continued through a variety of methods including Trust induction, basic and intermediate life support courses, the Bedside Emergency Assessment Course (BEACH) for Healthcare Staff, and Adult Life-threatening Events Recognition and Treatment course (ALERT).

How did we perform?



Compliance for Quarter 4 is 71%. Compliance throughout 2023/24 has remained above the upper threshold limit (10-30%). The Trust has achieved the upper threshold for compliance with the quality priority and CQUIN. The introduction of NerveCentre at Bedford has aligned processes for the documentation of observations cross site, associated training has taken place in line with RCP guidance.

1.3 Implementation of Patient Safety Strategy: Patient Safety Incident Response Framework (PSIRF)

Why was this a priority?

The National Patient Safety Strategy has been adopted across England with the introduction of a number of changes to practice including establishment of the national Learn from Patient Safety Events digital platform, the introduction of the Patient Safety Incident Response Framework, and with a focus on the patient voice through Patient Safety Partners being employed by Trusts. There has been a focus on the ethos of 'just culture' principles, openness and learning from incidents, improved timeliness of learning from incidents and meeting national compliance requirements for reporting systems.

What did we do?

- Produced a Trust wide PSIRF Plan and Policy for sign off October 2023.
- Transition to new framework in autumn 2023.
- Embedded a new risk management and incident reporting system, integrated cross-site, which is compliant with the requirements of national platform Learn from Patient Safety Events (LFPSE).
- Developed job descriptions and a recruitment strategy for the implementation of Patient Safety Partners within the Trust to commence in line with national strategy targets.

How did we perform?

- The PSIRF Plan and Policy was approved by Trust Board and the ICB, and the embedding of the new Framework commenced in October 2023.
- Pivotal to the work was the creation of two Executive led Panels each week with different functions :
    i. To review national and trust priority incidents, together with review of other more significant incidents. A decision is made as to which learning response tool and approach is most appropriate.
    ii. To review the learning response and improvement work undertaken following the incident.
- A trust priority for insulin incident thematic analysis has led to the creation of an Insulin Committee to look closely at insulin medicines management, and associated improvement work.
- At all points of review, a just culture approach is considered with an emphasis on system improvements rather than individuals. In alignment with the framework, individuals will be offered support as needed.
- Two part time Patient Safety Partners have been employed, with the Lead for Patient Experience and Engagement leading on the most effective approach to embedding their contribution into the trust quality and safety work.
- The multiprofessional trust wide PSIRF Working Group continues to monitor and evaluate PSIRF implementation.
- The Quality and Safety Governance team are developing metrics to track, monitor and evaluate progress.
- Training and education continues to be rolled out.

Priority 2: Improve Patient Experience

2.1 Supporting Patients to drink, eat and Mobilise (DrEaM) after surgery.

This was a CQUIN in 23/24, and a Trust Quality Priority.
This work will continue as a Trust Quality Priority for 2024/25

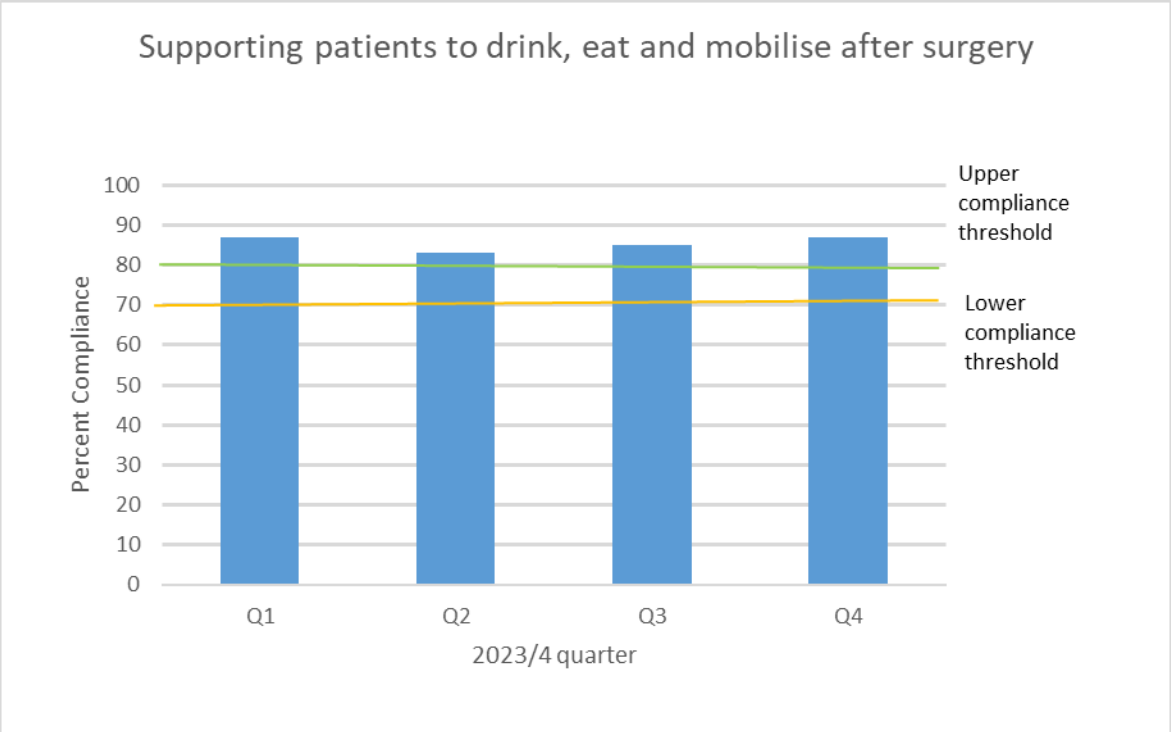
Why was this a priority?
Initially this key priority was published as a CQUIN for 2022/3 with the aim of supporting evidence based practice to ensure that patients drink, eat and mobilise as soon as possible after surgery. This is an element of the NHS's enhanced recovery programme and a top improvement priority associated with reduced complications and on average a 37.5% reduction in length of stay.

In 2023/4, the CQUIN continued with a wider range of major surgical procedures including endocrine, oral and maxillofacial, general surgery and ear, nose and throat. The CQUIN and quality priority requirements are to ensure that 80% of surgical inpatients are supported to drink, eating and mobilise within 24 hours of surgery ending.

What did we do?

- Aim to ensure that 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
- Set up a working group to develop and implement the improvement work.
- Ensured the provision of fluid, food and mobilisation for patients within the first 24 hours post-surgery.
- Ensured we shared audit results with the clinical teams to identify any further areas for improvement.
- Comprehensive documentation within the care plan (noted by the Physiotherapy team at Bedford site) for total knee replacement (TKR) and total hip replacement (THR) supporting documentation for mobilising patients.
- Head of Nursing for surgery attended the touchpoint DrEaMing Collaborative (NHS England) held in London to share the Trust's collaborative aim and learn from other trusts.

How did we perform?



The trust has achieved over 83% compliance for the quality priority and CQUIN and the upper compliance threshold achieved. Audit has shown that the majority of patients were supported in drinking and eating post-surgery. The most frequently missed aspect of the audit criteria was the documentation that patients had mobilised. Collaborative work has taken place with the physiotherapy team and nursing staff to ensure this aspect is recorded in the notes, and will be a focus of the continuing work. At Bedford Hospital, a

review of the post-operative documentation has commenced to include prompts to record when a patient has had oral fluids, eaten and mobilised. This is already in place in the Enhanced Recovery Care Plan at Luton and Dunstable Hospital.

The trust has signed up to NHS England's DrEaM Collaborative, and is undertaking a number of initiatives to facilitate supporting patients to eat drink and mobilise. This includes the creation of a group to drive improvement with ongoing collaborative working with the multidisciplinary team.

2.2 Priority 5: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (DMS)

Why was this a priority?

NICE guidance (NG5) recommends that relevant information about medicines should be shared with patients, and their family members or carers, where appropriate, and when a patient moves from one care setting to another to support high quality care. This should happen within one week of the patient being discharged. The Discharge Medicines Service (DMS) is a secure electronic medicines-related communication system used to support this.

Patients who are supported by the DMS are less likely to be readmitted (5.8% vs 16% at 30 days). If a patient is readmitted, they are likely to spend fewer days in hospital (7.2 days on average compared to 13.1 days for patients who did not have access to the service).

This quality priority, based on a national CQIUIN, aims for 1.5% (minimum threshold 0.5%, maximum threshold 1.5%) of acute Trust inpatients with a length of stay for more than 24 hours and have changes to medicines is communicated via secure electronic message using the DMS to the patients chosen community pharmacy within 48 hours following discharge. The following information should be included:

- Patient's demographic details
- The medicines being used by the patient at discharge
- Any changes to medicines (including those started or stopped, or dosage changes with a documented reason for the change)
- Contact details for the referring clinician or hospital department
- Trust / hospital name or data service code

What did we do?

- Reviewed our process for referrals to the DMS.
- Worked in collaboration with Bedford, Luton and Milton Keynes (BLMK) community pharmacy and general practitioner (GP) practices to review the impact of DMS referrals.
- Reviewed staffing levels to support referrals to the DMS.
- Worked with the digital team to implement electronic discharge information to facilitate referrals from the hospital.

How did we perform?

Over the course of 2023-24, we achieved a referral rate of 1.00% working within the recommended percentage compliance. This is down from an average of 1.31% in 2022-23.

2023-24 has been an operationally challenging year with a series of Industrial Actions (strikes) as well as recurrent OPEL-4 status as a consequence of secondary care needing to support gaps in primary care pathways. Both of these impacts on demand and capacity. Where temporary staff have been used this has impacted the ability to prioritise DMS referrals over other critical activities.

The majority of referrals continue to be completed for inpatients from the Luton and Dunstable Hospital site.

Summary of DMS referrals by quarter and YTD compliance:

Quarter	LDH referrals	BH referrals	BHFT referrals	YTD compliance
Q1	338	9	347	1.08%
Q2	461	7	468	1.27%
Q3	296	3	299	1.16%
Q4	164	0	164	1.00%

To support compliance and uptake at the Bedford Hospital site, changes were needed to the EPR and discharge system. In December 2023, a new ePMA (electronic prescribing and medicines administration) system was implemented including an interface with PharmOutcomes DMS.

During Q4, the number of referrals were significantly lower than other quarters. This was due to heavy winter pressures / on-going bed challenges impacting on the ability of staff to prioritise this. More substantially, an uncommunicated update of NHS.net security features was deployed mandating a two-stage login process; this prevented staff from accessing the system for several weeks.

In 2024/5, the pharmacy team will continue to support referrals aiming to increase compliance across both Acute sites of the Trust in accordance with the revised target of 1.3% to 3.0%.

2.3 Supporting timely personalised Treatment Escalation Plan (TEP) conversations and Do Not Attempt Cardiopulmonary (DNACPR) decisions

Why was this a priority?
DNACPR and TEPs are an effective way of considering and communicating decisions and plans of care. Effective communication and documentation of these discussions and decisions are essential to ensure involvement and clear understanding of all those involved.

When a DNACPR is completed there should always be a personalised TEP based on the individual's circumstances. Discussions should start with treatment escalation and lead to anticipatory decisions about whether or not to attempt resuscitation.

The British Medical Association (BMA), Resuscitation Council UK and the Royal College of Nursing (RCN) advocate decision making around patients care and treatment, including cardiopulmonary resuscitation (CPR) should be completed at the earliest opportunity.

What did we do?

- Set up a working group with representation from the Resuscitation and Deteriorating Patient Committee and End of Life Steering Group.
- Reviewed the DNACPR and TEP documents used across the Trust to identify the differences and determine what 'good looks like'.
- Reviewed and discussed the possibility of the Trust adopting the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process. (ReSPECT is supported by the Resuscitation Council UK and is increasingly being adopted in health communities around the UK).
- The Resuscitation Leads reached out to organisations across the East of England which are currently using or are in the process of adopting ReSPECT to discuss barriers, challenges and how best to facilitate implementation.

How did we perform?

We made early progress by reviewing DNACPR and TEP documents used across the Trust to identify the differences and determine what 'good looks like.' This led to discussions on an agreement to consider adopting the ReSPECT process. The process supports patient preferences and clinical judgement, creating a summary of personalised recommendations for a person's clinical care in a future emergency, such as cardiac arrest, in which they do not have capacity to make or express choices.

An agreed interim measure to align the TEP and DNACPR documents used across the two hospital sites is in progress. The Resuscitation Leads scoped out the implementation of adopting the ReSPECT process across the Trust and identified the need for an education strategy, a training needs analysis, a ReSPECT policy and communication strategy to ensure all staff are aware of it being implemented. This work will continue and will be managed in 2024/25 through a project plan.

Priority 3: Deliver Excellent Clinical Outcomes

3.1 Identification and Response to Frailty in Emergency Departments (ED)

Why was this a priority?

This key priority was published as a CQUIN for 2023/24 with the aim of supporting hospital teams to consider the need for early and appropriate assessment for people aged over 65 years, who are more likely to present with symptoms of frailty. Early identification of frailty prompts different clinical decisions and treatments, which may provide better outcomes and shared plans for future illness or events.

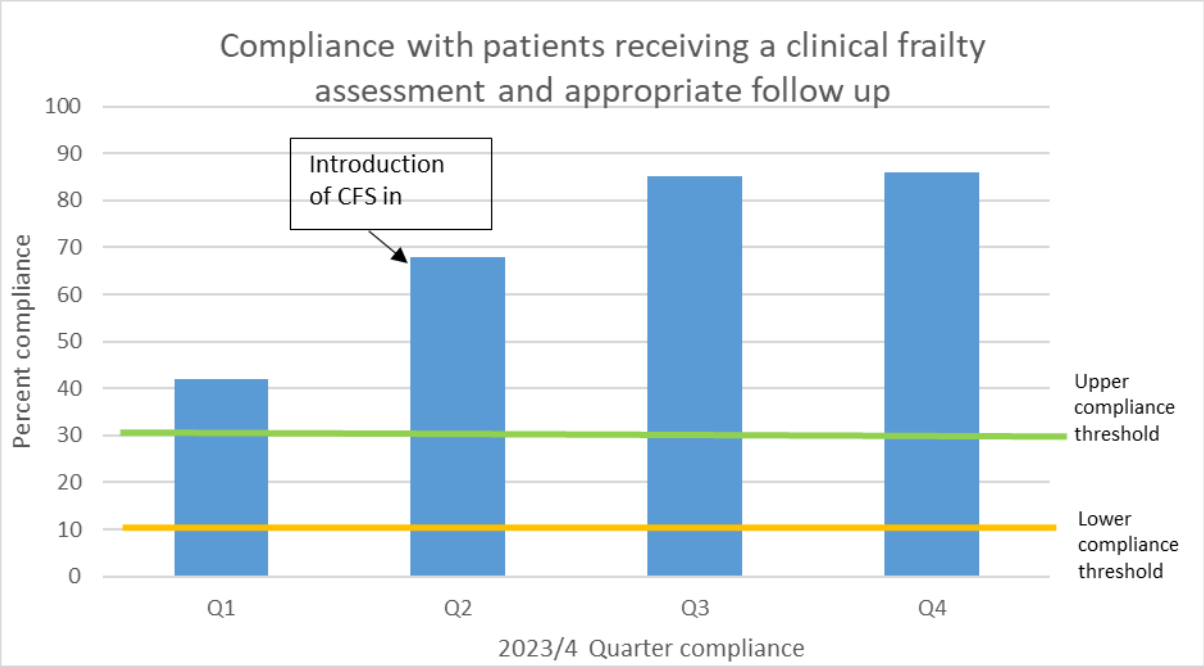
There are well-evidenced links between frailty and adverse health outcomes including deconditioning, malnutrition and irreversible cognitive decline, which may all lead to increased health and care requirements. Early identification of frailty can lessen some of these risks.

The CQUIN/Quality Priority aimed for 60% of patients 65 years and over attending the ED or Same Day Emergency Care (SDEC) to receive a Clinical Frailty Assessment (CFA) and appropriate follow up.

What did we do?

- We established a cross-site multidisciplinary working group, which met to undertake a review of the requirements and current processes and any changes needed.
- We standardised the process of documenting the Clinical Frailty Score (CFS) across site, so that it is now included in the electronic medical record (Symphony) used within the Emergency Department.
- An Advanced Care Practitioner undertook a quality improvement project to train Emergency Department nurses on assessing the Clinical Frailty Score and on improving accuracy when recording CFS within the Triage document.
- We have monitored compliance against the CQUIN standard that 'all patients who have a Clinical Frailty Assessment >6 receive Comprehensive Geriatric Assessment or frailty review.' We did this by auditing 100 patients per quarter in accordance with CQUIN requirements.

How did we perform?



Quarter 1 data showed variable compliance between the two sites with Luton and Dunstable Hospital achieving greater compliance than Bedford Hospital. This was mainly due to the Clinical Frailty Score (CFS) being embedded within the electronic medical record (Symphony) at Luton and Dunstable Hospital but not at Bedford Hospital. In September 2023, the Symphony system was updated at Bedford Hospital to include a prompt for completion of CSF. The inclusion of this field in Symphony increased Bedford Hospital compliance and therefore trust wide compliance.

Patients with a CFS of 6 or more require initiation of a Comprehensive Geriatric Assessment (CGA), or referral to the frailty service. 30 patients had a CFS of 6 or more and a CGA took place in 60% of these patients. Compliance was highest when patients were admitted under the Care of the Elderly teams and lower when patients were admitted under General Medical or Surgical teams, or discharged home. Data capture was impacted by the use of multiple systems - electronic and paper.

The Emergency Departments are aligning systems in 2024 which will involve the replacement of the current electronic system (Symphony) with NerveCentre. Work is taking place to ensure that CFS remains a mandated field, and options to use NerveCentre to support the recording of CGA assessments are being explored.

Priority 3: Deliver Excellent Clinical Outcomes

3.2 Improving the blood culture pathway

Why was this a priority?

Blood cultures remain the primary diagnostic test available to detect blood stream infections (BSI) and direct the most appropriate antimicrobial (antibiotic) therapy to treat the infection.

NHS England and NHS Improvement undertook a national review of the blood culture pathway and published guidance in April 2022 incorporating recommendations to improve and promote good practice across the blood culture pathway.

Bacterial infections account for approximately 40% of emergency admissions[1], with 33% of inpatients being on antibiotics at any one time. The wide-ranging benefits to improving the blood culture pathway include:

- Improved speed of detection of positive blood cultures
- Improved patient outcomes from early detection of significant BSI, supporting a more accurate infection diagnosis, guiding specific investigations and further management.
- Improved antimicrobial stewardship through reduction in unrequired use of antibiotics
- Timely infection control interventions
- Reduced length of stay

For adults it is recommended that 8-10 millilitres of blood is collected per blood culture bottle. Although lower samples can be used, detection of organisms may be improved using a sample volume closer to the recommended volume. Once blood culture sample bottles are collected, they should be loaded into the blood culture analyser as soon as possible, ideally within four hours.

Optimising and standardising the blood culture pathway will help to reduce unwanted variations in service delivery to improve antimicrobial stewardship and ensure the best outcomes for patients. Each significant positive blood culture provides an opportunity to improve patient care and outcomes.

What did we do?

- Set up a working group to review processes cross-site with representation from microbiology.
- Reviewed the blood culture sampling process on both sites to work on aligning practice.
- Identified an adaptor compatible with the blood culture bottles used in the Trust, which can also connect directly to central venous access devices (CVADs). This adaptor will be implemented as part of standard practice for blood culture sampling.

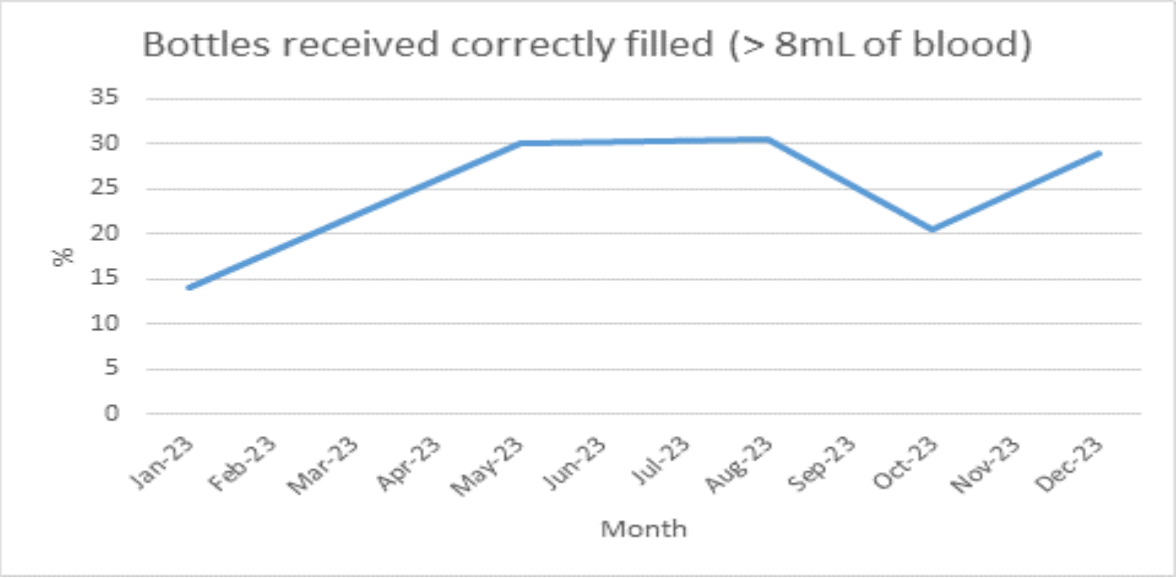
- A business case was submitted to the executive team for support and approval for a standard blood culture pack.
- Developed educational posters outlining the process for blood culture sampling in collaboration with the manufacturer in preparation for roll out.
- Reviewed training for blood culture sampling and started to develop an e-learning module for staff.
- Reviewed the functionality of the blood culture analysers on both sites to enable measurement of blood fill volumes for blood culture bottles with reporting of under filled bottles on ICE (electronic pathology reporting system).

How did we perform?

A review of the process for blood culture sampling across the Trust identified differences in practice and the equipment being used. The working group reviewed equipment available and identified an adaptor to connect directly to the blood culture bottles to be used as part of standard practice.

A standard operating procedure to align the process for blood culture sampling using the adaptor is in progress. This focuses on using an aseptic / non-touch technique to reduce the risk of contamination as well as recommending adequate fill volumes, and ensuring prompt collection of samples and receipt by the laboratory.

The laboratory routinely monitors the fill volumes of blood culture samples received, indicating under filled samples on ICE reports. The graph below outlines the percentage compliance for the number of adult blood culture samples received with the recommended fill volume (8-10 millilitres).



Specific improvement activities in 2024/5 will focus on increasing the number of blood culture samples received by the laboratory with the recommended fill volume supported by training. Posters have been developed and an e-learning module for staff including video

demonstrations alongside a multiple-choice assessment. This will be rolled out across relevant clinical areas in 2024/5.

Reference

[1] UKHSA SMI S12 Guidance
Public Health England, UK Standards for Microbiology Investigation B37 Investigation of blood cultures (for organisms other than Mycobacterium) updated September 2018 https://www.gov.uk/government/publications/smi-b37- investigation-of-blood-cultures-for-organisms-other-than-mycobacteriumspecies. SMI B37 is replaced in 2023 with SMI Syndromic12
https://content.govdelivery.com/attachments/UKHPA/2023/01/31/file_attachments/2395398/S%2012i1.pdf

3.3 Optimising time to surgery for patients admitted with a fragility hip fracture

Why was this a priority?

NICE guidance (CG124) on the Management of Hip Fractures recommends that surgery should take place on the day of admission to hospital or the following day. Increased time to surgery is uncomfortable, undignified and distressing to the patient as they are unable to get up out of bed until they have had their operation. This can reduce patient's recovery and long-term mobility.
A prompt time to surgery would mean that post-operative interventions were commenced as soon as possible, improving patient experience, outcomes and reducing length of stay (LOS).

What did we do?

- We set up a Fracture Neck of Femur Programme Board, which oversees progress with the fragility fracture pathway.
- Site-specific quality groups have been set up to review local improvement initiatives, these feed into the programme board.
- As part of the Programme, we have worked with the Theatre Transformation Team to optimise the capacity and productivity of theatres.
- We have reviewed Length of Stay at each of the hospital sites, and worked on initiatives to streamline the pathway.
- We have allocated a dedicated member of staff to enter monthly data onto the National Hip Fracture database to enable benchmarking of national data and information for payment of the Best Practice Tariff.

How did we perform?

Since the introduction of the Fracture Neck of Femur Improvement Programme the number of patients, receiving surgery within 36 hours at Luton has improved from 78% to 85% during the financial year 2023/24.
At Bedford the number of patients receiving surgery within 36 hours has improved from 30% to 41%. Work is taking place to increase theatre utilisation at Bedford which should reduce the time patients wait for surgery. To further streamline the patient journey we have implemented daily board rounds, daily reviews of patients on non-speciality wards and worked with the therapy teams in order to streamline the pathway and to optimise recovery.

Comparative data is not available for the whole year due to a gap in resource at the beginning of the year. However, both hospital sites now have a dedicated member of staff entering data monthly, which will support benchmarking and identify areas of improvement.

Consultation in relation to the future design of the fragility fracture service is underway and a review of pain protocols to support prompt mobilisation post operatively and reduce length of stay.

2.2 QUALITY PRIORITIES 2024/25

The Trust has always aimed to work in partnership with patients, staff and the communities we serve to improve the quality of services delivered and this will continue throughout the coming year.

The quality priority works streams are aligned with the nationally recognised quality priorities:

- to improve patient safety
- to improve patient experience
- to deliver excellent clinical outcomes

Each of the work streams are presented as headings in the tables below, with details of three quality priorities under each of these headings. A rationale is provided for their inclusion, in addition to measures of success and the reporting structure to oversee how the progress made throughout the year.

QUALITY PRIORITIES FOR 2024-2025

CORPORATE OBJECTIVE	IMPROVE PATIENT SAFETY
Quality Priorities	1. Implement Staff flu vaccination programme
	2. Recording of NEWS2 score, escalation time and response time for critical care admissions
	3. To support clinical areas to identify and learn from Variable Rate Intravenous Insulin Infusions (VRIII) incidents.
Rationale	1. Flu vaccinations for frontline healthcare workers (HCW)* are critical in reducing the spread of flu during winter months, therefore protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID 19 at the same time which is associated with poorer health outcomes. Increased uptake should reduce staff absence and the risk to the continuity of running safe services. **Exclusions – staff with no patient contact, social care workers, staff not in contact with patients for the whole of the flu vaccination period (e.g. maternity leave, long-term sickness). Temporary staff members who have not been working for more than 13 weeks are not included).*

	2. The NEWS2 protocol is the Royal College of Physicians (RCP) and NHS-endorsed best practice for recognising the signs of deterioration and ensuring a timely response, the importance of which was emphasised during the pandemic. This quality priority will support adherence to evidence-based steps in the identification and recording of deterioration, and response. Nationally, as many as 20,000 deaths in hospitals each year could be preventable and deterioration is linked to 90% of NHS bed days. Reducing the need for higher levels of care will free up capacity particularly in Critical Care Units by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts. *Exclusions - patients admitted directly to resuscitation, pregnant patients and patients who are agreed as end of life patients prior to critical care admission.*
	3. Insulin is recognised as a high-risk medication and is one of the Trust priorities for Patient Safety Incident Responses Framework (PSIRF) in the first year of PSIRF implementation. As a PSIRF Learning Response a thematic review of insulin related incidents in 2023 (Q3) was completed which showed that the highest insulin related incident category was missed doses of insulin, followed by administration, and prescription errors and prescribing omissions.
Measures of Success	1. Uptake = 65% of total number of frontline HCWs including non-clinical staff who have contact with patients between 1 September 2024 and 28 February 2025.
	2. Achieving 60% of unplanned adult critical care unit admissions (aged 18 years or above) from non-critical care wards having a timely response to deterioration in line with Royal College Physicians (RCP) NEWS2 guidelines. Audit of 100 patients cross site, in each quarter of the year.
	3.A Trust wide Inpatient Diabetes Committee in place with auditable trail recording progress with quality improvement initiatives. A standardised report which will: • permit benchmarking of rates of incidents regarding VRIII • encourage incident reporting (just culture) within CSLs and aim to focus on reduction in levels of harm Feedback to Inpatient Diabetes Committee to include: • current training and future requirements • current clinical guidance and any updated required Support specific ward areas cross-site to develop and test improvement activities based on incident data, with a focus on VRIII in accordance with Trust and national guidance
Monitoring Committee	Clinical Quality Operational Board (CQUOB) and the Trust Board Quality Sub- Committee
CORPORATE OBJECTIVE	**IMPROVE PATIENT EXPERIENCE**

Quality Priorities	4. Further development of the Trust framework to involve Trust employed Patient Safety Partners (PSPs) in the work of the Patient Safety Incident Response Framework (PSIRF).
	5. Consistent assessment and documentation of pressure ulcer risks for adult in patients (excluding maternity) supported by the National Wound Care Strategy.
	6. Responsiveness to feedback from patients and service users, to support improvements in patient experience
Rationale	4. Enhance Just Culture, openness and learning from incidents, for improvements in patient care and experience following incidents To meet national regulatory compliance requirements for learning National Patient Safety Strategy requirement to involve patients in safety improvement work.
	5. The National Wound Care Strategy recommends the use of the Purpose-T tool for Pressure Ulcer Risk assessment; the TVN team are transitioning this onto NerveCentre in 2024. Supports preventative advice, and appropriate management of care for adult in patients (excluding maternity). This is a continuation of the CQUIN work of 23/24
	6. Data from surveys and concerns, formal complaints, and compliments enables the Trust to learn from patients and service users with lived experience.
Measures of success	4. PSPs visible within organisation and participating in key quality committees
	5. In collaboration with Pressure Ulcer Review Panel and other stakeholders, design metrics for monitoring and identifying improvement activity. Develop approach for effective implementation in ED Implementation of the Purpose-T Tool for adult inpatients (excluding maternity). Completion of the Purpose-T Tool for adult inpatients (excluding maternity). Evidence that the Pressure Ulcer prevention leaflet has been provided to the patient/carer/care provider.
	6. Improved performance in response to Complaints
Monitoring Committee	Clinical Quality Operational Board (CQUOB) and the Trust Board Quality Sub- Committee
CORPORATE OBJECTIVE	**DELIVER EXCELLENT CLINICAL OUTCOMES**
Quality	7. Improve clinical outcomes for patients presenting at ED with mechanical lower back pain through re-designed pathway of car

Priorities	8. Achieve 75 % or greater, patients receiving definitive cancer diagnosis or the ruling out of cancer following : Urgent suspected cancer, screening patients, within 28 days (This standard due to be operationalised nationally by March 24) – Cancer waiting times | Nuffield Trust
	9. Supporting Patients to drink, eat and mobilise (DrEaM) within 24 hours of surgery – continuing the national collaborative programme (one of two trusts in the region).
Rationale	7. Internal audit of patients attending ED with lower back pain has indicated that admission could be avoided, for those requiring admission the wait for investigations may result in an extended length of stay. The aim of the pathway is to improve the patient experience, improve the flow of patients through ED, reduce inpatient admissions, and if admission is required, reduce length. A pilot of the project scheduled to take place on June 2024.
	8. Timeliness of diagnosis is the start of the patient's cancer journey for best possible outcomes. Nuffield Trust states : 'Waiting for a diagnosis can be a very stressful experience for patients and their loved ones, making reduced wait times helpful in alleviating patients from needless worry if cancer is not detected. Alternatively, it can result in early detection and shorter time to begin treatment.'
	9. Embedding this work Trust wide (or in the designated areas) will have benefits of reduction in complication rates, reduced length of stay and improved patient experience. Supports NHS Enhanced Recovery Programme. Continuing specific work from the CQUIN 23/24.
Measures of Success	7. o Patients booked onto Symphony and seen by Advanced o Physiotherapy Practitioner. o Patient satisfaction survey data. o Audit data to show patient wait times and outcomes. o Documented agreement of future service
	8. Regular monitoring and performance review by cancer service, meeting with operational teams from all relevant services to track, mitigate and improve performance where possible. o To maintain, over time, 75 % or greater, patients receiving definitive cancer diagnosis or non-cancer diagnosis following urgent suspected cancer referral from GP, patients referred on screening pathway, within 28 days

	9. ○ Develop outcome measures focussed on Length of Stay, complication rates, and patient satisfaction. ○ Establishment of network of DrEaMing Champions across the surgical pathway. ○ Awareness/ visibility of clinical benefits. ○ Opportunities to improve patient conditioning. ○ Collaborative work with trust Patient Safety Partners. ○ Digital solution to support and monitor compliance.
Monitoring Committee	Theatres Board Clinical Quality Operational Board (CQUOB) Trust Board Quality Sub- Committee

Part 3 Statements of Assurance from the Board

3.1 Review of services

During 2023/24, the Bedfordshire Hospitals NHS Foundation Trust provided and/or sub-contracted 47 clinical services.

We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes.

The Board of Directors considers performance reports quarterly including progress against national quality and performance targets. The Board also receives reports from its Quality Committee subcommittee.

The income generated by the relevant health services reviewed during 2023/24 represents 100% of the total income generated from the provision of relevant health services by the Bedfordshire Hospitals NHS Foundation Trust.

3.2 Participation in Clinical Audits and National Confidential Enquiries

A clinical audit aims to improve patient care by reviewing services against agreed standards of care and making changes where necessary. National Confidential Enquiries investigate an area of health care and recommend ways to improve it.

The Trust are committed to participating in relevant national audits and National Confidential Enquiries through data submission to help the collective assessment of quality of healthcare nationally, which will inform recommendations for safety and effectiveness.

During 2023/24, we took part in 88 national clinical audits and 10 national Confidential Enquiries (split equally between both sites).
The table includes the number of cases submitted for the current audit cycle. For some audits, the number is not confirmed until later in the year or where the audit is still in progress, these are identified as continuous data collection.

The national clinical audits and national confidential enquiries that the Trust were eligible to participate in during 2023/24 are shown in the tables below.

No. and work streams		Audit Title	Did Luton and Dunstable Hospital participate ?	Stage/ number or % of Cases submitted Luton and Dunstable Hospital	Did Bedford hospital participate	Stage/ number or %of Cases submitted Bedford hospital
1.	1.	Adult Respiratory Support Audit	Yes	11 cases	Yes	17 cases
2.	2.	BAUS Nephrostomy	Did not participate		Did not participate	

3.	3.	Breast and Cosmetic Implant Registry	Not applicable to this organization.			
4.	4.	British Hernia Society	Not applicable to this organization.			
5.	5.	Case Mix Programme	Yes	746 cases	Yes	359 cases
6.	6.	Child Health Clinical Outcome Review Programme [1]	Participation in Clinical Outcome Review Programmes 2023/24 listed in table below			
7.	7.	Cleft Registry and Audit Network Database	Not applicable to this organization.			
8.	8.	Elective Surgery: National PROMs Programme	Continuous data collection		Continuous data collection	
9.	9.	Emergency Medicine Quality Improvement Projects:				
		a. Care of older people	Yes	229 cases	Yes	171 cases
	10.	b. Mental Health (Self harm)	Yes	209 cases	Yes	272 cases
10.	11.	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People Epilepsy 12 [1]	Yes	94 cases	Yes	7 cases
11.	12.	Falls and Fragility Fracture Audit Programme [1] :				
		a. Fracture Liaison Service Database	No service on this site		Yes	655 cases
	13.	b. National Audit of Inpatient Falls	No	Did not have any fractured NoF's during this period	No	Did not have any fractured NoF's during this period
	14.	c. National Hip Fracture Database	Yes	361 cases	Yes	319 cases
12.	15.	Improving Quality in Crohn's and colitis (IQICC)(previously Inflammatory Bowel Disease Audit)	No data submitted this year due to limited capacity and workforce resource			
13.	16.	LeDeR - Learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	Yes	12 cases	Yes	9 cases
14.	17.	Maternal and Newborn Infant Clinical Outcome Review Programme [1]	Continuous data collection		Continuous data collection	
15.	18.	Medical and Surgical Clinical Outcome Review Programme [1]	Participation in Clinical Outcome Review Programmes 2023 - 24 listed in table below			
16.	19.	Mental Health Clinical Outcome Review Programme 1	Not applicable to this organization.			
17.	20.	National Adult Diabetes Audit [1:]				
		a) National Diabetes Foot care Audit	Yes	100 cases	Yes	157 cases
	21.	b) National Diabetes Inpatient Safety Audit	Yes	9 cases	Yes	10 cases
	22.	c) National Diabetes Pregnancy and diabetes Care Audit	Yes	87 cases	Yes	55 cases
	23.	d) National Diabetes Core Audit:	Yes	5546 cases	Yes	1124 cases
18.	24.	National Asthma and Chronic Obstructive Pulmonary Disease Audit [1] :				
		a. Chronic Obstructive Pulmonary Disease Secondary Care	Yes	152 cases	Yes	834 cases
	25.	b. Pulmonary Rehabilitation	Yes	179 cases	Yes	258 cases

	26.	c. Adult Asthma Secondary Care	Yes	57 cases	Yes	302 cases
	27.	d. Children and Young people asthma Secondary care	Yes	78 cases	Yes	Continuous data collection
19.	28.	National Audit of Cardiac Rehabilitation	Yes	987 cases	Yes	395 cases
20.	29.	National Audit of Cardiovascular Disease Prevention (Primary Care) [1]	Not applicable for both sites			
21.	30.	National Audit of Care at the End-of-Life [1]	100 cases cross-site			
22.	31.	National Audit of Dementia [1]	Yes	179 cases	Yes	148 cases
23.	32.	National Audit of Pulmonary Hypertension	Trust does not have service set up or resources on either site.			
24.	33.	National Bariatric Surgery Registry	Continuous data collection		No	Not practiced on the site
25.	34.	National cancer audit Collaborating center – National audit of Metastatic Breast cancer	Data automatically collected from hospitals to the National Disease Registration Service (NDRS) .			
26.	35.	National cancer audit Collaborating center –National audit of Primary Breast cancer	Data automatically collected from hospitals to the National Disease Registration Service (NDRS) .			
27.	36.	National Cardiac Arrest Audit	Yes	85 cases	Yes	75 cases
28.	37.	National Cardiac Audit Programme:				
		a. National Adult Cardiac Surgery Audit	Not applicable to either site.			
	38.	b. National Congenital Heart Disease	Trust does not have service set up or resources on either site.			
	39.	c. National Heart Failure Audit	Yes	424 cases	Yes	Continuous data collection
	40.	d. National Audit of Cardiac Rhythm Management	Yes	203 cases	Yes	213 cases
	41.	e.Myocardial Ischaemia National Audit Project	Yes	508 cases	Yes	397 cases
	42.	f. National Audit of Percutaneous Coronary Interventions(NAPCI)	Yes	544 cases	Yes	Continuous data collection
	43.	g. National audit of Mitral Valve leaflet repairs (MVLR)	This will not be applicable to either site as both do not perform mitral valve leaflet repairs			
	44.	h. The UK Trans catheter aortic Valve implantation (TAVI) registry	Not relevant to this Trust			
29.	45.	National Child Mortality Database [1]	Part of the Child Death Overview Panel (CDOP) process and managed in the community.			
30.	46.	National Clinical Audit of Psychosis [1]	Not applicable			
31.	47.	National comparative audit of Blood transfusion A.2023 audit of blood transfusion against Nice Quality Standard 138.	Yes	10 cases	Yes	10 cases
	48.	B.2023 bedside transfusion Audit.	Audit running from March 2024 till May 2024			
32.	49.	National Early Inflammatory Arthritis Audit [1]	Yes	30 cases	No	Not participating due to workforce

							capacity
33.	50.	National Emergency Laparotomy Audit		Yes	Continuous data collection	Yes	82 cases
34.	51.	National Gastro-intestinal Cancer Programme(GICAP)	a. National Oesophago-gastric Cancer	Yes	Continuous data collection	Yes	Continuous data collection
	52.		b. National Bowel Cancer Audit	Yes	Continuous data collection	Yes	19 cases
35.	53.	National Joint Registry		Continuous data collection		Continuous data collection	
36.	54.	National Lung Cancer Audit [1]		Yes	181 cases	Yes	273 cases
37.	55.	National Maternity and Perinatal Audit1		The publication of NMPA clinical reports using recent data are overdue owing to significant delays in receiving English maternity services data. The NMPA have now received these data (in February 2024) which cover births up to March 2023. Due to the complex nature of this new dataset and over 4 years' worth of data being received, it will take the NMPA some time to produce results. https://maternityaudit.org.uk/pages/home			
38.	56.	National Neonatal Audit Programme [1]		Yes	652 cases	Yes	476 cases
39.	57.	National Obesity Audit[1]		Not applicable			
40.	58.	National Ophthalmology Database	National cataract audit	No	Not applicable to this site.	Yes (Moorfields)	Submitted by Moorfields)
41.	59.	National Paediatric Diabetes Audit [1]		Yes	241 cases	Yes	187 cases
42.	60.	National Prostate Cancer Audit [1]		Continuous data collection		Continuous data collection	
43.	61.	National Vascular Registry [1]		Not applicable		460 cases	
44.	62.	Out-of-Hospital Cardiac Arrest Outcomes(OHCAO)		Not applicable to this organisation			
45.	63.	Paediatric Intensive Care Audit(PicaNet)		Not applicable to this organisation			
46.	64.	Perinatal Mortality Review Tool		53		10	
47.	65.	Perioperative Quality improvement program		Not applicable to this organization.			
	66.	Prescribing Observatory for Mental Health (POMH)					
		a. Use of medicines with anticholinergic (antimuscarinic) properties in older people mental health services		Not applicable to this organisation			
48.	67.	b. Monitoring of patient prescribed lithium		Not applicable to this organisation			
49.	68.	Sentinel Stroke National Audit Programme		Yes	593 cases	Yes	135 cases
50.	69.	Serious Hazards of Transfusion UK National Haemovigilance Scheme		Yes	19 cases	Yes	10 cases
51.	70.	Society for Acute Medicine Benchmarking Audit		Yes	88 cases	Yes	73 cases
52.	71.	Trauma Audit and Research Network		Unable to submit data since Jun-23. NHS England system not currently accessible			
53.	72.	UK Cystic Fibrosis Registry		Not applicable to both sites - applicable to tertiary centres			
54.	73.	UK Renal Registry chronic kidney Disease audit		Not applicable on either site			

55.	74.	UK Renal Registry national acute kidney injury audit	Not applicable on either site

Footnotes:

1 National Clinical Audit and Patient Outcomes Programme (NCAPOP)

2 Programme participates in the Clinical Outcomes Publication (COP)

3 Programmes with multiple work streams are listed in HQIP's The Directory

Participation in Clinical Outcome Review Programmes 2023-24:

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an organisation in which currently practising clinicians review the management of patients undergoing medical and surgical care by undertaking confidential surveys that enables review of care provision and resources through data from the units carrying out the care.
As a Trust we participated in five NCEPOD review programs across both sites, of which one enquiry achieved 100% submission. See listing table below:

Name of Enquiry	Did Luton and Dunstable Hospital participate?	Stage / % of cases submitted	Did Bedford hospital participate?	Stage / % of cases submitted
Testicular torsion study: clinician questionnaire (Continued from 2022-2023)	Yes	2 (33%) questionnaires submitted	Yes	2 (40%) questionnaires submitted
End of Life care	Yes	3 (60%) questionnaires submitted (data collection still in progress)	Yes	2 (67%) questionnaires submitted (data collection still in progress)
Endometriosis	Yes	5 (70%) questionnaires submitted	Yes	6 (100%) questionnaires submitted
Juvenile idiopathic arthritis study	Yes	3 cases submitted (100%)	Yes	4 cases submitted (100%)
ICU Rehabilitation	In the process of data collection.			

Name of Enquiry	Did Luton and Dunstable Hospital participate?	Stage / % of cases submitted	Did Bedford hospital participate?	Stage / % of cases submitted
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE) – Perinatal mortality surveillance	Yes*	Total = 66 100%	Yes*	Total = 19 100%

Maternal, New-born and Infant Clinical Outcome Review Programme – Maternal mortality surveillance and confidential enquiry	Yes	2 maternal deaths 100%	Yes	2 maternal deaths 100%
Maternal, New-born and Infant Clinical Outcome Review Programme – Perinatal confidential enquiries	Yes	Same as MBRRACE Perinatal Mortality Surveillance	Yes	Same as MBRRACE Perinatal Mortality Surveillance

*****All cases that meet MBRRACE requirements have been reported

National Audits

The table below lists a selection of outcomes / actions following publication of national audit reports in 2023 /2024

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
Luton	Anaesthetics	Cappuccini Test: supervision of SAS doctors to ensure patient safety	• The SAS (specialist, associate specialist) doctors in the anaesthetic department are aware to contact the co-ordinating consultant if they feel they need help
Luton	Acute	Society for Acute Medicine Benchmarking Audit - SAMBA 2023 Report.	• To increase the numbers of triage nurses at least with another additional nursing officer which will reduce waiting time for 1st EWS (Early Warning System)
Luton	Cardiology	National Audit of Percutaneous Coronary Intervention (NAPCI)	• A doubling of PCI (Percutaneous coronary intervention) activity over historic norms in the centre [the Trust were usually doing about 250 cases a year] • Funding for a second Cath lab - due to start May 2024 • Repatriation of complex work from Harefield Hospital, via use of Shockwave, to retain tariff and complete complex work at the Trust • Accommodation and support of cross-Trust acute need patients in times where labs have lost operability on both sites • Weekend lists to improve outpatient waits and facilitate some inpatient activity outside core hours **Actions required for further improvement** • Work on achieving appropriate turnover for 72 hour pathway for NSTEMI (Non-ST-Elevation Myocardial Infarction) • Explore funding for further calcium modification services via Rotablation / Orbital Atherectomy, to deliver service locally in a prompt timescale and retain tariff / earn funding • Discussion between sites on how to work together to develop activity at both sites • Thoughts on how to leverage the presence of two Cath labs, regarding NSTEMI and pacing work efficiency • On a broader scale, ongoing discussion with primary care and research partners on improving unequal health outcomes for cardiovascular disease in Trust catchment area.

Luton	Cardiology	National audit of Myocardial Ischaemia	• Achieving good door-to-balloon (DTB) (Non-ST-Elevation Myocardial Infarction) times for in-hospital STEMIs (ST-elevation myocardial infarction) • Most patients with ACS have cardiology involvement • Good referral pathway for cardiac rehab • Good secondary prevention medication prescribing. **Actions required for further improvement** • Ensure accurate reporting for TTE (transthoracic echocardiogram) in patients during MINAP (Myocardial Ischaemia national audit programme) audit – can do local audit to assess this within 1 year. • Highlight importance of secondary prevention medications such as aldosterone antagonists on cardiology ward – posters etc. • Weekend lists already in place. Possibility of clearance lists when new lab opens. Local re-audit re 72-hour wait in 8 months.
Luton	Cardiology	National Audit of Cardiac Rehabilitation	• We currently offer our programme to all priority groups including post-transplant and valve patients. • We have an excellent MDT (multidisciplinary team) who work well together under extreme pressure, and have a clear record of staff retention. • With a successful bid to NHS England, we recruited an exercise physiologist for a 12-month fixed term that has enabled us to extend the duration of the exercise component to 10 weeks, incorporating a comprehensive pre and post assessment clinic on week 1 and 10. • A focus on adding in additional allocated time for phone calls and staffing additional review clinics has reduced the waiting times significantly for patients to commence core rehab. **Actions required for further improvement** • Schedule additional clinics to meet service demand. • Allocate protected telephone call time to contact patients following referral. • Run an extra 10-week group of exercise. • Change from Phases to core/early data entry to reflect service more accurately. • Ensure text reminder service is implemented. • Extend duration of exercise component of programme from eight to 10 weeks.
Bedford and Luton	Corporate	National Audit of Dementia: Care in General Hospitals 2022-2023 Round 5 Audit Report	• Dementia nurse to enquire with NAD (National Audit of Dementia) network how other Trusts measure quality of care against staff training. Align dementia reporting with annual dementia statements and NAD recommendations. • InPhase team to encourage the use of the word Dementia in incident reporting. • PLACE (Patient Led assessment of care environment) inspection team to include Dementia nurse in the action plan and findings of PLACE inspections. • Re start Dementia steering group to focus on NAD audit results.

			• Trust board to decide if data relating specifically to dementia for delayed transfer of care and readmissions is required for NHSE (National Health Service in England) /ICB (Integrated Care board) dashboards. • Work collaboratively with trusted assessors to improve the transfer of care/discharge planning with the assurance of community support. • Increase the referral to DISS (Dementia Intensive Support Service) on discharge to assure support to care homes with the management of Behavioural and psychological symptoms of dementia (BPSD). Community MH support is required to facilitate the management of complex cases with BPSD. • Dementia nurses contact the pain team to help monitor and encourage the use of the Abbey Pain Tool and its equivalent. • Dementia nurse to request evidence of E-learning for health (E-lfh) pain modules from Training and Development team. E-lfh module for pain to be recommended with the T2 training on offer.
Luton	Corporate	National Cardiac Arrest Audit (NCAA)	• Cardiac arrest rate is 0.68, which is lower than the NCAA (National Cardiac Arrest Audit) rate of 1.0. • ROSC (Return of spontaneous circulation) rate is 66%, which is higher than the NCAA rate of 49.5%. • STHD (Survival-to- hospital discharge patients) rate is 32.1%, which is higher than the NCAA rate of 22.7%. • ROSC and STHD rates are higher than the NCAA expected rates for the Luton and Dunstable hospital. • Previously, we have seen high ROSC rates and lower STHD rates at the Luton and Dunstable site. High ROSC rates and low cardiac arrest rates are indicative of early recognition of the deteriorating patient, good quality CPR and early defibrillation. • In instances of low STHD, the Trust should consider review of variation in resuscitation decisions across both sites. • There is a quality improvement project to support timely TEP (Treatment Escalation Plans) and DNACPR (Do not attempt cardiopulmonary resuscitation) decisions
Luton	Clinical Haematology	National Comparative Audit of Blood Sample Collection and Labelling	Monthly, National average 4%, our current average is 9%, we feedback to clinical areas who action locally with users. **Actions required for further improvement** • Implement electronic bedside sampling system to reduce rejection of incorrect spelling / missing details / wrong blood in tube incidents • Check ICE request from matches sample details before sending off to blood bank for testing by each individual user • Check and confirm positive patient identity at bedside by each individual user.
Luton	Clinical Haematology	National comparative audit of blood transfusion programme-	• We are doing extremely well in giving written and verbal communication to patients and checking Hb and assessing clinically post transfusion.

		Audit of Patient Blood Management & NICE Guidelines	• We should share the results at the HTC as despite the tremendous effort that was put on the anaemia clinic prior to elective surgery, our performance is adversely affected by the absence of a functional clinic. • We should also highlight the importance of Tranexamic acid in surgeries with likelihood to have significant blood loss and the importance of documenting clearly, when it was not given.
Bedford	Diabetes & Endocrinology	National Diabetes Audit - Adults Foot care	• 23% alive and ulcer free at 12 weeks – improvement from 11.3% 2022-23. • Major Amputation rates remained the same as 2022-23. • 49% ulcers in 23/24 classed as severe improvement from 62% the previous year
Bedford	Diabetes & Endocrinology	National Diabetes Inpatient Safety Audit(previously NADIA IP Audit (HARMS)	• Perioperative pathways pilot launched • Hypoglycaemia awareness week- hypoglycaemia simulation teaching • Insulin safety training to nurses and doctors • DKA (Diabetic ketoacidosis) audit.
Luton	Department of Medicine for the Elderly (DME)	UK Parkinson's Audit	• Options for remote consultations, awareness of the importance of activity and exercise, and inductions for new therapists have all improved. • It is particularly pleasing to see such an improvement in the assessment and management of bone health, which was one of the key service improvement priorities identified following the 2019 audit. • In response to this, we launched a national multi-centre service improvement project, collaborating with 44 Parkinson's services across the UK.
Bedford	Emergency Medicine	Royal College of Medicine: Pain in Children	• Introduction of Pain score on to Symphony • Introduction of Wong Baker pain score • Introduction of re-assessment of pain DEP (direct insertion probe) on Symphony • Multiple PDSA (plan-do-study-act improvement work testing changes) cycles and teaching to doctors and nurses • Need to teach doctors and nurses emphasizing early pain assessment and prescribing the medications. For moderate and severe pain, re-assessment of pain score should be done within 60 minutes of initial analgesia.
Luton	Emergency Medicine	Royal College of Medicine: Pain in Children	The only area where department were below the national average was in time to triage/pain assessment within 15 minutes of arrival. This is more of a reflection of triage time, and there is ongoing departmental review of this within our triage teams. It is also a reflection of the continual demands/pressures EDs (Emergency Departments) have faced throughout the year and this is likely to continue. • Ongoing work on meeting national triage times which would meet the time to pain review - ED Triage Team • NerveCentre implementation will help with repeat e-obs and pain review and capturing data - NerveCentre Team

Luton	Neurology	UK Parkinson's Audit	• Documented evidence with patient/ carer and/or provision of written information regarding potential adverse effects for any new medications – 91.2% • Evidence patients taking dopaminergic drugs are monitored re: impulsive/ compulsive behaviour – 90.9% • Evidence the patient/ carer has been offered information about, or has set up a Lasting Power of Attorney – 67.6% • Documented discussions regarding end of life care issues/ care plans within 12 months – 66.7% • Access to Parkinson's Nurse – 93.3% • Quality of Service provided by Parkinson's specialist doctor – Excellent 57.1% and Good 42.9% • Enough information given about Parkinson's on diagnosis – 73.3% • Enough information given on new medication prescribed including side-effects – 73.3%
Bedford	Paediatrics	The National Paediatric Diabetes Audit (NPDA)	• Check list in place, Annual Review appointments in place to enable this. The team has discussed how to record on a database, to enable data gathering. Review and increase of clinic capacity to enable these checks to be completed • Ongoing training with primary care, with paediatric focus on diagnostics and referral pathways regular practice manager meetings in place • Discussion with research team regarding studies being funded to derive evidence for interventions supporting pre-diabetic children's young people to avoid progression to Type 2 diabetes
Luton	Respiratory	National Asthma and COPD Audit Programme (NACAP)	• All patients seen by Respiratory with possible asthma/COPD (Chronic obstructive pulmonary disease) offered outpatient lung function testing and follow up. • Transition clinics with paediatric consultant, nurse, Respiratory Consultant and Respiratory Clinical nurse specialist (CNS). Monthly MDT with community Respiratory CNS and ad hoc communication. Discharge bundles completed with high best practice tariff completion. **Actions required for further improvement** • Quality Improvement Plan in progress in conjunction with ED for next 12 months. • Ongoing work to reduce DNA (Did not attend) rates. • Increase frequency of MDT with improved workforce
Bedford	Respiratory	National Asthma and COPD Audit Programme (NACAP)	• We have a dedicated staff who input the data on the system. • We have amended the questionnaire (which is completed by the clinical staff) and are collecting data relevant to the audit • We have an internal spreadsheet of patients who have been coded as either having Asthma/ COPD that is cross-referenced with the audit record, and if any have been missed, the data is updated.

Bedford	Respiratory	National Lung Cancer Audit	• Vast majority of targets exceeding the national average. • Improved two week wait initial appointment timescales. • Log Mean Temperature Difference (LMDT) resourced according to commissioning guidance.
Luton	Respiratory	National Lung Cancer Audit	• Ongoing rollout of targeted lung health check, increasing amount of detected early stage disease • Increased amount of reflex mutation testing on confirmed cancer biopsies to speed pathway to treatment • Use of cross-site diagnostic pathways and service level agreements (SLAs) with partner Trusts to allow earlier biopsies through interventional radiology and bronchoscopy/EBUS (Endobronchial Ultra sound) • Pathway review meeting 22/11/23 prompting imminent move to daily triage, and possible future introduction of ctDNA diagnostics.
Luton	Rheumatology	National Early Inflammatory Arthritis Audit	• Maintain above national target/performance for time to first review by specialist within 3 weeks of referral and time to Early Inflammatory Arthritis (EIA) referral within 3 days • Already/continue to provide EIA clinic and pathway. • Access to specialist telephone line • Provision of medication education and self-management support • Access to relevant Allied health professions (AHPs) services • Improved numbers submitted via our Luton Rheumatology Department site since 2022-2023 data entry period.
Bedford	Rheumatology	The Fracture Liaison Service Database (FLS-DB)	• There is an improvement on KPI2 (Identify Spinal Fractures). The success of improving is a result of team effort involving radiology department and FLS. • There is also an improvement KPI 6 (Falls risk assessment) + KPI (Key Performance indicators) eight (Strength Balance by 16 weeks). With the launching of the Falls team+ falls clinic + referral system to falls team + every patient admitted through FLS has a falls risk assessment done there evident an improvement of quality of the service provided for patients with Fragility fractures. • On KPI7 (Bone treatment). There is an improvement for this standard. Patients who have had a DEXA/DXA scan (a scan which measures bone mineral density) with blood tests looking for secondary causes for osteoporosis, and then have been put on active bone treatment, as per national guidelines. **Actions required for further improvement** • Participation in developing the falls team by Falls team (north wing site) + Orthogeriatrician Consultant. • Implementation of osteoporosis treatment, regular practice in patients by Fracture Liaison Service + Orthogeriatrician Consultant.

Luton	Stroke	Sentinel Stroke National Audit programme (SSNAP)	• Overall retained a B rating. MDT working improved from D to C, Stroke unit improved from E to C/D.
Bedford	Stroke	Sentinel Stroke National Audit programme (SSNAP)	• Overall score moved from E to D, Audit compliance now A from E

LOCAL CLINICAL AUDITS

In 2023-24, 332 local clinical audits were registered. The table below lists a selection of outcomes/ actions following the receipt of outcome forms/actions plans.

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
Bedford	Acute Medicine	Clinical Shadowing & Integration Program (CLIP) - A pilot project in medicine	• The Clinical Shadowing and Integration Program (CLIP) for new international medical graduates (IMGs) is an ongoing pilot project in the Department of Medicine at Bedford Hospital. CLIP has received appreciation from Bedford Hospital's Service Managers and Clinical Directors for its potential for wider implementation within the hospital due to its achievable and pragmatic design. • The program has also been discussed with LED tutors at Luton Hospital, who have expressed interest in utilizing elements of CLIP for their own induction processes, and a cross-site adaptation. CLIP demonstrates scope for scalability and wider implementation across both hospitals in the Trust. As the program moves forward, adapting components of CLIP into online formats could enhance the on boarding experience for new enrolees through a better user interface as well as reduce paper consumption and carbon footprint. • Overall, the promising reception of CLIP highlights its capacity to improve inclusion, experience, and development opportunities for IMGs (International Medical Graduate) joining the Trust at non-training grade level.

Luton	Acute Medicine	Hospital Acquired Pressure Damage	**Actions to be completed:** • Notes review to identify patients for Waterlow assessment the following day. • PDN to review hospital-acquired incidents - provide training for gaps in practice that did not identify a need for preventive measures. With renewed competency assessment. • Senior nurses sign off that all preventative measures have been implemented - Job list of outstanding measures the following day. Regular escalation of delayed equipment. • Discuss policy at ward level meetings and opportunity for training or competency assessment from PDN (Private Duty Nurse) for staff who request. • Include skin checks in new starter induction with competency assessment. • For all patients think reposition at points of essential care, including a verbal reminder for able patients. • Continued challenge of poor documentation as this presents a patient safety risk, hinders investigation and learning
Luton	Anaesthetics	Factors contributing to General anaesthetic for elective caesarean section	• We are achieving the standards set by Royal College of anaesthetists. Our incidence of GA for elective cases is 1.8 %(RCO recommends <5%) • There are some factors acted on which scan bring incidence further down. • Patient counselling in anxious pts who deny regional for elective section • Use of ultrasound in difficult cases. • Re attempt at regional incidence can be improved further. • Postponing case to other date in case of inadequate block level.
Luton	Anaesthetics	Survey for IV ibuprofen	• A new medicine with a triple-action profile: analgesic, anti-pyretic, and anti-inflammatory effects. • It is ready to administer – and does not require reconstitution. • IV administration can be extended to the ward - could be administered by nurses in the ward. • It is the only NSAIDS (Non-steroidal anti-inflammatory drugs) licensed for children from 20kg or 6yrs. low cost-effectiveness
Bedford	Anaesthetics	Management of acute haematoma post thyroid surgery education and training	• Not all staff involved in the care of patients undergoing thyroid surgery were aware of the local protocol/poster/box. • Staff confidence levels in recognising and managing this complication were low. • This is a rare complication so keeping training up to date is very important. • We now have 6-monthly training update sessions in the anaesthetic department for all staff involved in the care of these patients in theatres and

			recovery.
LDH	Breast Screening	Uniformity of assessment practice review	• All variation in practice was within national NHSBSP (National Health Service Breast Screening Programme) guidelines • Good overall compliance • Review assessment sheets, Dec 2024, Change NBSS (National Breast Screening System) to I2 if discharging from assessment, March 2024
Luton	Cardiology	Dual antiplatelet prescribing - Audit results and opportunities for improvement	• Methods of improvement identified: Automatically inputting TomCat angiography report to ICE discharge and/or EVOLVE letters, as this usually states duration of therapy Adding stopdate to pharmacy prescriptions dispensed in hospital • Giving patients app/card/leaflet given to them at angiogram to specify antiplatelet duration. • Following on from presentation, we have engaged pharmacy and cardiac rehabilitation teams to assist in facilitating this goal for our patients. All patients audited were prescribed appropriate dual antiplatelets following PCI.
Luton	Cardiology	Evaluate the use of CTCA and assessing underlying CAD and radiation dose at LDH	Upgradation of CT scanner to avoid high dose of radiation and avoid cancellation of procedures. **Actions required for further improvement** • Minimize use of padding time with the step-and-shoot scan increases radiation exposure (45% increase per 100-msec increase in padding time). • Reducing tube voltage from the standard 120 kVp to 100 or 80 kVp reduces radiation dose 30%–50%.
Bedford	Critical Care	Decision to Admission Time to Critical Care	• There is still room for improvement with regards to the quality of the documentation of the decision to admit time and reason for delay over 1 hour. • 94% of patients were admitted to ICU within the suggested national target of 4 hours from the decision to admit time. The other 6% of the patients were undergoing emergency surgery in theatre as reason for delay over 4 hours. Our compliance with our locally agreed target of 1 hour has improved from 30% last year to 60.7% this year. • Standardised Metavision training for all new doctors now includes doctor's admission form training, Change options on doctor's admission for to avoid confusion between planned/unplanned admission.
Luton	Critical Care	ICU(Intensive Care Unit delirium medication at hospital discharge	• Some patients may need ongoing treatment for acute delirium and a de-escalation plan is not always made or taken note of. Need to improve ITU to ward handover processes. 3/100 patients were discharged home on antipsychotics, which were started on ITU. It was appropriate to remain on them in only one of the patients. • Implement digital prescribing on ITU to bring it in

			line with the rest of the hospital. Move to using Nerve Centre for ITU discharges. Review dates to be included onto EPMA when anti-psychotics are prescribed.
Luton	Diabetes & Endocrinology	An audit on hyponatremia referrals and management	• Trust Guidelines on Hyponatremia management is very clear-but not followed Preliminary Investigations were not properly carried out before referral. • Most referrals are not appropriate. SIADH (Syndrome of inappropriate antidiuretic hormone secretion) cases- admitting team requesting for clinic appointment • Areas identified for improvement : Fluid charts maintenance ; information in discharge letters **Actions required for further improvement** • Educating junior doctors on audit findings. • Update ICE referral format for hyponatremia. • Updating Hyponatremia Trust Guidelines • Presenting the audit results in acute medical teaching and to circulate through e-mail on expectations. • Re-audit in 6 months.
Luton	Diabetes & Endocrinology	L & D- Diabetes Inpatient Audit -Local)	• Improved staff knowledge and patient satisfaction. Improved foot risk assessment. No increase and slight downward trend for prescription and management error. • Good and improved patient satisfaction based on 31 returns, staff knowledge >95% and patient satisfied with DM care > 90%. • Success of mandatory ESR training for Safe use of insulin, and regular DM study days forward staff, and proactive in reaching by Diabetes Inpatient Specialist Nurse (DISN) for patient care and staff support. • Overall success of first performance of local NaDIA audit using IQVIA patient experience tool. **Actions required for further improvement** • Maintain full DISN whole time equivalent staffing - ongoing. • Check if prevalence has increased over last few years since reduction in community podiatry service • Improvement due to introduction of NC foot assessment tool on admission. Check NC foot assessment tool not allowing 'bypass'. • Consider reviewing case notes of 9 patients for causes of delay. • Provide more training to junior staff on dose adjustment. Resume yearly (now made 2 yearly) F1 teaching session (in-patient DM management). • Cross-site thematic review on insulin error

			working group already set up - with patient/ medication safety teams by F1 teaching. • If national NaDIA does not resume, then repeat local NaDIA in 2yrs.
Luton	Diabetes & Endocrinology	Management of Adult Diabetic Ketoacidosis (DKA)	• The hospital performed well in most aspects of the DKA audit. These included correct diagnosis without delay, prescribing basal insulin for DKA (v) patients on admission, good potassium replacement practice, and timely review by the diabetes team within 24 hours.
Bedford	Diabetes & Endocrinology	Steroid emergency card	• There is no national average. However, the standard should be above 95%. Performance needs improvement.
Luton	Department of Medicine for the Elderly (DME)	Delirium Audit	• Elderly patients with confusion were promptly admitted for investigation and management. **Actions required for further improvement** • Re-train Senior House Officers (SHOs) /Registrars in Geriatric departments on delirium assessment and diagnosis • Introduce the change in NICE guidelines for delirium assessment. 4AT assessment tool highlighted in Comprehensive Geriatric Assessment (CGA) form
Luton	DME	An Audit on Medical health record keeping	• We have assessed eight standards, and we are fully compliant in three areas. The use of standardised structure and proformas in medical record keeping. The date suggests that the available proformas are well used. **Actions required for further improvement** • Improve knowledge among staff on importance of medical record keeping and standards by presenting the full audit data in the DME Clinical Governance meeting
Luton	DME	Prompt mobilisation in post-operative neck of femur fracture patients (re-audit)	• We have improved practice by ensuring patients have adequate analgesia prescribed on drug charts. We have regularly encouraged patients to ask for painkillers if they need them. • During weekly and daily MDTs we highlight the need for adequate analgesia to nursing and physiotherapy staff
Luton	DME	Audit on steroid emergency card, a simple way to avoid emergency	• Now data gathering is much more effective from clinical portal availability but EVOLVE clinic letters are always useful. • Nerve centre EPMA is indeed better than previous ePMA and helpful to recognise preadmission medication. Also verbal alerts by pharmacists & restart written alerts by green colour on notes to improve more safety.
LDH	Dermatology	Audit on Day Light Photo Dynamic Therapy (PDT)	• We are lower than expected on the following: Prescribing Urea based moisturizer prior to

			treatment. Following up patient at 3 months after Photo Dynamic Therapy (PDT) Treatment response >75% • We are 100% compliant with Adherence to Treatment protocol on the day of the treatment with checklist and somewhat reasonable compliance with Documentation of response at the follow up appointment but latter can be optimised more. • Prescribing an Urea based moisturizer when requesting PDT-clinician requesting PDT-May 24,Tick systemic box in 18 week form to arrange follow up in 3 months-PDT Nurse-May 2024, To assess treatment response document treatment response as a percentage, take follow up images of treated areas-Clinician at follow up-Jan 2025, Consideration of indoor day light PDT lamp-Financial Team-Jan 2025. Re-audit required December 2026
Luton	Emergency Medicine	Oral Fluid Rehydration in the Management of Gastroenteritis for Children Aged 0-5 years in Bedford Hospital Emergency Department	**Actions to be completed:** • Guidance posters to be hung up in 'Pre-existing diseases' (PED) triage room and doctors 'see and treat' rooms • Data entry point to be added to Symphony ED software to improve documentation of oral fluid challenges • In person teaching seminars for doctors and nurses on audit results and NG tube insertion training • New gastroenteritis in under 5 year olds local guideline to be created and uploaded to hospital intranet, for easy access by ED doctors staffing the PED who may be unfamiliar of ideal management of these patients
Luton	ENT	Audit of 2WW Target Compliance Before and After Rapid-Access Clinic	• Increasing rapid access clinic capacity ensuring appropriate patients are streamed to rapid access clinic • Good improvement in diagnosis for patients in rapid access clinic - high compliance to standard.
Bedford	Gastroenterology	Management of Acute Severe Ulcerative Colitis according to BSG guidelines	• All patients with UC Flare have had Bloods and electrolytes checked on admission. • All patients started on IV Hydrocortisone
Luton	Gastroenterology	Diagnosis of Bile Salt Malabsorption using SEHCAT Study in a District University Hospital	• Further re-audits might be needed depending on the consultant clinician's decision and since the data collection was over one year period and the outcome was well within the standards, we have not agreed on a re-audit date yet. At present, there is not an identifiable risk to patient safety. • The true positives for SeHCAT (selenium homocholic acid taurine) study are well within the national and regional guidance and within the limits set by the NICE standards. A correct management is prescribed in all the patients with

			a positive study, which is almost within the standards set by NICE.
Bedford	General Surgery	Outcome of Appendectomy in Right Iliac Fossa pain patients	• Learn to assess patient clinically rather than rely on investigation in patients with equivocal appendicitis and persistent RIF(Right Iliac Fossa) pain
Bedford	General Surgery	Fluid prescribing in Surgical Paediatrics patients in Riverbank	• Only one patient out of the data was not prescribed the right amount of fluid. All other patients were compliant. Low risk of developing dehydration for the patient.
Luton	General Surgery	A Re-Audit: Radiological Investigations In Patients Diagnosed With Gallstone Disease	• Number of patients having CTAP (Computed tomography arterial portography) as first radiological investigation has decreased by 45% from initial audit to re-audit. We have presented this finding in the general surgery clinical governance meeting and outlined the importance of using ultrasound as the first line investigation. • Raise awareness amongst junior doctors with posters in different areas of hospital outlining NICE guidelines. • Introduction of guidance on gallstone pathway management that is accessible for other specialities.
Luton	Neurology	Incidental white matter lesions on MRI: an audit from the Luton and Dunstable Hospital-pre Covid -2019 and post-Covid 2021	• Magnetic resonance imaging (MRI) of the brain is increasingly used both in research and in clinical practice, resulting in the detection of incidental findings with different clinical implications. • The most common incidental MRI findings are non-specific incidental white matter.
Luton	Neurology	Safety of Cladribine in people with MS treated in a district general hospital	• Since its approval in December 2017, Cladribine has been prescribed for 12 patients with MS at the Luton and Dunstable Hospital. There was a delay in prescribing Cladribine compared to the approval date. The first patient on Cladribine was started on 01/08/2021. • The clinical features of the patients on Cladribine were in keeping with a relapsing-remitting population with more active disease or non-responsive to previous disease modifying therapies (DMTs) (mean age about 40 years, EDSS between 1 and 6.0).There was 100% compliance rate achieved by majority of standards. 25/30 audit standards showed 100% compliance.
Luton	Neurophysiology	An evaluation of system change in report dissemination' (re-audit)	• Following a consultation with our referrers, we determined that their expectation for routine outpatient study reports to be returned to them was 10 working days. • We had previously managed to bring down report turnaround times in 2018 (uploading to Evolve) to 1.8 days.
Cross site	Oral/maxilla Facial	Assessment of risks discussed in relation to consent forms involving	• The majority of the complications were documented 82-100%. The lower risk complications were documented less frequently

		surgical and non-surgical extraction of wisdom teeth	bringing the average down significantly. Many of these complications, although low risk, can have a significant patient impact and a requirement to disclose following Montgomery legal test. • Risks that were pre-printed were accounted for 100% of the time. • 84% of the consent forms involved exodontia of mandibular third molars, 44% involved maxillary third molars and 4% included coronectomies. Generalised risks were well documented, with bleeding and infection being noted 100% of the time. Damage to adjacent structures was less so, this could be attributed to not always being necessary. (E.g. full clearance, no adjacent teeth etc.) Consent forms that included mandibular 3rd molars noted altered sensation or numbness of lip chin and tongue were noted most frequently. Altered sensation of taste and mandible fracture was noted the least – to consider consistency across Consultants. OAC was only mentioned 55% of the time when maxillary third molars were removed. Conclusion: Common risks were mentioned most often (pain, bleeding, infection) whereas less common risks were mentioned least often (e.g. mandibular fracture). Many of these complications, although low risk, can have a significant patient impact and a requirement to disclose after Montgomery. Risks that were pre-printed were accounted for 100% of the time. Therefore, a procedure specific consent form with all relevant risks included was designed to improve the validity of the consent process by including all material risks. The risks for each type of procedure can be ticked off with space to add any specific or material risks to the patient as an individual. Improving the validity of the consent form reduced patient complaints and Trust litigation patient's expectations will be appropriately managed. • Procedure specific consent form designed. Procedure specific consent form to be implemented in clinics, • Second audit cycle to re-assess-May 2024
Bedford	Radiology	Osteomyelitis in Diabetic foot patients : Current role of X rays	• Early MRI evaluation should become a norm rather than afterthought following negative initial x ray evaluation of a diabetic foot patient with clinical suspicion for osteomyelitis • MRI foot is being done in 80% patients with clinically suspected osteomyelitis in diabetic foot patients, which indicates good compliance. Baseline X ray - the national average is not known however the compliance can be improved further with target of at least 95% • Further increase in compliance for MRI Foot as

			the norm for clinically suspected osteomyelitis
Luton	Stroke	Transient Ischaemic Attack (TIA) and imaging - what we do and a way forward	• We have been running 7 day a week stroke and TIA clinic service more than a decade in the Trust, with 4 available MRI slots with carotid doppler USS imagings. In line with NICE, MRI brain is the first imaging modality in the suspected TIA patients, we achieved in 83% of patients having MRI brain scan done and 55% of the patients having carotid dopler USS scan done.
Luton	Stroke	Using existing IT systems to improve stroke pathway	• There was a reduction in the median time from door to CT scan for patients for whom SIREN was available. This will be shared with the East of England ISDN team and further engagement with EEAST to increase the availability of SIREN data prior to patients' arrival in hospital. **Actions for improvement** • Continue to use SIREN for pre-alerted stroke calls. • Continue to monitor door to CT times through SSNAP • Engagement with EEAST to increase availability of SIREN records prior to arrival. • Share with ED operational performance meeting. • Share with EoE ISDN
Luton	Renal	Acute Kidney Injury: Prevention, Detection and Management	• Screening for AKI is done well. Medication review and Urine Output monitoring has improved significantly compared to previous. **Actions for improvement** • Include training on bundles in Induction Education update • Discharge letter update to include section on AKI.
BH	Respiratory	Inpatient management of Pulmonary embolism (PE) as per NICE Guidelines- QIP 2nd cycle	• There is improvement in all indicators as compared to cycle 1 specifically patients are now started on correct form of anticoagulation. **Actions for improvement** • All patients with unprovoked PE should have risk stratification done for malignancy and imaging should be only done if patient have risk factors present. • Correct form of anti-coagulation on admission.
Luton	Respiratory	To assess whether the British Thoracic Society (BTS) 2010 guidelines are being followed for the management of spontaneous pneumothorax	• Chest x-ray findings to identify pneumothorax discussed during meeting to be completed. • Print copy of guideline chart and put in doctor's office • Meeting with respiratory team, focused on BTS guidelines - discussed points where implementation is lacking and plans to improve
Luton	Rheumatology	TOC STOP, a national service evaluation of outcomes after tocilizumab cessation of GCA	• Our outcomes were in line with the national average. Since its approval in December 2017, Cladribine has been prescribed in 12 patients

			with MS at the Luton and Dunstable Hospital. There was a delay in prescribing Cladribine compared to the approval date. There was 100% compliance rate achieved by majority of standards. 25/30 audit standards showed 100% compliance. **Actions for improvement** • Review that MRI is arranged before commencing Cladribine without delaying commencing treatment. • Blood test monitoring should be more rigorous and reflect the local protocol for safety. • Adherence with the guidance about normal lymphocyte count before commencement of Cladribine is not always feasible due to patients switching from other DMTs that affect lymphocyte count; therefore, a review of the local protocol regarding guidance on specific for DMT switching to Cladribine is needed.
Luton	Rheumatology	Aromatase inhibitor induced osteoporosis management	• Accepted for oral presentation at European Congress of Rheumatology (EULAR)
Bedford	Urology	Introduction of Disposable Flexible Cystoscopies (QIP)	• A system has been introduced to assure continuous supply of cystoscopies for the emergency team at all times. Documentation of the flexible cystoscopies in theatre operation notes will be completed and reviewed. • There has been a successful implementation of disposable flexible cystoscopies in the Urology Department, which has shown improvement in patient care and subsequent financial benefits for the department, and Trust. • Documentation of Cystoscopy results in Operation Notes - June 2024 • Write patient details in diary provided in Ambu Scope Monitor Bag June 2024
Bedford	Vascular	Amputation and Outcomes Post-Amputation between 2018-2022	• Below the knee / Above the knee (BKA:AKA) - 1:0.9 - Standard met however with close margins. Centralised database for amputation outcomes - the Trust meet the guidelines set however a centralised database is still required • All standards met however standard of BKA>AKA was met with close margin. Death rate 30 days post op was significantly low We had more AKA than BKA which is in keeping to NVR guidelines • Centralised database - June 2025.Centralised database-Bedford Hospital-Jan-2026

3.3 Participation in Clinical Research

Participation in clinical research demonstrates the Trust's commitment to improve the quality of care we offer whilst making a contribution to wider health improvement. Our clinical staff keep up-to-date with the latest treatment possibilities and active participation in research leads to improved patient outcomes. All articles published as a result of research in the Trust can be found in the Annual Academic Report.
In 2023/24, 3045 patients receiving NHS services provided by the Trust were recruited to participate in research approved by a Research Ethics Committee. The Trust was involved in conducting 204 clinical research studies involving 200 Portfolio studies, i.e. adopted by the National Institute for Health and Care Research (NIHR) plus 4 Non-Portfolio studies. It has been encouraging that several specialities either have become active in research for the first time or resumed research activity after a long period of non-participation - these services include bariatrics, anaesthetics and respiratory medicine.

The Trust has participated in the NIHR Research Internship with the first three research interns at Luton & Dunstable Hospital completing and submitting an action plan stating how they will embed research within their departments. This scheme will continue in 2024/2025.

The NIHR Associate Principal Investigator Scheme has become more popular amongst Trust staff and will continue.

The Trust continues to work on the ongoing 'inclusion project' with East of England Clinical Research Network. In order to increase and widen inclusivity in research the department has developed posters, leaflets and banners to promote participation of the whole community served by the Trust.

3.4 Commissioning for Quality and Innovation payment framework (CQUIN)

Commissioning for Quality and Innovation (CQUIN) is a framework that allows commissioners to agree payments to hospitals based on agreed quality improvement work.

The contract value of CQUIN across all non-specialised commissioner schemes is approximately £6.6 million, representing 1.25% of the expected annual contract value.

In 2023/24, the Trust monitored delivery and performance across the ten national CQUIN schemes with five of these financially incentivised CQUINs. Each scheme has a minimum and maximum threshold, with partial payments being calculated if achievement falls between these thresholds and full payment achieved for all performance at or above the maximum threshold.

Of the ten CQUINs, eight focused on acute care with two specialist schemes, all focused on evidence based practice that supports the NHS Long Term Plan, promoting improved outcomes for patients.

CQUINS rating end of year 2023/4

Did not meet the threshold for achievement of the CQUIN
Met the threshold for achievement of the element of the CQUIN
Fully achieved the CQUIN

* No submission required
** Data not available

CQUIN Reference	Description	Q1	Q2	Q3	Q4
CQUIN 01 *incentivised*	Achieving 75-80% uptake of flu vaccinations by frontline staff with patient contact between 1 September 2023 and 28 February 2024.	*	*	*	52.8%
CQUIN 02 *incentivised*	Ensuring 70-80% of surgical inpatients are supported to drink, eat and mobilise (DrEaM) within 24 hours of surgery ending.	87%	83%	85%	87%
CQUIN 03	Achieving 40% (or fewer - minimum 60%) patients still receiving IV antibiotics past the point at which they meet switching criteria. *Note :* *For this CQUIN a lower percentage = better performance*	36.5%	43%	31%	32%
CQUIN 04	Achieving 35-55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head and neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways.	39%	41%	50%	55%
CQUIN 05 *incentivised*	Achieving 10-30% of patients aged 65+ attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.	42%	68%	85%	86%
CQUIN 06 *incentivised*	Achieving 0.5-1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.	**	**	**	1.0 %
CQUIN 07 *incentivised*	Achieving 10-30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.	69%	61%	61%	71%
CQUIN 08	Following guidance published by the Vascular Society, to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia, and in turn to reduce length of stay, in-hospital mortality rates, readmissions and amputation rates (45-65%).	46%	58%	41%	48%
CQUIN 10	Achieving 80-85% of patients aged 18+ with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-2) referred for treatment with curative intent.	*	*	*	77%
CQUIN 12	Achieving 70-85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.	49%	42%	54%	49%

3.5 Care Quality Commission (CQC) registration and compliance

The Care Quality Commission (CQC) is the organisation that regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain specified 'essential standards' in order to retain their registration.

As part of its role, the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards. Their assessment of quality is based on a range of diverse sources of external information about each Trust that is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections. If an issue raises concern during the data review process or from other sources of information, CQC may undertake an unplanned, responsive inspection.

The Trust underwent a Care Quality Commission Inspection of its Maternity Services at both the Luton and Dunstable and Bedford hospital sites in November 2023; the final outcome is not yet published.

Full details of the Trust's registration and inspection findings can be found on the CQC website via the following link www.cqc.org.uk/provider/RC9

3.6 Data Quality

The Trust recognises the importance of high quality, reliable information especially for the delivery of patient care and is committed to collecting and processing data according to nationally and locally defined standards. All decisions, whether clinical, managerial or financial need to be based on information that is of the highest quality. The Trust's patient activity information is derived from individual data items, collected from a number of sources whether they are on paper, or increasingly with, electronic patient records (EPR). With the implementation of the Trust's EPR, there will be a greater need for high quality administrative data to support the clinical record.

Data quality is everyone's responsibility and is an integral part of everybody's role. Although specific management and leadership responsibility is assigned to designated individuals with ultimate responsibility resting with the Chief Executive, in an organisation of over 7,500 people, everyone entering, processing or using data has a part to play in ensuring that the information derived from that data is of the highest quality. The Trust must ensure that all information is accurate and where necessary kept up to date to ensure compliance with the Data Protection Act 2018.

Good quality data can be achieved by monitoring key data items and activity events, with the results being reported to the service lines responsible. Although reporting on errors and completeness within key data items is essential for reporting gaps, it is more effective and

efficient for the data to be entered correctly first time. In order to achieve this, workplace procedures must exist for key areas processing information.

2023/24 Data Quality Improvement
Development of a suite of Power BI reports to highlight missing or invalid data on a self-service platform has meant data issues along with good practices are made transparent for key staff to review and resolve.

Externally we continue to use external sources of data to monitor and improve the quality of the data held by the Trust.
Examples of External Data Quality Reports:

- NHS England Dashboards
- Data Quality Summary CHKS
- Mortality Metrics (SHMI,HSMR Alerts)
- Model Hospital
- Data Security and Protection Toolkit
- External commissioned audits

The Team has continued to monitor the key data requirements across the two sites (as above) to ensure accuracy and in addition:

- We have reviewed the functions of the Data Assurance team, ensuring all staff have clearly defined roles. As part of this an existing staff have now be migrated to the newly formed data development team. This team will assist with the development of data across the Trust to assisting in digital projects as experts in Information, data quality and Data standards.
- We are working in partnership with external ICB and Clinical Support Unit colleagues to review key data quality concerns and joint Data quality meetings are in place.

- Implementation of a new in house Power BI report for data quality. This report is in the same format to the national reports to ensure continuity of use for staff but also includes local data quality indicators to help ensure our data is complete and consistent.

- To implement a new Information portal so that all reports produced by data quality and information can be published in one place, allowing quicker and easier access for service lines.

- We have increased batch tracing further and patient's data is now sent daily, weekly and monthly. We have engaged with service lines who are actively monitoring their own data and are implementing first line checks to ensure data is right first time.

- We continue to merge the Trust data warehouse so that there is one cross-site repository for data, allowing for more consistent and accurate reporting. All tables are now available in one repository.

- Supporting the Elective recovery projects and working closely with the national elective recovery teams to ensure our national Waiting list Minimum data set (MDS) is of good quality and supplied within the national deadlines to assist with the national programme of recovery for our elective patients.

- Continue to support UEC Type3 service providing support and education to ensure we are able to submit all Type3 data within the national deadlines.

- Continue to work very closely with NHS England to improve the quality of data capture for Type1 and Type3 activity.

- We continue to work with NHS England in the implementation of ECDSv4 and actively engage and contribute to support the Trust's EPR solution that will ensure ECDSV4 compliance.

- We continue to improve our faster daily flows data (FDF) and strive to meet the submission deadline.

Action Plan for 2024/25 Data Quality Improvement

Reporting

- To produce a Trust wide data quality strategy that works alongside the information and digital strategies.

- To continue to adapt and increase the number of indicators available within the Trusts data quality dashboards, ensuring that data is clear and accessible to all that require this to improve and assure the quality of Bedfordshire Hospital Trust's patient data.

- To further develop the existing reconciliation from pre and post SUS inclusions to ensure all activity is flowing accurately and in a timely manner.

- Review end to end process of financial flows to improve efficiencies in the current process

- Continue to participate in all digital projects to ensure information and data processes are compliant and meet national data standards. To have designated staff from data quality and information development as key stakeholders in digital projects, this will ensure we have data that is compliant with the national data standards and is available to ensure robust data quality and performance reporting for the Trust.

- Continue close working on Data requirements with Data Engineering. This includes the scoping of new reports to improve the use of data across the Trust to ensure that all data that is being submitted externally is accurate and timely.

- To enhance the data quality overview reports for service lines, in addition to the data quality (DQ) dashboards. These will be produced weekly and monthly and are

intended to be used as a summary for each service line so that they are aware of where data quality needs improvement plans.

- To create tailored individual data quality improvement plans (DQIPS) where required based on key data items, performance metrics and improvements (e.g. ethnicity, NHS numbers, GP practices, RTT outcomes and validation).

- To work with Data Engineering and Information services to review reports to ensure there is no duplication and only one version of the truth.
- To complete a gap analysis on CDS, ECDS and FDF submissions to review if these can now be submitted with data captured in the new EPR (NerveCentre)

- To have closer links to co dependant functions, working together to improve the Trusts corporate data and to instil a robust data culture across all staffing groups.

- To form part of the Trust's task and finish group, alongside e-health records to improve demographic data capture across all areas of the Trust

Education and implementation

- Continue work with the clinical systems training team to standardise systems training across sites, not only to stress the importance of data quality but also to ensure we have a consistent approach to data entry, which will improve cross site reporting.

- To work with the clinical systems training team to review all eLearning, ensuring it highlights areas where data quality needs to be maximised and to promote a robust data culture.

- To work with all digital colleagues to provide expert knowledge, advice and support in relation to any changes to or new implementations of clinical systems. Ensuring that all data that is captured is appropriate conforms to the data standards and can be reported on where required.

- To work with recruitment to explore data quality as part of standard induction training.

- To work with HR to reinstate data quality as a key role in all Job Descriptions.

- To continue to work with internal departments, spending more time with each service on the ground to offer advice and support on improving their data quality and capture.

- To implement a new cross site quarterly escalation meeting. This meeting will be an action group for areas that require improvement (based on data that is being sent out in the monthly DQ overview reports) and will be upward reported to the IG board and Trust board where required.

- To create electronic training packages to sit alongside clinical systems training.

- To offer regular DQ training sessions linked to clinical systems training completion.

- To offer DQ training drop in sessions to offer staff support on data entry and national data standards where required.

- To work with recruitment and HR to ensure that all staff are given a smart card as part of the on-boarding process. This will ensure that there are not delays in staff not being able to check key patient's data on other national and community based systems like Summary care records and SystmOne so that we can be assured our patient records are as up to date and accurate as possible.

Audits and system data quality

- To build a robust audit plan for the Trust data warehouse to ensure data is accurate and complete.
- To audit localised mapping on the data warehouse to ensure manual mapping as is per the data standards
- To audit national submissions and reports that go external to ensure all data fields are accurately mapped to the correct locations and are a true representation of the activity completed.
- To complete a full audit on all reference value tables in the back end of clinical systems. This will provide assurance that all data items are as per national data dictionaries and definitions so that cross-site data is comparably and consistent.
- To review and align data capture processes across sites, this will provide consistent reporting.

3.7 NHS Number and General Medical Practice Code Validity

Bedfordshire Hospitals NHS Foundation Trust submitted records during reporting period 2023/24 to the secondary user service for inclusion in the Hospital Episodes statistics which are included in the latest published data.

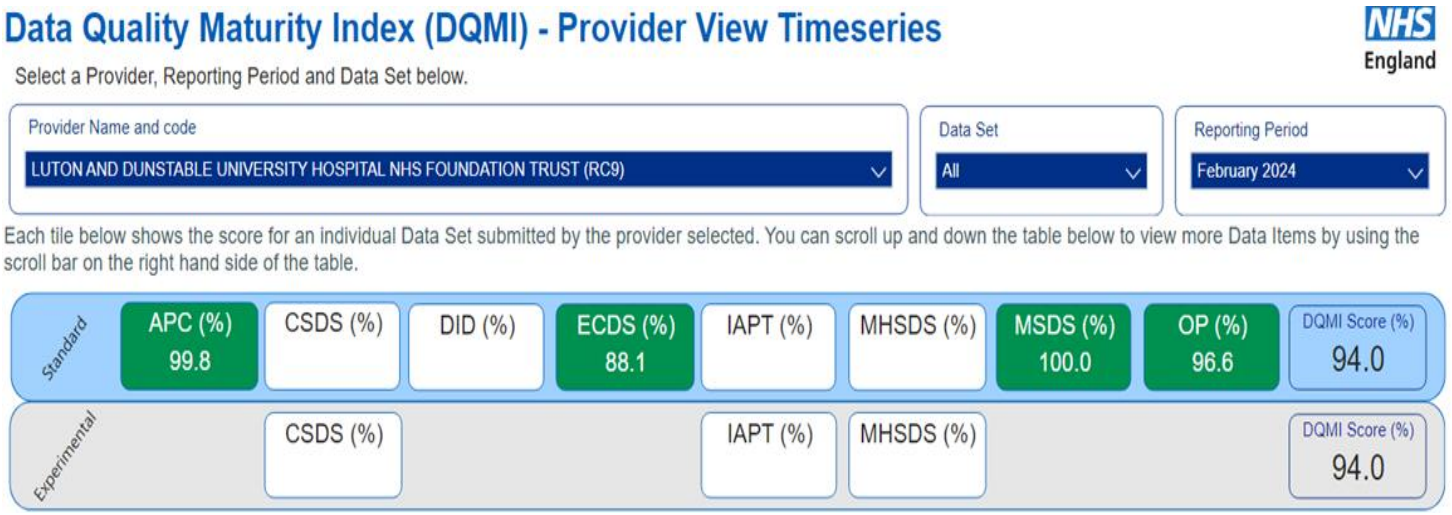
The percentage of records in the published data as at February 2024:

- Which included the patient's valid NHS number was:
    - 99.6% for admitted patient care
    - 99.9% for outpatient care
    - 98.9% for accident and emergency care

- Which included the patients valid General Medical Practice Code was:
    - 100% for admitted patient care
    - 99.9% for outpatient care
    - 98.9% for accident and emergency care

Data Quality Maturity Index (DQMI)

The DQMI is a monthly publication about data quality in the NHS, which provides data submitters with timely and transparent information. The Trusts current DQMI score is 94%



3.8 Clinical Coding Error rate

For diagnoses and procedure coding the accuracy rates reported in the latest published audit for reporting period April 2023 – March 2024 have been sustained with an attainment of 95.6% and 92.1%, respectively compared to the reporting period for April 2022 – March 2023 when the Trust achieved 94.4% and 92.5% accuracy rates, respectively.

3.9 Information Governance / Data Security and Protection Toolkit (DSPT) Attainment levels

Bedfordshire Hospitals NHS Foundation Trust published its assessment on the 30th June 2023. 110 of 113 mandatory evidence items were provided.

The Trusts status was Standards Not Met whilst NHSD reviewed the accompanying action/improvement plan. NHSD agreed that the improvement plan was acceptable and amended the status to Approaching Standards on the 30th June 2023.

To achieve Standards met compliance The Trust must meet the requirements of all assertions.

More recently, the Trust submitted a baseline assessment on the 28th February 2024.

The Trust's current baseline position is:

- **104 of 108** mandatory evidence items completed
- **29 of 34** assertions confirmed

The next submission of the DSPT will be published on 30th June 2023.

IG Incident Reporting Tool

The DSP Toolkit also incorporates an IG Incident Reporting Tool which the Trust is required to use for reporting IG incidents. Under GDPR, serious IG breaches (defined as incidents that are highly likely to have an impact on the 'rights and freedoms' of the individuals concerned), must be reported to the Information Commissioner's Office (ICO) within 72 hours of the Trust becoming aware of the incident.

Once information about an incident has been submitted through the tool, the details are automatically transferred to the ICO unless the tool determines from the information provided that it is not a reportable incident.

There have been 6 reported incidents (using this tool) for the last year. Four of these required further involvement from the Information Commissioner's Office.

Incident	**Response**
Personal Data breach	No further action x 3
Personal Data breach	Investigation complete, ICO response x 3
Cyber incident	No Further Action
Cyber incident	Investigation complete, ICO Response
Unlawful Access	Investigation complete, ICO response.
Unlawful Processing of personal data	Investigation complete
ICO Decision notice received	No Further Action
Unlawful Processing of personal data	No Further Action

Audit

The Trusts external 2024 DSPT audit is scheduled from the 22nd of March 2024.

3.10 Learning from Deaths 2023/24

3.10.1 Introduction

Achieving the highest standards in mortality governance, including learning from the care provided to patients who die, remains a key priority for the Trust.

The following sections provide a summary of the activity and outcome reporting presented at the Trust's monthly Learning from Deaths (LfDs) Board, with upwards reporting to the Clinical Quality Operational Board (CQuOB) and the Quality Committee.

3.10.2 Key updates 2023/2024

Mortality reporting and review outcomes are shared with the multi-disciplinary teams (MDTs) via clinical service line (CSL) and wider Trust governance meetings. Identifying opportunities for sharing and learning continue, including through mortality forums and quality improvement newsletters and individual clinical and educational supervision.

Emerging themes are reported to the CQuOB on a monthly basis and quarterly reports to the Quality Committee and Trust Board. Following the implementation of the Patient Safety Incident Response Framework (PSIRF), this includes any cases escalated to a Patient Safety Incident Response Panel (PSIRP), where assigned a judgement score of probably, strongly or definitely avoidable.

Work is ongoing to ensure crosscutting themes are shared across the CSLs, and where highlighted, with system partners. This includes case level feedback on the community response for non-admitted patients, and in admitted patients who die within 24 hours, to establish if there were missed opportunities for advanced care planning and admission avoidance in respect of end of life care.

In acknowledging the need for timely completion of Structured Judgement Reviews to support mortality governance activities, alternative routes of escalation and feedback by the Medical Examiner (ME) are considered. This includes direct feedback to the CSL Clinical Directors/Governance Leads, with a request for specialist review if indicated.

Refinement of InPhase as the Trust's risk management system continues, including the reporting functionality to meet local and statutory requirements. In addition, the development of the Power BI dashboard to support CSL mortality governance activities is ongoing, with planned additions to include national mortality indicators.

In advance of the introduction of mandatory ME review of all deaths before registration under new legislation coming into effect from September 2024, the recruitment and training of GP MEs is complete and the required IT infrastructure is established

3.10.3 <u>Summary of key changes to be introduced as part of the legislation:</u>

- There will be a new digital Medical Certificate of the Cause of Death (MCCD) this remains in development.
- All MCCDs will need to be countersigned by an ME before they can be sent to the registrar, this includes neonatal and community deaths.
- After the introduction of the new MCCD, cremation form 4 will no longer be required.
- Interaction between the ME Office, Registrar's Office and HMC - in the event the acceptability of a cause of death is challenged once the ME review has been completed, the registrar must refer the case back to the ME Office.
- The five day registration window for deaths to be registered - currently, this starts at the time of death. The new legislation will start at the date and time the ME approved MCCD is sent electronically to the Registrar's Office.

3.10.4 Monthly mortality reporting

Both hospital site and combined Trust data is reported monthly to identify themes, trends and areas for focus. Monthly reporting includes Comparative Health Knowledge System (CHKS) mortality alerts and national mortality indicators. In addition, deaths within 24 hours, and non-admitted Emergency Department (ED) deaths, are reviewed by a Deputy Medical Director (LDH) and the Associate Medical Director for Mortality Governance (BH) and presented at the monthly LfDs Board.

Stillbirths, neonatal and maternal deaths are reported and investigated through MBRRACE-UK (Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries across the UK). Neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool (PMRT) with the summary findings reported quarterly at the LfDs Board.

Child deaths are investigated through the Child Death Overview Process (CDOP). In addition to existing routes for reporting, summary findings including any themes and learning will also be presented quarterly at the LfDs Board.

3.10.5 Learning disability deaths (LeDeR)

Monthly reporting also includes learning disability deaths (LeDeR), with a total of 26 deaths in 2023/24.

<u>The LeDer process:</u>

System and Trust governance structures and processes are in place and in depth reviews are completed at the initial review stage. Following completion, all LeDeR reviews are presented to a system Quality Assurance panel (BLMK). This includes representation by the

Lead Learning Disability (LD) Nurse from both hospital sites, with learning cascaded to the safeguarding team.

Clinical case review highlights the complexity involved and the opportunities for learning across hospital sites. Key learning and updates identified in 2023/24 include:

Communication with family/ relatives

Best interest decision making should be multidisciplinary and take into account the views of family and those people who know the person well, when the person themselves cannot be consulted.

A trial of MDTs was arranged for patients with a LD which commenced in September. This was agreed following a review of readmissions to hospital, and some incidents where people had been discharged without all necessary equipment or medications. These meetings bring together hospital and community professionals involved in the person's care, along with family members, carers, discharge managers and the LD liaison nurses. This is having a positive impact, with equipment arranged, increased staffing arrangements, and a change in placement identified as an MDT outcome. This has also ensured that the receiving care team have their queries and concerns answered, and are able to put appropriate care plans in place ahead of discharge.

This has also successfully opened up the option of multiple discharge pathways being available to a service user, with discharge to assess pathways have been used with good outcomes for the service user.

Do not attempt cardiopulmonary resuscitation (DNACPR)

All providers should follow professional/Trust standards when assessing mental capacity for DNACPR decision making, and ensure the clinical rationale for not providing resuscitation is appropriate.

All DNACPR decisions were reviewed by the Acute Liaison Learning Disability Nurse. Communication was sent to all medical staff during 2023/24 to highlight the need for robust completion of these documents.

Mental Capacity Assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

The team continues to support ward staff in recognising the need for mental capacity assessments and deprivation of liberty safeguards. The team will signpost staff to the available MCA training provided by the safeguarding team, which helps staff to be able to ensure decisions are time and decision specific.

This work stream continues to be monitored, with team members supporting professionals as and when required.

The team commenced MCA/ DoLS & Learning Disability training days in 2023/24, with good attendance and feedback from staff.

Identification of patients with a confirmed LD diagnosis

An Acute Liaison leaflet and posters has bene developed and distributed to inpatient wards. These have also been sent to all GP's across Beds and Luton to encourage these to be displayed in surgeries so patients can contact the team as needed.

The LD team now receive information electronically to highlight patients that have a LD whom are inpatients, outpatients and have died.

Training

Training was also reviewed for LD within the acute setting during 2023/24. A review of the training needs analysis was completed. The Oliver McGowan training package commenced in Q3 and has received good feedback, and is now classed as mandatory training. In addition to this package, bespoke training is available and delivered by both LD teams on each hospital site.

Digitalised feedback

The team have recently been involved in work to digitalise feedback questionnaires across the Trust using iPads. This functionality is now available on ward iPads with work ongoing to include a QR code. The aim is to use the QR code in letters and leaflets to capture feedback from a wider audience of patients and carers going forward.

In addition, a LD Strategy was completed for the Trust in 2023/24, identifying the Trust's vision to improve services over the next few years. A LD policy was also completed to assist staff in supporting patients with a LD.

3.10.6 National data submission

Table 1: Quarterly breakdown of the number of admitted deaths at Bedfordshire Hospitals NHS Foundation Trust by hospital site in 2023/24

Table 1

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals (BHT)	**469**	**435**	**495**	**532**	**1931***
Bedford Hospital (BH)	231	164	220	250	865

Luton and Dunstable Hospital (LDH)	238	271	275	282	1066

Excludes stillbirth, neonatal (no. 71) and child deaths (no.4)*
(Data source: Trust reporting including Power Bi mortality dashboard)

Tables 2a and 2b: Number of completed Primary (2a) and Structured Judgement Reviews (SJRs) (2b), by quarter, at Bedfordshire Hospitals NHS Foundation Trust and by hospital site in 2023/24

Primary reviews (Table 2a)

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals	**501**	**492**	**591**	**634**	**2218***
Bedford Hospital	226	182	253	281	942
Luton and Dunstable Hospital	275	310	338	353	1276

Total no.s include acute adult deaths, non-admitted Emergency Department (ED) deaths. In addition neonatal, child acute deaths (no.17) and community death reviews (no.78) **
(Data source: ME monthly reports and InPhase mortality module)

A primary (first) review was undertaken for 98.4% of admitted deaths across the Trust in 2023/24, of these, to date, an SJR has been completed in 7.0% cases (142/2123**). The total no. primary reviews completed (no. 2218) excluding community (no. 78), neonatal and child deaths (no.17) **

SJRs (Table 2b)

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals	**40**	**30**	**45**	**27**	**142**
Bedford Hospital	24	15	22	11	72
Luton and Dunstable Hospital	16	15	23	16	70

An additional 14 SJRs have been requested, allocated and are awaiting completion for deaths in 2023/24 This equates to a total of 156/2123 (7.3%) SJRs.

This excludes SJRs allocated but not completed, with referrals pre-dating Q4 2023/2024. These referrals (LDH, n = 60) have been subject to senior clinical review by a Deputy Medical Director (DMD) and Lead ME to identify potential learning and onward action in advance of a decision to close (please see section below for summary methodology and outcomes). This has also been undertaken at BH, acknowledging there were a fewer number of outstanding SJRs awaiting completion.

Figure 1 illustrates the reason for referral for all completed and approved SJRs, by Trust (n = 142) and hospital site (BH, n = 72 and LDH, n = 70).

Figure 1

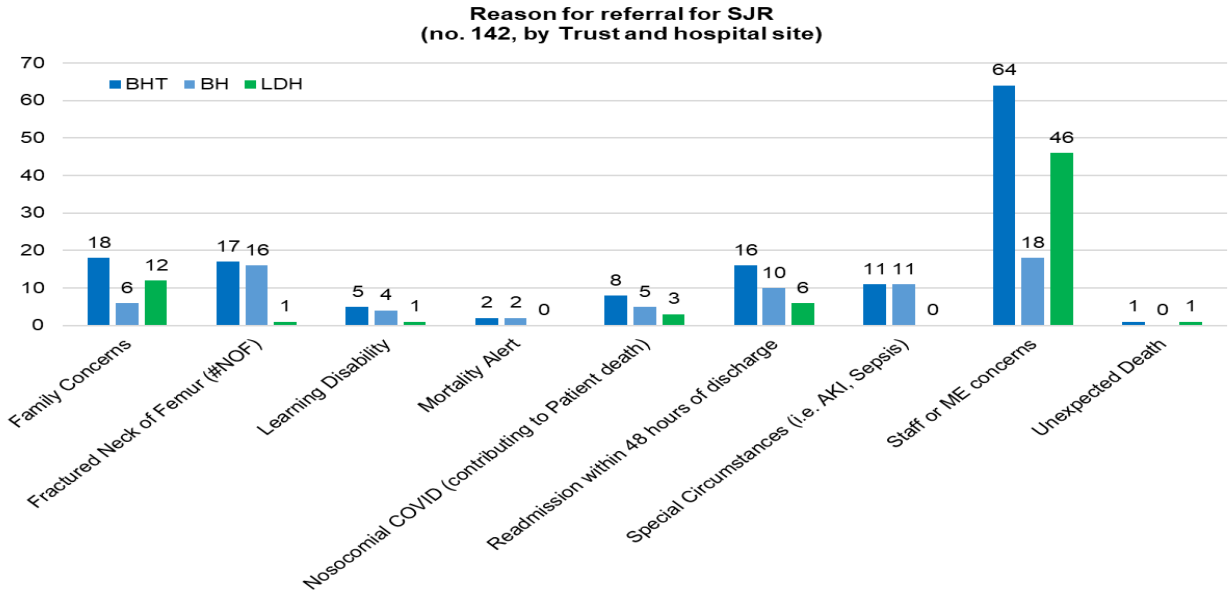


Figure 1 Reason for referral all completed and approved SJRs (n = 142)

Table 3 below illustrates the number of deaths by quarter, where following a SJR, it is considered that the death was more likely than not to have been due to problems in the care provided (avoidability judgment score of 1, 2 and 3).

Table 3

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals	**3**	**2**	**10**	**2**	**17***
Bedford Hospital	1	0	3	0	4
Luton and Dunstable Hospital	2	2	7	2	13

1 case was assigned an avoidability score of 1, definitely avoidable*
7 case assigned an avoidability score of 2, strong evidence of avoidability
9 cases assigned an avoidability score of 3, probably avoidable (>50:50)

The 17 deaths identified represents 0.9% (17/1931) of all admitted deaths in 2023/24 (excluding stillbirth, neonatal and child deaths). This remains unchanged from 2022/23.

Figures 2 - 4 illustrate the number and percentage of assigned avoidability scores for all SJRs completed in 2023/24 by Trust and hospital site.

Figure 2

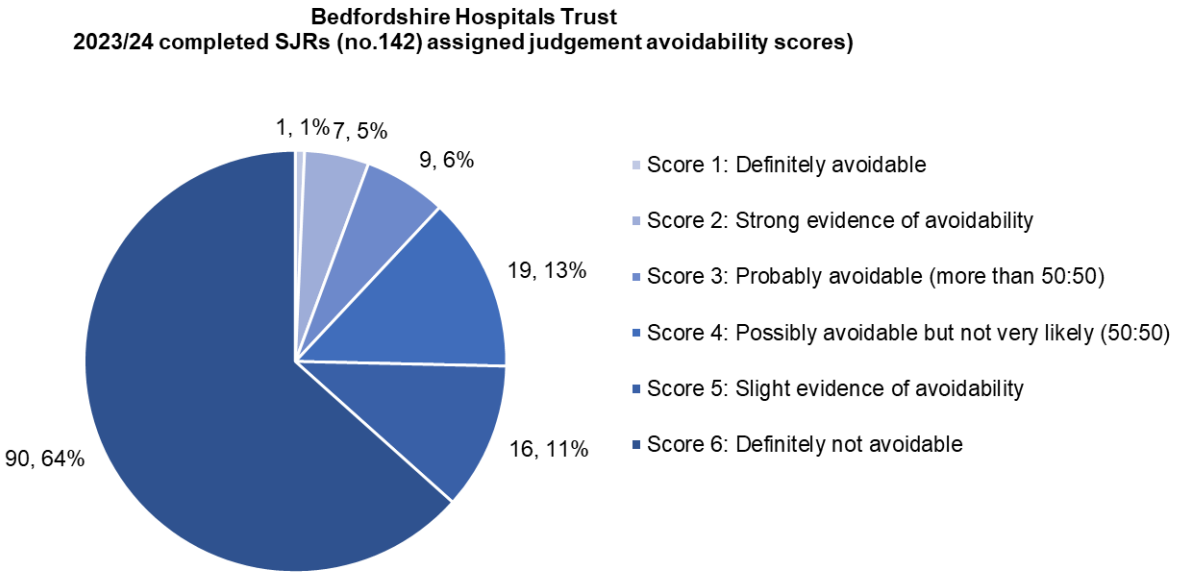


Figure 2 BHTs - Assigned avoidability scores for completed SJRs (n= 142)

Figure 3

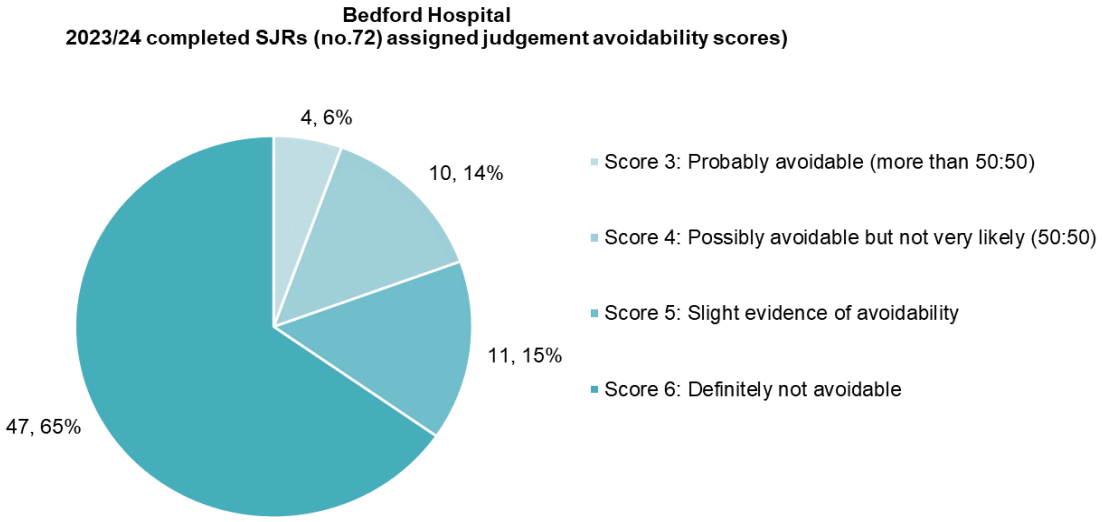


Figure 3 BH - Assigned avoidability scores for completed SJRs (n = 72)

Figure 4

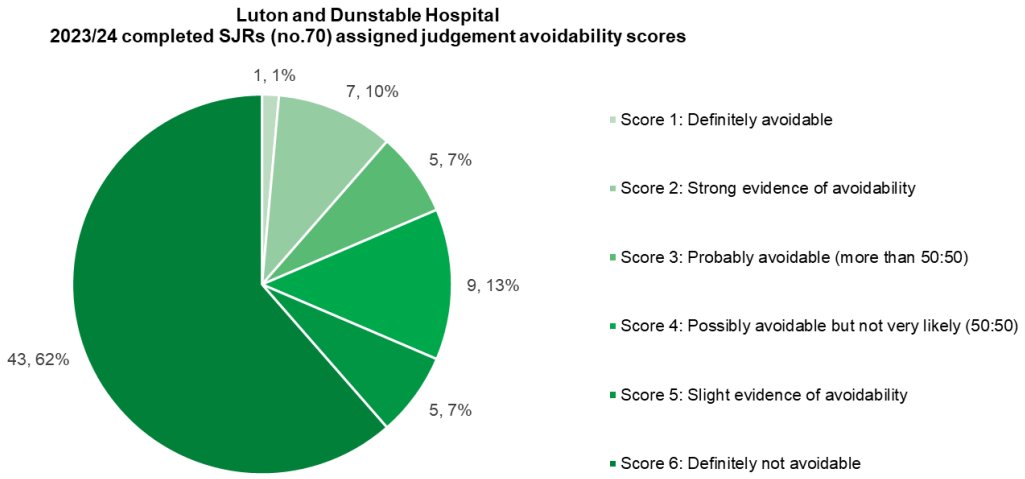


Figure 4 LDH - Assigned avoidability scores for completed SJRs (n = 70)

A data refresh is undertaken for the previous quarter and an update provided as part of the quarterly learning from deaths reporting to ensure all deaths, where it was considered more likely than not to have been due to problems in care, are captured and key learning is identified.

3.10.7 Case review to inform alternative routes of escalation

To support timely learning from deaths, senior clinical review of SJRs allocated but not yet completed was undertaken by Deputy Medical Directors (DMDs) and the Lead ME (LDH) and Associate Medical Director (AMD) for Mortality Governance (BH).

Case note review was undertaken for 67 referrals (LDH) that pre-date Q4 2023/24. Clinical review findings were triangulated with other data sources including cardiac arrest reviews and complaint responses, in addition to PSIRP panel findings for those cases that had already been escalated to the MD following primary review by the MD.

In 7/67 cases an SJR was subsequently completed, with assigned judgment avoidability scores of 5, slight evidence of avoidability or 6, definitely not avoidable. These cases are included in the 2023/24 and 2022/23 data in sections 4.0 and 6.0.

In 55/60 cases the referral has been closed as no further opportunities for learning were identified. Alternative routes of escalation, included highlighting cases for presentation at service line mortality forums were actioned. For the remaining 5/60 cases further information

is required to inform any additional learning and if onward action is required, including if an SJR is still indicated.

Key themes identified included concerns relating to delays/problems in care, delayed discharge, recognition of end of life and timely decision making and communication with family/carer. In 13/60 cases there were no concerns highlighted by the ME and referral was made in view of the femur fracture, learning disability or readmission within 48 hours referral criteria.

3.10.8 Summary learning

All completed SJRs are reviewed and approved by the MD; this includes any cases escalated to a PSIRP. In addition, MEs, following completion of the primary review, and in advance of or instead of SJR completion also escalate more immediate concerns to the MD. Following completion, the SJR findings inform any further actions/planned investigations identified as part of the PSIRF process.

SJRs are used to inform discussion within and across clinical teams, even if findings may not be fully congruent with speciality opinion.

From the completed SJRs assigned a judgement score of probably, strongly or definitely avoidable (n = 17) the following key areas are highlighted and learning identified:

- Inherent delays in patients managed by a number of speciality teams, tertiary centres, including where a malignancy is suspected
- Timeliness of specialty referral/involvement
- Timely escalation and consideration for higher level care in a deteriorating patient
- Timely surgical intervention /management,
- The importance of timely recognition and treatment commencement in the management of sepsis.
- Importance of clear documentation of management plans to guide decision making and support effective handover and communication
- Timely review and actioning of test results, including management of electrolytes
- Management of fluid balance
- Impact of longer lengths of stay, including delayed discharge.
- Recognition and timeliness of end of life decision making

3.10.9 2022/23 update

The following section provides an update on the previous reporting period (2022/23)

Table 4: Number of primary reviews and SJRs completed for the previous reporting period (2022/23)

Table 4

	Total no. deaths (2022/23)	Primary reviews completed	SJRs completed
Bedfordshire Hospitals	**2241***	**2234****	**258**
Bedford Hospital	1013	854	114
Luton and Dunstable Hospital	1228	1380	144

Excludes non-admitted deaths and stillbirth, neonatal and child deaths*
Includes non-admitted deaths**

Figures 5 - 7 illustrate the assigned avoidability scores for all SJRs completed in 2022/23 by Trust and hospital site

Figure 5

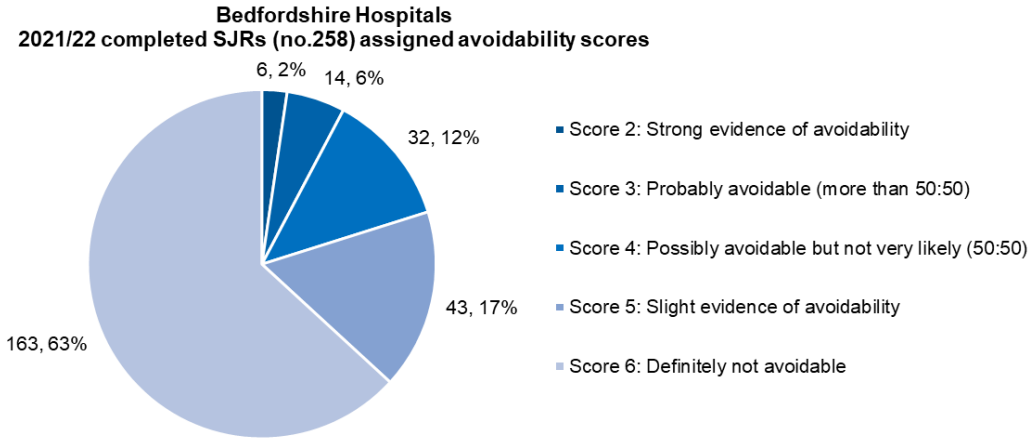


Figure 5 BHT- Assigned avoidability score for completed SJRs (n = 258)

Figure 6

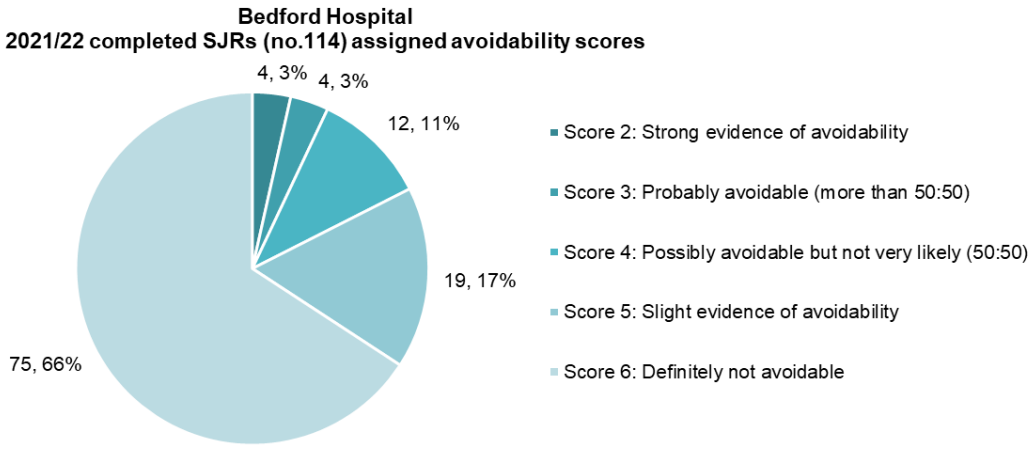


Figure 6 BH - Assigned avoidability score for completed SJRs (n = 114)

Figure 7

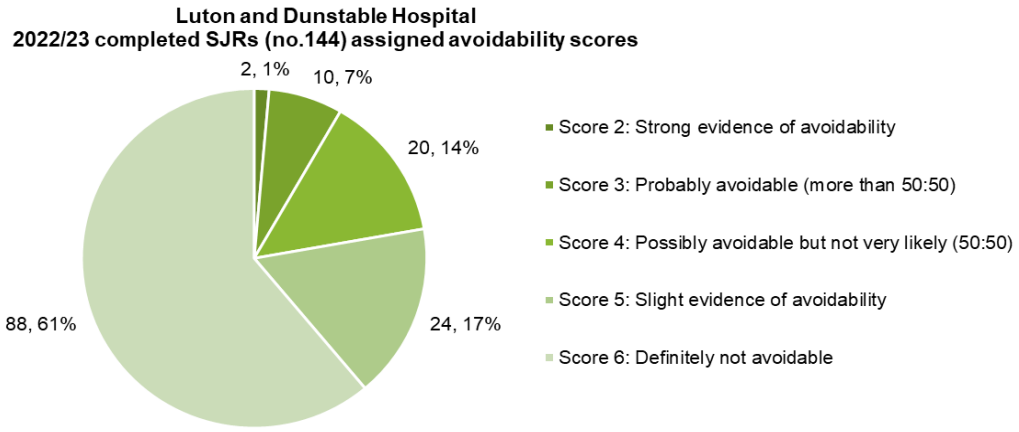


Figure 7 LDH - Assigned avoidability score for completed SJRs (n = 144)

Following a data refresh for 2022/23 there were 20/258 completed SJRs assigned an avoidability score of 2 or 3, this represents 0.9% of all deaths (2022/23) where it was considered that the death was more likely than not to have been due to problems in the care provided.

There were no cases assigned an avoidability score of 1, definitely avoidable.

3.10.10 Learning from Deaths - 2024/25 key priorities

Work continues to ensure mortality governance is embedded within CSLs and also that the impact of learning from deaths and resultant quality improvements are captured and shared.

To embed processes for sharing review findings with system partners, including case level feedback on the community response and to establish if there were missed opportunities for advanced care planning and admission avoidance.

3.11 Freedom to Speak Up (FTSU) and Guardians

Freedom to Speak Up (FTSU) Guardian Quality Report 2023/24

This overview of the FTSU activity that took place for the four quarters of 2023/24 across the Luton & Bedford sites includes actions taken to improve speaking up at Bedfordshire Hospitals and an assessment of the number and themes of concerns raised.

Background

The Trust has two Guardians: one at the Bedford site and one at the Luton site. They are supported by a network of eight FTSU champions spread across both sites.

While there are many existing routes for workers to speak up through their line manager, union representative or through incident reporting mechanisms, there may be occasions where none of these channels are suitable or trusted. Some people may be fearful that they might be victimised for speaking up or they have tried to raise matters before and been blocked or ignored, or as a new member of staff, they may be uncertain of who to speak to or even, whether they can.

FTSU Guardians provide an additional channel for healthcare workers, volunteers, students, trainees, contractors, partners and others, working proactively to support a positive speaking up culture.

They thank staff for speaking up, listen, offer support, act to preserve confidentiality where requested and if possible, ensure action is taken and feedback given. Any speaking up matter can be brought to a Guardian - a safeguarding concern, a patient safety issue, concerns about bullying and harassment but also suggestions for improvement where there is no obvious place to raise it. Guardians will signpost and escalate to the appropriate person in the organisation, maintaining confidentiality or supporting the staff member to speak for themselves.

Additionally, the Trust has expanded the number of Peer Listeners on the L&D site. All Peer Listeners undertake Mental Health First Aid Training and are supported by regular Group meetings with the Trust’s Principal Psychologist.

Cases Opened

Contacts made and cases opened in the period April 2023 – March 2024 covering Quarter 1 (April-June), Quarter 2 (July - Sept), Quarter 3 (Oct-Dec) and Quarter 4 (Jan - March). A regular detailed report is provided to the Workforce Committee and Audit and Risk Committee.

There are a number of issues raised to either the Guardians or Champions that simply require sign posting and are usually resolved informally. Cases are opened when matters are more complex and require further action and investigation. Through the signposting process, some cases proceed to formal complaints or are then being through a Human Resources department process.

Number & Types of concerns raised

	Number of cases where there is an element of patient safety/quality	Number of cases where there is an element of worker safety and wellbeing	Number of cases where there is an element of bullying and harassment	Number of cases where there is an element of other inappropriate attitudes and behaviours	Number of cases raised anonymously
Quarter 1	35	58	21	77	2
Quarter 2	8	14	10	27	2
Quarter 3	1	64	64	74	1
Quarter 4	2	15	7	23	2
Count	**46**	**151**	**102**	**201**	**7**

Note: One concern may cover multiple different elements

Concerns raised by different staff groups

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Medical & Dental	5	3	2	2	**12**
Registered Nurses & Midwives	61	26	16	19	**122**
Allied Health Professionals	4	5	2	3	**14**
Administrative & Clerical	21	8	21	8	**58**
Additional Professional Scientific & Technical	0	0	1	3	**4**
Additional Clinical Services	0	0	0	2	**2**
Healthcare Scientists	0	0	0	1	**1**
Estates & Ancillary	0	0	35	2	**37**
Other	0	0	0	0	**0**

Not Known	1	1	0	0	**2**
Total number of individuals who raised a concern	**92**	**43**	**77**	**40**	**252**

Assessment of Cases

A total of 252 members of staff raised concerns across Bedfordshire Hospitals. This is a three-fold increase from the previous 12 months, in part due to a change in how concerns are recorded. The national reporting criteria requires a count of each individual involved in raising a concern. Previously where a group raised a joint concern, it was recorded as one concern.

The themes and nature of concerns raised continues to be predominantly matters that concern staff wellbeing as a result of inappropriate behaviours and attitudes, rather than patient safety specifically. The extreme local operational and national pressures continue to test the resilience of our staff with the majority of concerns about attitudes and behaviours, often caused by misunderstandings, perceived incivility or poor communications.

Learning and Improvement

At a monthly meeting, key Trust stakeholders discuss cases/themes and trends; the key learning for 2023/24 is:

- Consistent with what is being reported nationally, within and outside the NHS, the majority of cases raised have an element of inappropriate attitudes and behaviours (usually at line manager level and above) and worker safety and wellbeing.
- The importance of managers being visible to their teams, open to listening to issues and communicating where action can or cannot be taken.
- Fair and consistent application of policies; the harmonisation of policies across both sites should support this.
- The staff group raising the most concerns are the Trust's largest staff group - nurses and midwives (48.41%). This group is followed by Admin and Clerical (23%), Estates and Ancillary (14.68%), Allied Health Professionals (5.55%) and Medical & Dental Staff (4.76%). A smaller number of concerns were raised by other staff groups.
- The importance of ongoing pastoral support for our internationally educated staff and the need for improved culturally awareness of the challenges and difficulties that these new recruits may face.
- The importance of communicating how decisions are taken which affect groups of staff differently and the rationale behind those decisions.

Reporting mechanisms and accountability

National picture

The National FTSU Guardian requires data to be reported quarterly through the Speak Up data portal. This then informs a national picture of the number and types of concerns raised, staff groups raising them, whether a concern was raised anonymously and if they felt they would it be to their detriment if they raised a concern.

FTSU Reporting Within the Trust

The Guardians report quarterly to the Workforce Committee, the Audit & Risk Committee and the Trust Board.

Guardian Activity and Support

Externally

Guardians are supported by the National FTSU Guardian/Guardian Office, who provide initial and top-up training for Guardians, Mentorship, and Guardian 1:1's.

Both Guardians and our Non-Executive Lead attended the National FTSU Guardians Conference on 14 March 2024. The event had thought-provoking panellists exploring the barriers to speaking up – these included leaders, experts by experience, professionals from other sectors and FTSU Guardians. Challenges, concerns, successes and ideas for improvement were shared.

Internally

The Trust Guardians have an open-door policy with senior leaders in the organisation including the Chief/Deputy Executive, HR Director, Chief Nurse and Director of Organisational Development (OD). Gordon Johns (Non-Executive Director) has been the named FTSU Board Lead to whom the Guardians can contact for support and updates.

Tansi Harper (Non-Executive Director) has recently replaced Gordon Johns as Board Executive Lead for FTSU following his retirement. The FTSU Guardians and Champions would like to thank Gordon for his support in bringing FTSU issues to the Trust Board Executive.

There are monthly meetings between the Guardians, the Human Resources Director and the Director of OD. The Guardians find it particularly useful to talk through concerns, review cases raised, themes and lessons learned and debrief where necessary.

The Guardians continue to work closely with OD and HR colleagues to try to resolve staff concerns about behaviours appropriately and sensitively. The objective is to achieve an early respectful resolution whenever possible. General Managers, HR Business Partners and Senior Nurses have involved Guardians and Champions in listening events with staff an independent cog in the resolution chain to help understand what may be going on and how staff are feeling after concerns have been raised.

The Guardians, Union colleagues and HR/OD teams attended an away day to ensure consistency of approach and the Guardians plan to continue this collaborative work with a regular meeting between the Director of OD, HR Director, Guardians, Guardian for Safer Working Hours, Health & Safety, Staff-side Leads and Network leads to discuss cases raised, analyse trends and themes, enlist collaborative efforts for resolution and share learning.

Trust Induction

The Guardians attend a number of induction events including Junior Doctors Induction, Multi-Disciplinary Team (MDT) Preceptorship. They also introduce themselves to different year

groups on the undergraduate/post-Graduate nursing programme and to all newly appointed consultants and internationally educated Nurses and Midwives.

Trust events

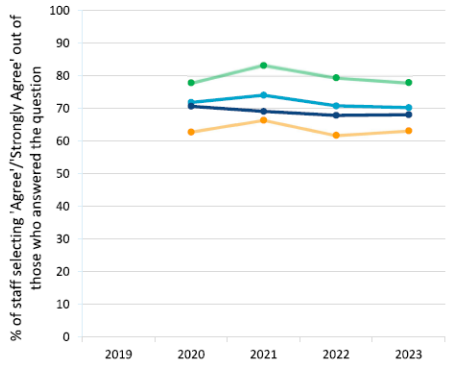
October is designated Speak Up month where we raised awareness through a publicity campaign via the Trust communications, a new FTSU Guardian video, FTSU stalls and events across the Trust and the relaunching of the FTSU brochure for staff.

In December 2023, the Trust staff engagement 'Event in the Tent' was held on both sites. This focussed on staff support and wellbeing and FTSU Guardians and Champions were present to listen to any staff concerns raised and champion the process of raising concerns through the Speak Up route.

2023 Staff Survey- FTSU

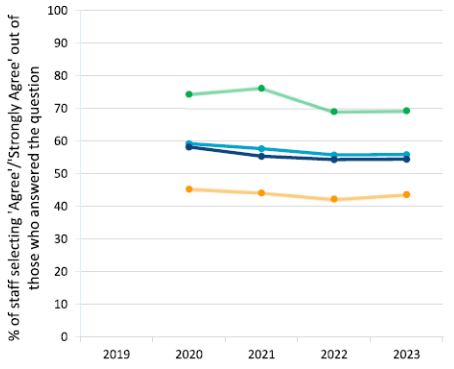
The 2023 NHS Staff Survey results have been published nationally. The national FTSU (raising concerns) sub-score has remained stable with the national average improving from 6.44 in 2022 to 6.46 in 2023 (+0.2% percentage change).There has been an improvement in responses to three out of the four FTSU Questions:

Q20a I would feel secure raising concerns about unsafe clinical practice.

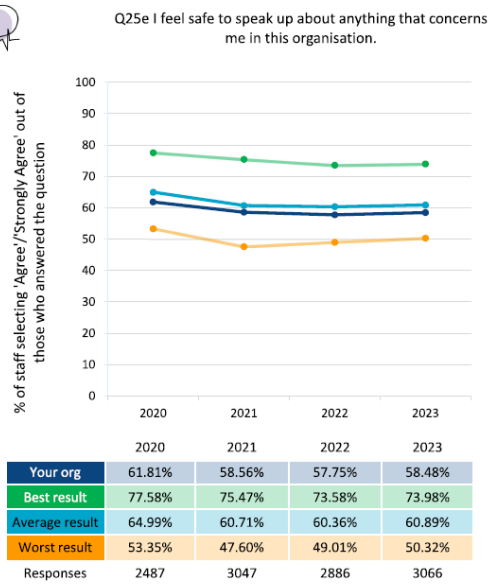


	2019	2020	2021	2022	2023
Your org	-	70.71%	69.14%	67.91%	68.11%
Best result	-	77.87%	83.19%	79.44%	77.96%
Average result	-	71.89%	74.07%	70.82%	70.24%
Worst result	-	62.81%	66.44%	61.78%	63.19%
Responses	-	2487	3069	2884	3068

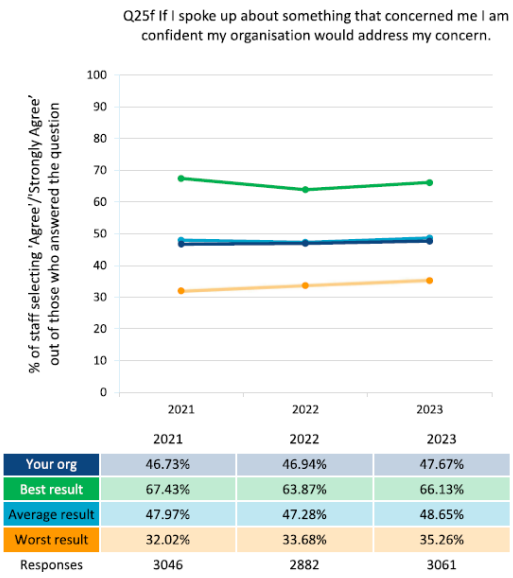
Q20b I am confident that my organisation would address my concern.



	2019	2020	2021	2022	2023
Your org	-	58.18%	55.34%	54.36%	54.45%
Best result	-	74.33%	76.17%	69.05%	69.29%
Average result	-	59.22%	57.69%	55.75%	55.90%
Worst result	-	45.27%	44.13%	42.27%	43.62%
Responses	-	2488	3073	2885	3064



	2020	2021	2022	2023
Your org	61.81%	58.56%	57.75%	58.48%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	2487	3047	2886	3066



	2021	2022	2023
Your org	46.73%	46.94%	47.67%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	3046	2882	3061

The Trust also asked two 'local questions':

- I am aware of the Trust's Freedom to Speak Up Guardians: Yes - 81% overall
- I am aware of the Trust's Peer to Peer Listening Service: Yes - 61% overall

We are tracking near average in comparison to other NHS organisations, although there is still work to do. We assure staff that Speaking Up is positively encouraged and that it should be 'Business as Usual' emphasising this when communicating the NHS Staff Survey results across the Trust.

The results are analysed and actions agreed for the next 12 months.

Actions taken to improve Speaking Up

<u>Increased resources to hear concerns and raise awareness</u>
Both Guardians have dedicated time for their FTSU Guardian roles and when Champions are signed up, part of the commitment from managers is to allow for Champion training and availability to support staff who raise concerns. The Speak Up recruitment pack has been updated and available on the Trust intranet.

Over the last year, we have recruited three more champions with another going through the recruitment process.

<u>Promoting the Speak Up role</u>
Guardian walk-arounds and visibility in Clinical areas and being involved in listening events again helps promote the FTSU Service. Guardians are directly approached by Heads of

Nursing, GM's and HR Business partners to get involved in 'hotspot' areas to support teams and be an impartial source of information gathering and practical support for the whole team.

Learning Lessons from the Thirlwall Inquiry

The statutory inquiry opened in 2023 to examine events at the Countess of Chester Hospital NHS Foundation Trust, and the implications of these events. This is following the trial and subsequent convictions, of former neonatal nurse Lucy Letby, where a number of babies sadly died and also other babies nearly died as a result of her intentional, harmful acts.
We recognise the value of a positive speaking up and listening culture within our organisation as fundamental to ensuring both patients and staff are safe, and we will continue the work to make improvements.

Priorities for 2024/25

- Embedding an organisational approach to closing the loop on issues
- Introduction of FTSU Training for all workers
- Policy and Strategy development
- Identifying Barriers to Speaking Up

3.12 Guardian of Safe Working Report Statement

In line with the Terms and Condition of Service (TCS) (2016) of the Junior Doctors Contract the Trust Board is expected to receive an annual report from the Guardian of Safe Working (GoSW). This contains information relating to exception reports, rota gaps and the plan for improvement to reduce gaps to ensure the safe working of doctors within the Trust. The Trust has a Guardian of Safe Working in place on each site.

Exception Reports

Exception reporting is the mechanism used by our doctors to inform us when their day-to-day work varies significantly and/or regularly from the agreed work schedule.
Primarily these variations will be:

a) differences in the total hours of work (including opportunities for rest breaks)
b) differences in the pattern of hours worked
c) differences in the educational opportunities and support available to the doctor, and/or
d) differences in the support available to the doctor during service commitments.

These exception reports allow us an opportunity to address issues as they arise, and to make timely adjustments to work schedules.

Guardian Fines

The GoSW is able to levy a fine to the areas in which the breach occurred when working hours breach one or more of the following provisions:

- The 48-hour average weekly working limit
- Contractual limit on maximum of 72 hours worked with any consecutive 7-day period
- Minimum 11-hour rest has been reduced to less than 8 hours
- Where meal breaks are missed on more than 25 per cent of occasions

Across the Trust as a whole, no financial penalties were imposed in 2023/24.

Luton and Dunstable hospital site

The following exceptions (388) were reported for April 2023 to 31st March 2024. *

Category of exception report	Number*
Number related to number of hours of working	354
Number related to pattern of work	11
Total	**365**
Additionally there were instances unrelated to Doctors working hours :	
Number related to educational opportunities	7
Number relating to service support available to the doctor	3
Number related to missed break	13
Number related to missed surgical opportunities	0
Of these above, number relating to immediate patient safety issues/immediate safety concern – these are not an exception type.	*5*
Total	**388**

These were spread across specialities as follows*

Medicine	156
Surgery	110
Paediatrics	1
Emergency Department	1
Obstetrics and Gynaecology	66
Ophthalmology	5
Trauma & Orthopaedics	5
Ear, nose and throat	0
Urology	6
Neonatal medicine	6
Oral and Maxillofacial surgery	0
General practice	19
Total	**375**

**Numbers for this information are not always the same as the content of reports may contain a mix of information*

Across the Trust, the majority of exception reports have related to hours of work, particularly in acute medicine and general surgery. These two departments host the largest number of doctors in training.

Exception reporting continues to highlight issues to consider in service improvement and redesign for the Trust.

Compared to last year, O&G has seen an increase in the number of exception reports. We are working with the department and the doctors to look at rota changes, with some changes already implemented, including shift pattern changes, and gynaecology clinics held with consultant support. Recruitment has resulted in increased capacity from end of May 2024.

Bedford site

The following exceptions (330) were reported for April 2023 to 31st March 2024. *

Category of exception report	**Number ***
Number relating to hours of working	308
Number relating to pattern of work	6
Total	**314**
Additionally there were instances unrelated to Doctors working hours :	
Number relating to educational opportunities	8
Number relating to service support available to the doctor	8
Of the above, number relating to immediate patient safety issues/immediate safety concern – these are not an exception type.	*7*

These were spread across specialities as follows*

Acute Medicine	26
Diabetes & endocrinology	5
General medicine	93
General surgery	136
Obstetrics and Gynaecology	2
Otolaryngology	9
Paediatrics	11
Respiratory Medicine	15
Orthopaedic Surgery	12
Urology	3
Vascular Surgery	2
Total	**314**

**Numbers for this information are not always the same as the content of reports may contain a mix of information*

Review of Quality Performance Indicators

3.13 Review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness indicators selected by our stakeholders. These indicators were selected in 2009/10 through a survey and the most popular indicators were selected.

Data for 2023 or 2023/24 is shown for Bedfordshire Hospitals NHS Foundation Trust overall, unless otherwise stated.

The legacy data for previous years, applies to Luton and Dunstable University Hospital NHS Foundation Trust, unless otherwise stated.

Performance Indicator	Type of Indicator and Source of data	2017* or 2017/18	2018* 2018/19	2019* 2019/20	2020* 2020/21	2021/ 2022	2022/ 2023	2023/ 2024	National Average
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	1	1	2	2	1	6	4	N/A
Hospital Standardised Mortality Ratio* (n)	Patient Safety CHKS*	105.1*	102.3	97.94	111.18	101.99	112	94.26	100
Number of hospital acquired C.difficile cases (n)	Patient Safety Trust Board Reports	9	5	42^	51^	64	76	73	N/A
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	12	14	5	33 (of which 1 was G4)	Data unavailable	66 (of which 2 were G4)		N/A
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	5	5	1	2 L&D	0	2		N/A
Cardiac arrest rate per 1000 admissions	Patient Safety Trust Board Report	1.1	0.69	0.96	1.15	0.75	0.89		1.0
Average Length of Stay (LOS) (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.2 days	3.0 days	3.1 days	3.3 days	3.9 days	3.9 days	3.4 days	N/A

Performance Indicator	Type of Indicator and Source of data	2017* or 2017/18	2018* 2018/19	2019* 2019/20	2020* 2020/21	2021/ 2022	2022/ 2023	2023/ 2024	National Average
Rate of falls per 1000 bed days for all patients Rate of falls per 1000 bed days for 16+ no maternity***	Clinical Effectiveness Trust Board Report	3.97 4.73***	4.08 4.89***	4.0 4.78	5.04 6.32	Data unavailable	3.3 3.94	B	 6.63
% of stroke patients spending 90% of their inpatient stay on the stroke unit	Clinical Effectiveness SSNAP data	85.3%	79.9%	87.6%	80.5% for Dec 2020 (SSNAP data not available)	56.6%	68.4% (as at end of Dec 2022)	71.4% (as at end of Dec 2023)	Target of 80%
% of fractured neck of femur to theatre in 36hrs [to end Feb '21] % of fractured neck of femur patients aged 65 or over operated for repair within 2 days of admission (excludes patients with no operation)	Clinical Effectiveness CHKS****	76%	71.3%	79.8%	85.74%	87.20%	88.12%	89.98%	69%
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness CHKS****	50.8*	63.16*	67.82	94.71	80.82	75.29	101.26	100
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness CHKS****	100.3*	76.5*	74.91	69.91	96.33	96.93	81.76	100
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness CHKS****	7.00%*	5.8%	6.6%	6.3%	5.7%	5.79%	4.96%	unavailable

Performance Indicator	Type of Indicator and Source of data	2017* or 2017/18	2018* 2018/19	2019* 2019/20	2020* 2020/21	2021/ 2022	2022/ 2023	2023/ 2024	National Average
% Caesarean Section rates	Patient Experience Obstetric dashboard	31.2%	31.3%%	33.09%	35.4%	33..2%	39.8%	42%	25%
Patients who felt that they were treated with respect and dignity**	Patient Experience CQC National inpatient survey	9.0	8.9	8.9	9.1	8.8	Data has not been published yet		Range 8.6 – 9.9
Complaints rate per 1000 discharges	Patient Experience Complaints data and coded discharges	5.50	4.70	4.31	5.1	5.4 436 - LDH	LDH = 4.6 BHT = 4.6 Trust = 4.6	LDH = 4.8 BHT = 3.2 Trust = 4.2	Unavailable
Patients disturbed at night by staff (n)	Patient Experience CQC National In patient Survey	8.1	8.2	7.6	7.5	7..6	Data has not been published yet		Range 7. – 9.
Venous thromboembolism risk assessment	Patient Safety Audit reported on Board Quality Report	Achieved >95%	Achieved >95%	>95%	96.5%^^	98.4%	97.8%	97.3% Data available up until Nov 23	National target >95%

(n) Denotes that this is data governed by standard national definitions

* Denotes calendar year

** The Trust has maintained low rates of MRSA but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.

*** The Royal College of Physicians requires the Trust to report this figure to be 16+ and non-maternity cases. This new result is now included. The national average is from the most recent RCP report, dated 2015.

**** The Trust used Dr Foster until May 2018

^ Three significant changes to the reporting algorithm for C. Difficile infections were made in 2019/20, impacting on Trust figures nationally. This included for example, reducing the number of days to identify healthcare associated cases from >3 days to >2 days following admission; cases occurring in the community (or within 2 days of admission) within 12 weeks of discharge from hospital. The ceiling set for Trust apportioned cases, which was adjusted for 2019/20 was 19.

^^ Bedford Hospital compliance 95.1% - data quality under review due to system glitch. Manual review of system information undertaken to confirm compliance data.

3.14 Complaints and Patient Advice and Liaison Service (PALS)

The Trust made every effort to ensure that all complaints are responded to within our agreed time frame of 45 working days. However, this ambition has not been achieved throughout 2023 for a variety of reasons including operational and non-operational pressures and ongoing industrial action that has affected the Trust and the NHS as a whole. The complaints team are continuing their efforts to work with Clinical Service Lines (CSLs) in addressing the

delays and during 2024 will be piloting a new triage and assessment process for complaints with the aim of enabling early resolution.

The Parliamentary Health Service Ombudsman (PHSO) continued to provide an independent complaint handing service where the Trusts process not reached a resolution to the complaint.

Learning from Complaints

Examples of learning and improvements made:

Case Study 1: Care of the Elderly
The family of an elderly patient on a ward raised a concern with the complaints team that staff were not always cleaning their dentures and providing good care to the patient and this was escalated to the appropriate ward. The ward manager reviewed the complaint and shared this with the rest of the ward team to raise awareness of the issue. As part of the ward routine, a new process was implemented where a healthcare assistant is allocated ensure this task is performed, on a daily basis. The ward manager monitored compliance by completing daily audits.

Case Study 2: Frailty
The patient was terminally ill and taking opioids for pain at home, however, when he was admitted to hospital he was wrongly given Naloxone (a medicine used to reverse or reduce the effects of opioids) and therefore was in a lot of pain. Following this complaint, we have recognised the need for junior staff to understand the importance of safe Naloxone administration.
As a result, the pharmacy team provided refresher training for the ward team.
The role of the pharmacy link nurse was reviewed to enhance working between the wards and the Pharmacy team and to provide visible teaching noticeboards in clinical room.

Compliments
The Trust maintained a log of compliments received via a combination of feedback from patients, staff, and clinical service lines. These are shared with the relevant teams or departments on receipt.

Examples of compliments received:

Stroke Department

Following my appointment …in March with Lead Nurse Stroke, who I found very professional, polite and very good listener and explained everything in understanding manner, I explained my issues and they took time to reassure me on my health and how to overcome some of my issues, they even got me a MRI scan that day save me coming back in few days, as I had mildly bang my head, They reassured me after the scan either explained the scan picture that there was nothing to worry about the knock. I found them a credit to that ward and the NHS and a value credit to the NHS, but I think everyone who works for the NHS deserves credit thank you.

X-Ray
I approached x-ray department straight after my blood test and found a person called 'P_____' at customer service desk very help and I was also very impressed with the whole X-ray department's speed and efficiency.

PALS
Good morning PALS, I would like to take this opportunity after our conversations over the past month or so to update you. I have successfully attended my breast clinic appointment and can confirm the new date for chest clinic 25th this month, if you could pass on to all relevant staff "Thank you so very much for your help, patience and understanding in assisting new appointments, especially for not making me feel silly or ignorant in why I kept putting off appointments and kept at arm's length, my sincere thanks, your help has also instigated in asking for help from others e.g., occupational health, etc.

3.15 Friends and Family Test

Bedfordshire Hospitals NHS Foundation Trust continued to collect feedback from patients using the national Friends and Family Test (FFT) survey. This national programme used to gather patient feedback provides transparency to the organisation about their experience in using the organisation.

The FFT text service method was used for the Emergency Department only and our ambition is to expand to this to other areas. Methods used to collect the FFT feedback included the use of iPads, paper returns and digital Quick Response (QR) codes. The QR codes on information leaflets and outpatient letters remained in place.

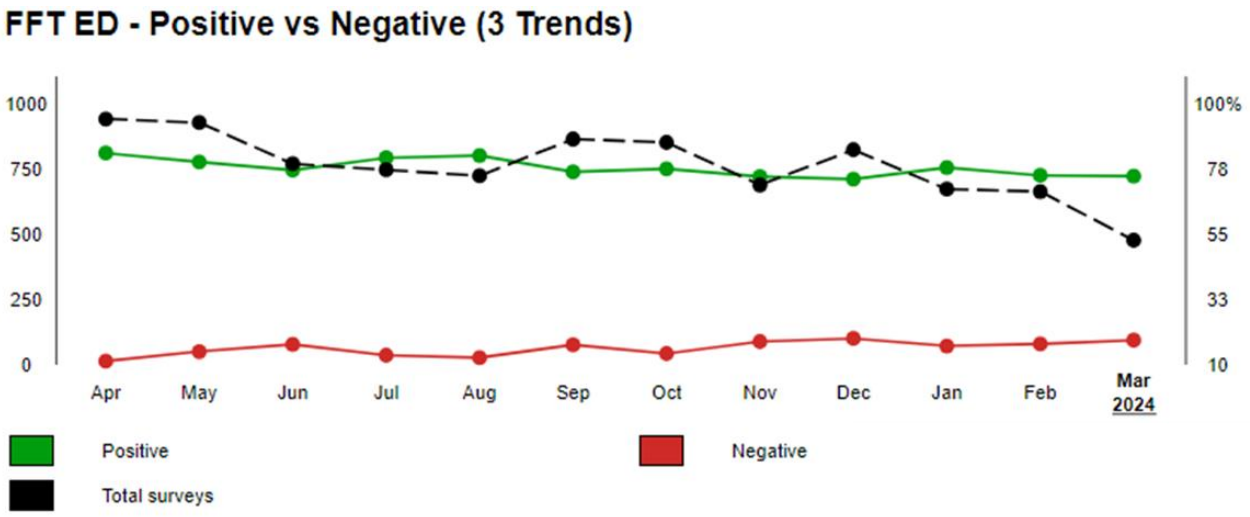
FFT feedback is collected from:

- Urgent and Emergency Care
- Women's and Children services
- Inpatient Services
- Outpatient Services

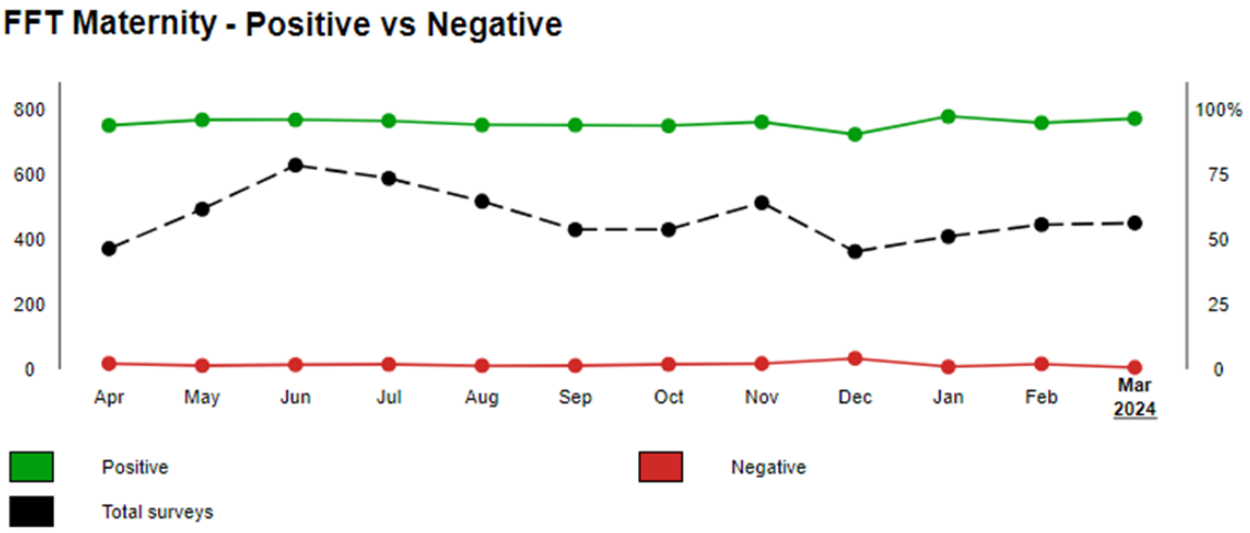
The Patient Experience Team (PET) provide monthly reports to the clinical service lines and the results are reviewed as part of their clinical governance review processes. The PET provide quarterly reports to the Clinical Quality Outcomes Board and Quality Committee (CQuOB) as part of PET assurance on the delivery of the patient experience and engagement agenda within the organisation.

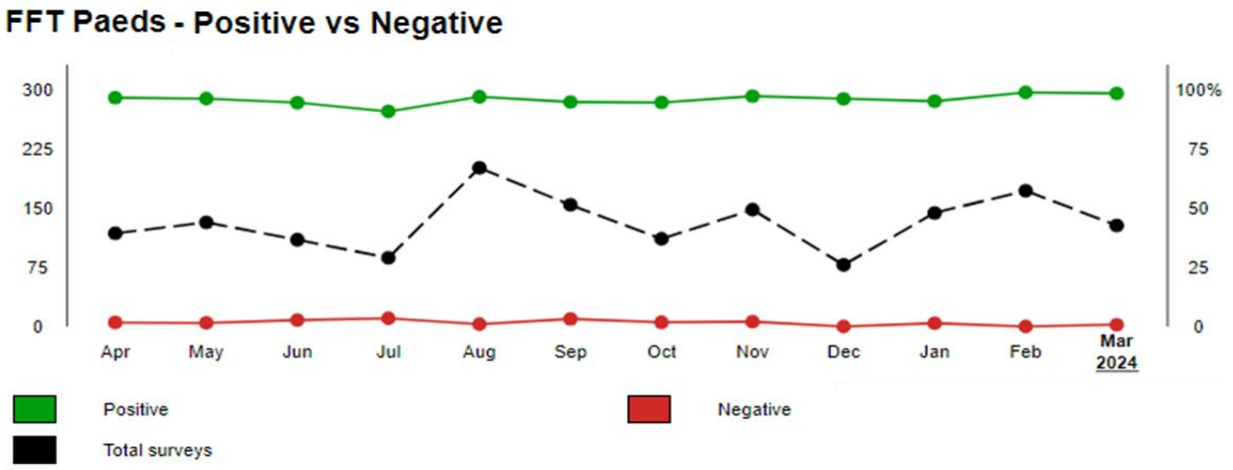
A sample of the FFT results are provided below and work continues to review the results and any required actions to improve these each month.

Emergency Department Trust wide FFT results April 2023 - March 2024

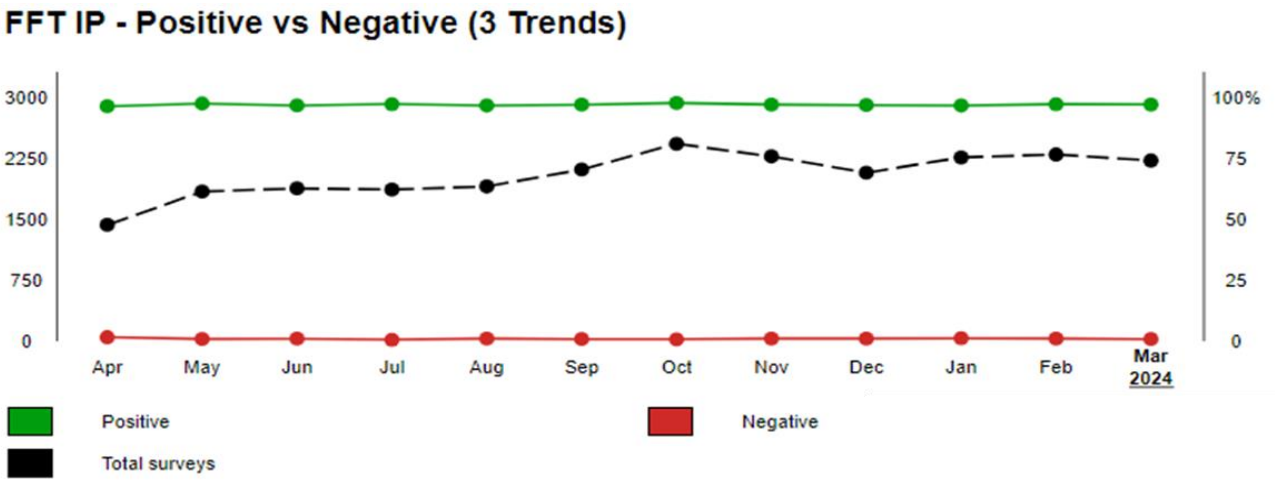


Women's and Children Services Trust wide FFT results April 2023 - March 2024

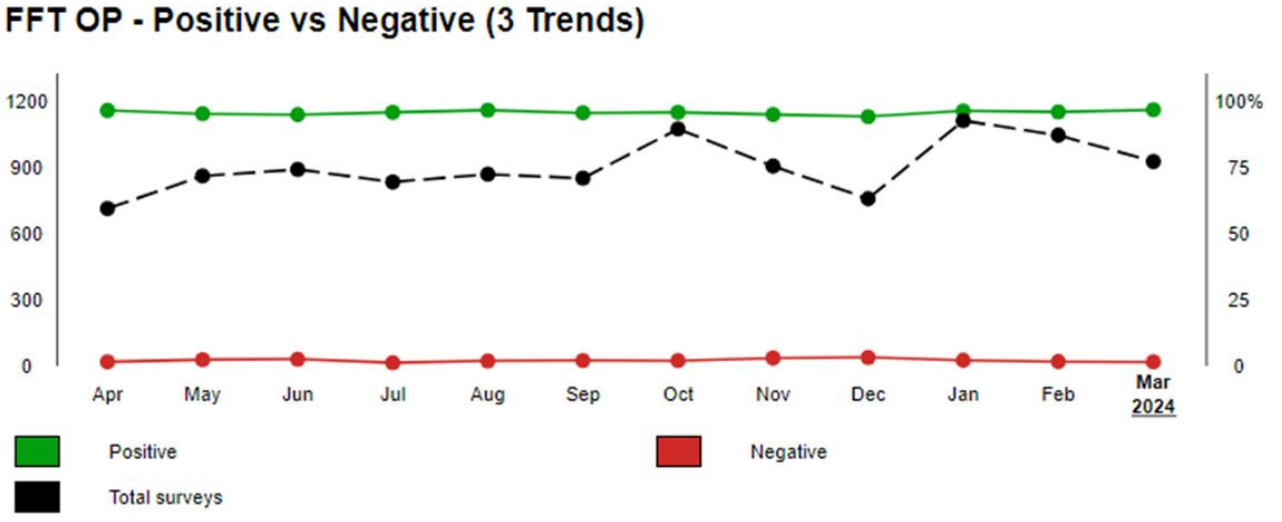




Inpatient Services Trust wide FFT results April 2023 - March 2024



Outpatient Services Trust wide FFT results April 2023 - March 2024



3.16 National Surveys

The Trust undertakes four national surveys annually within the following service lines:

- Adult inpatient services
- Urgent and Emergency Care
- Maternity Services
- Stroke Services
- Cancer services

For Children and Young People a national survey is undertaken on alternate years.

At the time of writing this report, the Inpatient Survey results are yet to be published; however, the response rate from the November 2022 adult inpatient survey was 37%, which is an increase from 34% over the previous year, November 2021.

The organisation undertakes an internal interim survey on the areas we performed least well in by continuing to collect feedback from patients. These results are analysed and shared with clinical service lines on a monthly basis.
We continue to work with the teams to ensure that changes made following the monthly feedback, resulted in sustained improvements for patients. The patient experience team also worked in partnership with the accreditation team to support ward audits and team feedback.

The response rate from the National CQC Maternity Survey from February 2023 was 38%, a decrease from 45% from the survey in 2022.

We observed the following changes in the ethnicity of those completing the survey, in 2022 highest responses were from white (64%), Asian (24%) respondents whilst in 2023 response rates changed with Asian (43%) and white (37%). It is perceived that the patient experience midwife role may have facilitated enhanced community engagement, which can anecdotally be attributed to this change.

The Trust performed worse than expected for the questions:

- *Before you were induced, were you given appropriate information and advice on the benefits associated with an induced labour?*
- *Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?*
- *Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?*
- *Were your decisions about how you wanted to feed your baby respected by midwives?*
- *Thinking about your postnatal care, were you involved in decisions about your care?*
- *Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?*

- *Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?*
- *Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?*
- *Were you given information about any changes you might experience to your mental health after having your baby?*

The questions were added to the maternity FFT survey to continuously review and understand the ongoing Trust position. The maternity team monitors the results and share theses via their governance meetings. Engagement work continued with external stakeholders for example Neonatal Maternity Voice Partners (NMVP) to support and improve patient experience.

Cancer Services Survey 2022

The National Cancer Patient Experience Survey is the eleventh iteration of the survey, first undertaken in 2010.

It has been designed to:

- Monitor national progress on cancer care
- Provide information to drive local quality improvements
- Assist commissioners and providers of cancer care
- Inform the work of the various charities and stakeholder groups supporting cancer patients

The survey was overseen by a national Cancer Patient Experience Advisory Group that set the principles and objectives of the survey programme and guided the questionnaire development. The survey was commissioned and managed by NHS England. The survey provider, Picker, is responsible for designing, running and analysing the survey.

The Trust response rate was 54%, just slightly below the national response rate at 55%.
The report highlighted the excellent standard of clinical and supportive care that is provided for our cancer patients and their families, not only by the clinical cancer teams and multidisciplinary teams but all staff who come into contact with cancer patients throughout their pathway both clinical and administration across the Trust.

The results demonstrated an increase in scores below the expected range, in particular relating to; communication, information giving and inpatient hospital care.
The survey was completed despite the ongoing COVID pandemic at the time patients were asked to complete the survey.
It is felt that many of the ‘below expected’ scores reflect the lack of face-to-face consultations with cancer teams, the change in channels of communication and challenges in ward areas.

The Trust's overall rating for NHS Care was 8.7, just below the national average 8.9. although some specialties achieved excellent scores, for example Gynaecological cancer [9.3], and Head and Neck cancer [9.2].
We have an ongoing live action plan in place to address key issues identified, which is monitored by the Cancer Operational Group and Cancer Board.

The Urgent and Emergency Services survey 2023 results are still pending, as are the annual Stroke response survey May-September 2023.

Visiting
Standard visiting has resumed to pre COVID arrangements on both sites. Exceptional visiting is available in areas such as Critical Care, NICU, and for those patients at End of Life, or with Dementia, Learning Disabilities and Complex Care needs. Maternity resumed overnight visiting for birthing partners on both sites. The Paediatric wards continued with special exceptions. The visiting restrictions remain under review, guided by the infection prevention and control team when required in situations of outbreaks.

Patient Experience Strategy and Council (PEC)
The PEC provides assurance to the Board that patient experience and feedback forms a core element of quality improvement within the organisation. There is internal and external stakeholder membership on the PEC which met quarterly to review the patient experience work plan. Stakeholder engagement events were held on both sites to review the current strategy and agree key themes for developing the new strategy.

3.17 NHS STAFF SURVEY

The NHS staff survey is conducted annually. The questions are grouped in to nine themes, the seven People Promises plus Staff Engagement and Morale. The survey ran from the end of September to the end November 2023 and was published on 7th March 2024.

The survey was a mixed mode with the majority of staff being invited through their Trust email address and via paper invitation for those with no digital access. 3,102 surveys were completed, and the response rate for Bedford was 39% slightly above L&D at 34% with an overall response rate of 37%. This response rate is the same as 2022; although our number of respondents increased in 2023, so too did the Trust headcount thus the percentage response rate remained consistent. The national average response rate for our benchmark group was 45%, up by 1% point on the previous year.

National Results
The indicator scores are based on a score out of 10 for specific questions with the score being the average of those. Scores for each indicator together with that of the survey benchmark group 'Acute and Acute and Community Trusts' are presented below.

	2023		2022		Change from 2022	
	Trust	Benchmark Group	Trust	Benchmark Group	Trust	Benchmark Group
We are compassionate and inclusive	7.2	7.2	7.1	7.2	↑	=
We are recognised and rewarded	5.9	5.9	5.6	5.7	↑	↑
We each have a voice that counts	6.7	6.7	6.6	6.6	↑	↑
We are safe and healthy	*	*	5.9	5.9	*	*
We are always learning	5.6	5.6	5.3	5.4	↑	↑
We work flexibly	6.0	6.2	5.7	6.0	↑	↑
We are a team	6.7	6.8	6.6	6.6	↑	↑
Staff engagement	6.9	6.9	6.8	6.8	↑	↑
Morale	5.9	5.9	5.7	5.7	↑	↑

Note: *Due to a technical error identified by the National Survey Coordination Centre, statistical bias concerns have emerged around some of the 'We are safe and healthy' questions. The decision was therefore taken centrally to not provide a collated score for this People Promise element. The Trust has been provided with the data for internal review however due to the aforementioned data quality concerns, these have not been shared publically.*

Overall, the results indicate an improving set of results. On all questions, the Trust response was either significantly better than 2022 (45 questions) or saw no significant change (52 questions). This compares to last year where only 8 questions saw significant improvement, 65 questions saw no significant change and 27 questions saw significant decline.
Despite the positive results, however, there are some themes that highlight slightly below average comparisons: it should be noted that the Trust overall average score was identical to the national benchmark group on 6 scores, 0.1 below on one theme "we are a team" and 0.2 below on one theme – "we work flexibly".

Local Analysis
Compared to last year it is encouraging to see the most improved areas are:

- Disability: the organisation made reasonable adjustment(s) to enable me to carry out work

- Enough staff at the organisation to do my job properly
- Satisfied with extent the organisation values my work
- Organisation is committed to helping balance work and home life
- Satisfied with level of pay

Whilst we have seen some improvement, the areas for attention identified last year require continued focus, with particular emphasis on flexible working and work life balance:

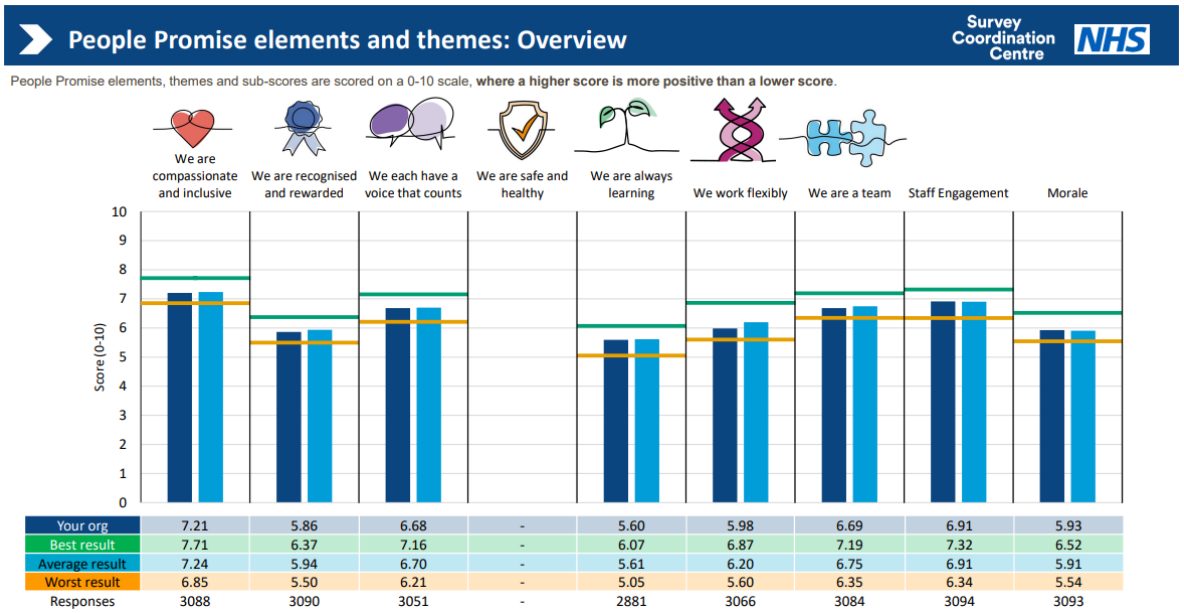
- We are always learning - increasing appraisal completion rates
- We are safe and healthy - health and wellbeing
- We work flexibly - flexible working/work life balance
- We each have a voice that counts - raising concerns about unsafe clinical practice
- We are recognised and rewarded – valuing work and recognition for good work

Work is already underway with the response and interventions forming a significant component of the Culture and OD programme.

NHS People Promise Progress

The themes and words that make up the NHS "Our People Promise" have come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace.

Using the NHS Staff Survey as the principal way to measure progress will enable our teams and departments, as well as the organisation as a whole, to review progress and take action to improve. The chart below shows our 2023 staff survey results based on NHS People Plan indicators.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.21	5.86	6.68	-	5.60	5.98	6.69	6.91	5.93
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	3088	3090	3051	-	2881	3066	3084	3094	3093

The staff survey results inform our priorities for Culture and OD activities for the year. The following is a summary of activities relating to our delivery of the People Promise in 2023.

	The pastoral support package for Internationally Educated staff is a very important part of welcoming them and helping them settle in to their new jobs and lives. The work with embedding our values, in conjunction with 'a Kind Life', is an important intervention in our aim to be a great place to work, creating a workplace where all our people feel they belong and can THRIVE. Following extensive planning and preparation over a number of years, the Transformational Reciprocal Mentoring for Inclusion Programme commenced in February 2024.
	The twice yearly staff engagement 'tent events' are an opportunity for us to say thank you to our staff, give them a break, some food and a gift. The winter 'tent event' theme was Health and Wellbeing. Monthly individual and team of the month awards are announced at the 'All Staff Briefing' by David Carter – Chief Executive. Other regular awards are the Daisy Award for Nursing and Midwifery and the Rose Award for Healthcare Support Workers. Our THRIVE values thank you cards are a quick and simple way to show appreciation to colleagues. The reintroduced Long Service Awards celebration evening was well attended and enjoyed by all. The 10 and 15 year badges continue to bring joy to the recipients.
	Our staff networks provide an important connection and support mechanism for our staff, we have three established networks: • BAME staff network • LGBTQ+ network • Disabilities and Carers network During the course of the year, they have contributed to Trust polices including the Menopause and Dress code policies. The Freedom to Speak Up Guardians work closely together across the sites and promote awareness of the different routes to raise matters of concern with a particular focus during Freedom to Speak Up month in October. Staff survey is an important source of staff feedback and the results are analysed and shared widely, we support our teams to work together on areas for improving staff experience. There is a well-established link between staff wellbeing, team working and patient experience. Embedding of the trust THRIVE values and a broader series of organisational development opportunities are used to make an impact on patient experience. The National Patient Safety Strategy provides a clear emphasis on the vital importance of a Just Culture and an environment conducive to staff feeling they are able to speak up when they have concerns about patient safety. The new NHS England Patient Safety Incident Response Framework (PSIRF), national Patient Safety Syllabus and

	Just Culture principles align to our THRIVE values. PSIRF advocates for each Trust to have a designated Patient Safety Specialist; the trust has implemented this, with a staff member in the Quality and Safety Governance team designated as a Patient Safety Specialist.
	We conducted a tendering process for our Employee Assistance Provider contract, Vita Health were successful and commenced contract on 1 February 2024. The Clinical Psychologists for staff wellbeing have continued to develop the service working with teams and individuals. Regular cohorts of Mental Health First Aid training is provided and this has in turn increased the number of Peer Listeners available. The Peer Listeners provide an avenue for staff to receive signposting to support or raise any raise concerns. The Peer Listeners are supported by the Clinical Psychologist and had their first away day developmental afternoon in March 2024. The 'Cost of Living' package and support for staff has been in place for over a year and has been gratefully received by those accessing support for whom it has made a tangible and essential difference. The support available includes a 'safe space' where staff can be supported to access food banks, emergency meal tokens and a range of advice and support and a Voluntary Benevolent Fund for our most vulnerable staff experiencing hardship. The Trust has committed to the Sexual Safety Charter and a small working group has been formed to take this forward. A new initiative by 'Five a Day' greengrocer commenced in March with a stall on both sites each week selling fresh produce, this has been welcomed by staff. The Health and Wellbeing Action Plan was refreshed in March 2024.
	During the course of the year, we have developed and launched a new bespoke in house Aspiring/Clinical Director Leadership programme which is already oversubscribed. The values based appraisal is now embedded with the 'Back on Track' campaign encourage participation A range of Values eLearning is available through the learning platform of the Electronic Staff Record and this is supplemented with regular virtual 'THRIVE in action' Workshops and 'Leading to THRIVE' masterclasses Our comprehensive programme of 90 minute Development Burst modules continues to prove popular with staff at all levels.
	Insightful internal research to understanding the barriers and perceptions of flexible working in the Trust has provided helpful conclusions and recommendations to be taken forward as a priority in 2024/25.

	Following last year's introduction of values based Appraisals, we have tools to help us move towards values based recruitment and the introduction of a Respectful Resolution approach dealing with behaviours. Over 800 managers and leaders have attended the Leading to THRIVE masterclasses and 200 THRIVE in action workshops for all staff underpin the embedding of our values. A wide range of Organisational Development interventions have taken place with a variety of teams both proactively on request and reactively in response to particular circumstances. We have benefited from Continuous Professional Development, Supervision and a network community of practice to support our internal trained coaches.

Further progress and improvement development will take place in the coming year building on the focus as below anchored firmly within our values set.

For 2024/25, the Trust has been enrolled onto the NHS People Promise pilot programme. The newly appointed People Promise Manager, alongside HR and OD teams, will be ensuring the Trust's efforts in improving staff experience, and subsequently retention, are coordinated effectively in partnership with the wider Integrated Care System (ICS) and region (East of England). This will ensure staff engagement/experience interventions and initiatives are embedded successfully.

3.18 Site Redevelopment

A significant amount of construction work is taking place across Bedfordshire Hospital in a coordinated programme to address significant estates risks, including infrastructure and decarbonisation; to support the Covid recovery position; and to underpin the Trust's clinical strategy, which focusses on improving population health and patient outcomes. There has been significant progress made on developments of both sites over the last year.

There are three main schemes to expand and enhance the L&D hospital;

i)New Clinical Buildings at the L&D
£150m investment to provide modern facilities for Maternity, Neonatal, Theatres and Critical Care, forecast to complete 2025. The scheme will deliver a 5-storey Acute Services Block (ASB) and 3-storey New Ward Block (NWB) that will house modern and enhanced facilities for maternity services, a level 3 neonatal intensive care unit, combined critical care unit and 8 new operating theatres.

The construction of the New Clinical Buildings (NCB) continues to progress at pace. The Project is adding significant social value to the local community. The Trust's clinical and support teams are focussed to manage this significant change programme and to transition services safely into the New Clinical Buildings in 2025.

New Clinical Buildings CJI

Acute Service Block North Elevation Façade Progress

ii)Energy Centre at the L&D

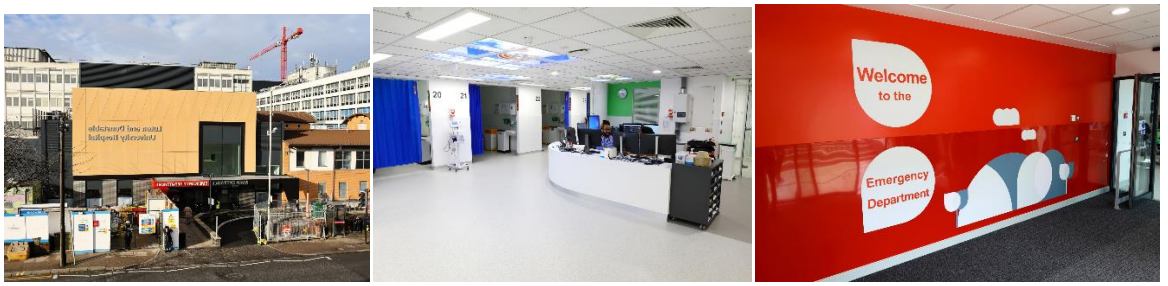
The Energy Centre Building is now functioning on site. The scheme replaced all obsolete and out of date heating equipment, making the L&D more environmentally friendly, and progressing the Hospital's road map to Net Zero Carbon. The Trust estate is benefitting from more efficient and resilient heat and power to the estate.

New Energy Centre CJI Image

New Energy Centre, L&D Hospital

iii)Emergency Department upgrades

On the L&D site, the project has delivered an expanded and refurbished ED with increased capacity; a fully segregated Paediatric ED; a CT scanner located within the department; and a re-modelled main entrance. The final phase due to complete at the end of 2024 will provide additional waiting room capacity, dedicated mental health facilities, and a re-modelled patient drop off area.



Luton Emergency Department-Front Entrance,
Lewsey Road

Bedford Hospital Schemes that have been progressed over the last year include:

i)Urgent & Emergency Care Phase 2 (CT)

The project includes a new CT imaging facility within the department to ensure rapid assessment for patients, and the re-provision of staff facilities, this completed in July 2023. This completes the urgent and emergency care construction project for Bedford Hospital to support increased capacity and improved patient flow, with earlier access to diagnostics and thus care plans.

Bedford Hospital, Emergency Department

CT Scanner - Bedford Hospital, Emergency Department

ii)Electrical Infrastructure Phase 1

To allow the planned strategic developments to take place, developing the infrastructure at Bedford Hospital is fundamental. Phase 1 of a multi-phase plan is now complete, which provides electrical capacity to part of the hospital site. The project is the first step on a series of significant steps required working towards infrastructure capacity, resilience and a decarbonised estate.

A Courtyard Garden area which is part funded by Bedford Charity & Friends has been created as part of the first phase of this project and will provide outdoor space for staff, patients and visitors.

iii)BLMK North Wing Projects - Community Diagnostic Centre (CDC) & Primary Care Hub (PCH)

Construction works started in March 2024 in Gilbert Hitchcock House, a Trust building on the Bedford Health village site, to create new diagnostic facilities and Trust led primary care facilities, including Phlebotomy, Therapies and Retinopathy space. This important project is due to complete in 2026. The Trust will increase their imaging capacity by 50% supporting improved access for patients and importantly, earlier access to diagnostics and treatment plans.

Master Planning, Luton & Bedford

The Trust delivered a master plan for both Bedford and the L&D Hospital site in the summer of 2023. The master plan brings together capital planning requirements and creates an aspirational view of how the Trust envisions and needs the sites to develop over the next 20 years to provide modern healthcare facilities and to support the enablement of the Trust's Clinical Strategy. The master plan document is to inform and regulate development, and

enable an effective framework for future decision-making. The Trust Board adopted the Master Plan in October 2023.

The Master Plan proposes to target investment on planning for phase 2 of development at Luton and at Bedford to be in a position of readiness should the opportunity to seek capital funding become apparent.

3.19 Maternity Quality Improvement

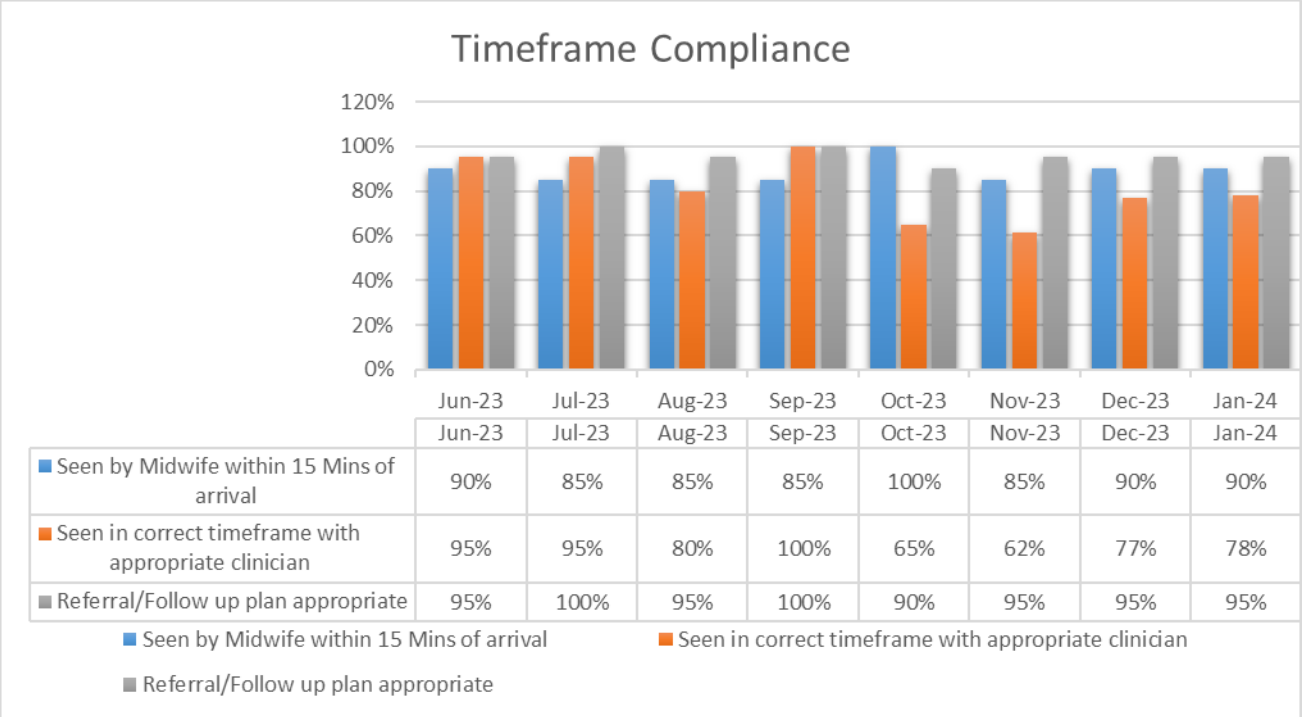
Bedford Hospital Maternity Triage

Following some reconfiguration and building works, the Maternity Triage at Bedford Hospital was opened in June 2023.

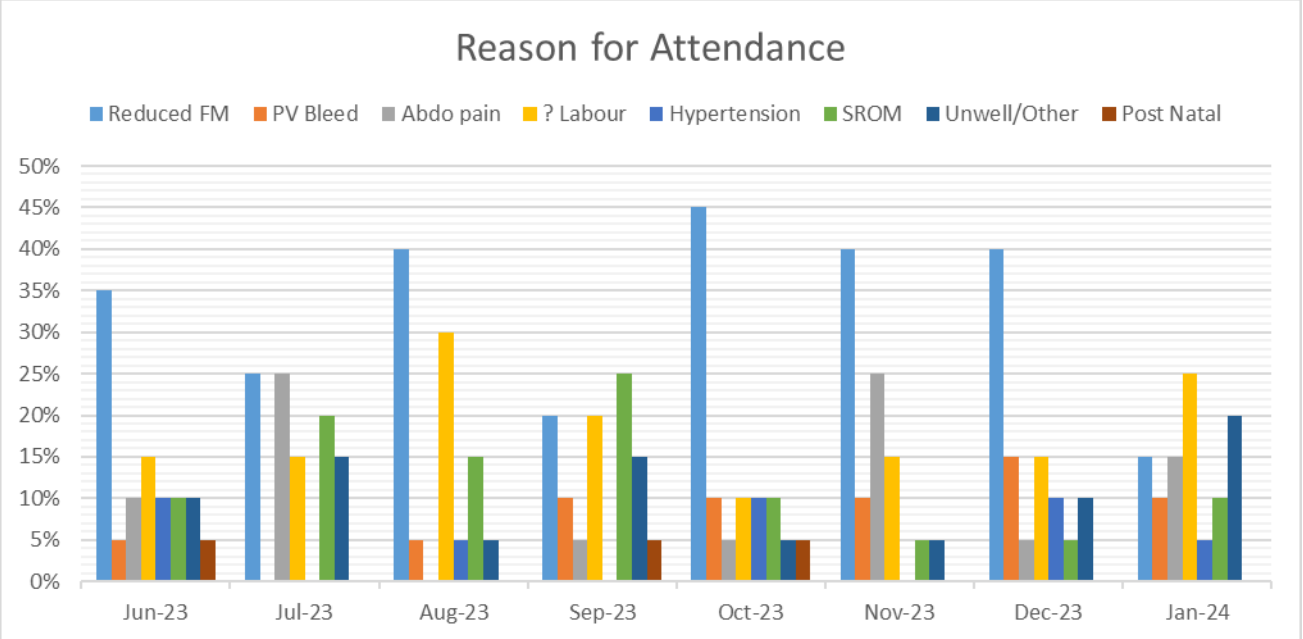
Maternity triage provides acute emergency obstetric care to women during their pregnancy and up to 28 days after delivery. The service is provided by experienced midwives working closely together with the obstetric team. The Birmingham Symptom Specific Obstetric Triage System (BSOTS) provides a means to systematically assess and triage women efficiently and improve the overall running of the department. It allows better allocation of staff and resources, making the triage area clinically safer for patients. It creates a quick and simple visual overview of the department:

An audit on the compliance of Triage functions in line with BSOTS for the BH site department was undertaken June 2023 - January 2024 against the following 4 indicators, using a sample size of 10% of births per month.

- First assessment reviews within 15 minutes of arrival
- Appropriate timeframe for clinician
- Following up planning (as required)
- Staffing response planning following external review recommendations/CQC feedback



	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Seen by Midwife within 15 Mins of arrival	90%	85%	85%	85%	100%	85%	90%	90%
Seen in correct timeframe with appropriate clinician	95%	95%	80%	100%	65%	62%	77%	78%
Referral/Follow up plan appropriate	95%	100%	95%	100%	90%	95%	95%	95%



The highest reason for attendance is consistently, reduced fetal movements, except for January 2024 where this became onset of labour.

Bedford Improvement measures following audit:

- Increase in initial assessment by midwife in first 15mins from 85% to 90%.

Bedford Areas requiring further focus:

- Meeting correct timeframe with appropriate clinician, in particular medical reviews.

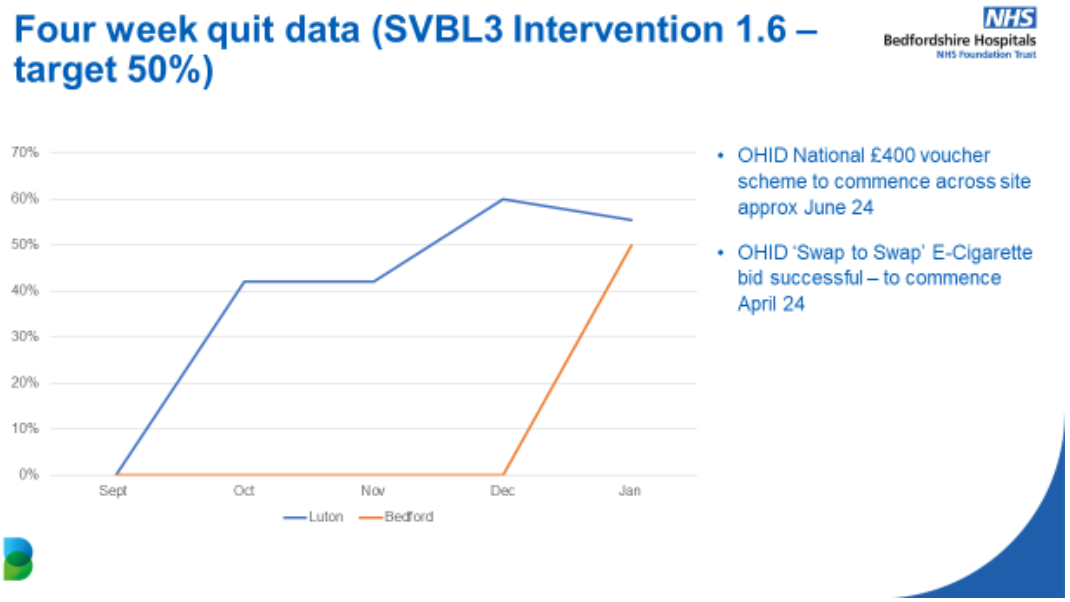
Smoking cessation

Stopping smoking in pregnancy is the most modifiable risk factor in pregnancy to reduce poor birth outcomes, which include still birth, miscarriage and pre-term births.

The Keeping Well in Pregnancy (KWIP) in house smoking service was launched in March 2023 at both sites with women now able to access one to one support from maternity stop smoking advisors.
On average 50% women are achieving a quit status in pregnancy within 4 weeks of accessing support meeting national targets (Saving baby's lives v 3). Women are contacted within 1 day of referral from a midwife/obstetrician and seen within 5 working days to increase engagement levels and continue to be seen up to 28 days postnatal.

This support enables women and their families to continue with a smoke free home, and are more likely to be smoke free in the next pregnancy. Prior to the launch of the KWiP service, women would have been referred to local authority stop smoking service and been seen within 14 - 30 days.

Carbon monoxide monitoring in pregnancy is offered routinely at booking and 36 weeks and at every contact for smokers and for non- smoking women who blow a CO score above 4 at booking. There have been several cases of faulty gas boilers being detected in homes of women who have a high CO reading that have been screened by our midwives. Monthly Co screening audits are undertaken to monitor compliance for CO screening and identify any areas of training.



Partners staying overnight

From 1 August 2023, we welcomed one birth partner for each woman/birthing person to stay overnight at our maternity units which included:

- Orchard Ward, Bedford Hospital
- Ward 32, L&D
- Ward 33, L&D

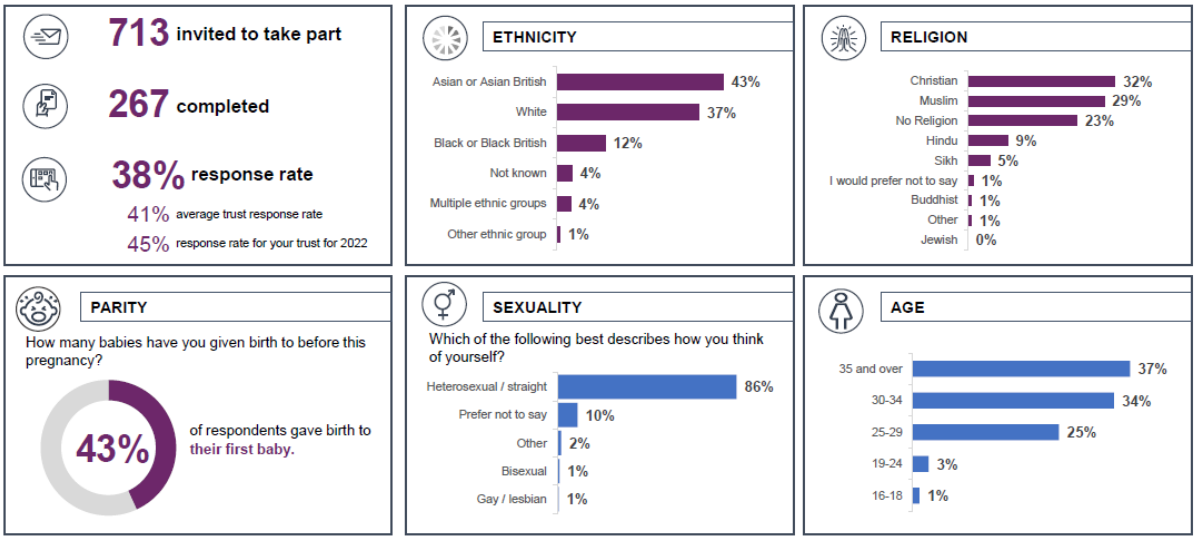
This initiative was in response to the overwhelming feedback from the people who use our service, that it is important to them that their partner is able to stay with them, throughout their birthing journey. This offers the opportunity for them to provide practical help and support whilst on the ward, as well as acknowledging the importance of keeping families together. We recognised that this helps with family bonding and reduces anxiety amongst mothers/birthing people. A reclining chair where possible, is provided for partners to rest.

The department created a booklet that outlines expectations and etiquette recommended for staying on the ward, which is signed by the mother/birthing person. For health and safety purposes, a register is held for overnight stays and the partner/companion is given a wristband. Since the reinstatement of overnight visiting, we have observed a significant reduction in complaints in relation to partners not having the opportunity to stay overnight, from FFT surveys, our MNVP and formal complaints.

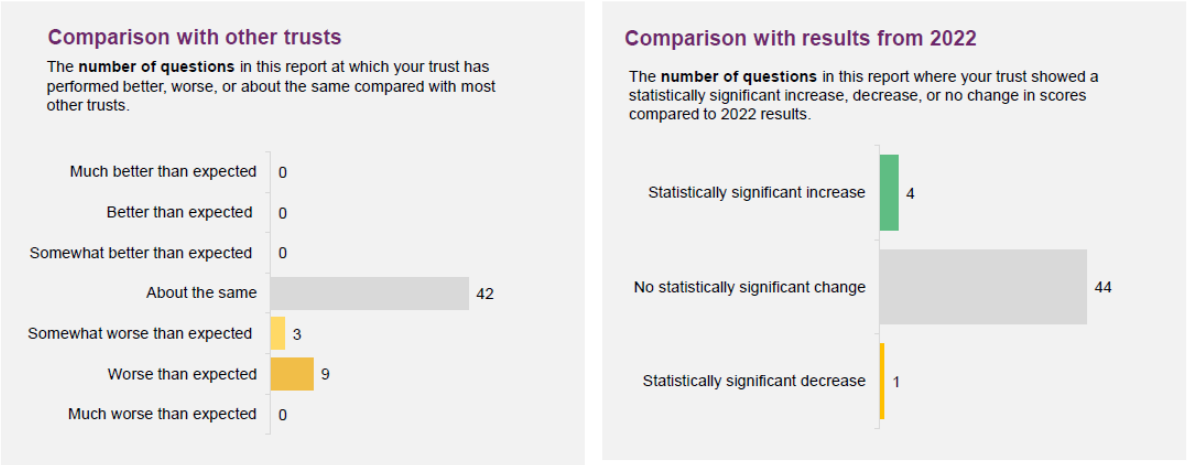
CQC maternity survey

The 2023 Maternity Survey informs the CQC, for use of the results in the regulation, monitoring and inspection of NHS Trusts in England. The fieldwork took place between May and August 2023. The maternity survey is split into three sections that asks questions about antenatal care, labour and birth and postnatal care.

Summary below of the population of the maternity service users who took part in the survey:



The charts below demonstrate an overview of benchmarking for the Trust, overall the Trust scored about the same in comparison to other Trusts in 42 areas



The Trust scored ‘worse’ in 9 areas and ‘somewhat worse’ in 3 areas of the survey. Statistically significant differences in the Trust mean score between 2023 and 2022 were observed in 5 areas, which demonstrates meaningful change between the years. There was 1 area where there was an observed significant decrease and 4 areas with a significant increase.

The following table presents “Where mothers’ experience is best”; which includes the five results for the Trust that are highest compared with the average of all Trusts who took part in the survey:

- ✓ Midwives providing service users with relevant information, during their pregnancy, about feeding their baby.
- ✓ Maternity service users being given enough support for their mental health during pregnancy.
- ✓ Maternity service users being spoken to in a way they could understand during their antenatal care.
- ✓ Maternity service users being treated with respect and dignity during their antenatal care.
- ✓ Midwives listening to service users during antenatal check-ups.

The following table presents “Where mothers’ experience could improve”: which includes the five results for the Trust that are lowest compared with the average of all Trusts who took part in the survey:

- Partners or someone else involved in the service user’s care being able to stay with them as much as the service user wanted during their stay in the hospital.
- Maternity service users being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- Maternity service users being given appropriate information and advice on the benefits associated with an induced labour, before being induced.
- Maternity service users being able to see or speak to a midwife as much as they wanted during their care after birth.
- The midwife or midwifery team appearing to be aware of the medical history of the service user and baby during care after birth.

Next Steps
The teams are identifying priority actions with their local teams and MNVP, which will inform an action plan.

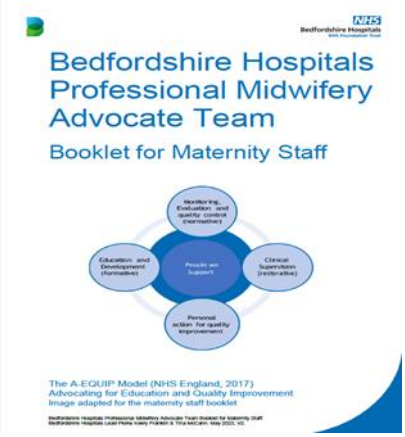
HOPE Box Pilot Winners of Excellence in Experience at the East of England Celebration Event (March 2024).

Hold on pain eases (HOPE) box pilot study was implemented at both maternity units by the safeguarding lead midwives between December 2022 - September 2023. The HOPE Boxes are an intervention to help support women who are separated from their baby close to birth due to safeguarding concerns. The boxes are designed to help mothers capture important memories prior to separation and importantly to promote the ongoing connection post separation. Women are eligible if they are delivering at Bedfordshire Hospitals NHS Trust (Luton or Bedford site).
9 sets of boxes given at Bedford Hospital and 5 sets of boxes have been given at Luton & Dunstable Hospital.
This project has now been embedded into practice as a permanent quality improvement initiative to support families.

- One box for Mother and one for baby.
- Activities to promote bonding & attachment.
- A poem and letter written by the lived experience group.
- Aim to promote the ongoing connection between mother and baby.
- Motivate mothers engagement with her baby.
- Help parents grieve their immediate loss and acknowledge their maternal identity.
- Allow parents some control in a process that many report as feeling dehumanising.

Professional Midwifery Advocate Booklet
Runner up in the Excellence in Innovation category at East of England Celebration Event March 2024.

The Bedfordshire Hospitals Lead Professional Midwifery Advocates have devised a maternity staff booklet which focuses on the A-EQUIP supervision model. Staff feedback has been extremely positive and the PMA booklet has now been adopted by other Trusts regionally and nationally the lead PMA have presented nationally and most recently at the British Journal of Midwifery conference in 2024.



Contents

Maternity hubs

Community based maternity hubs are Midwife-led centres where women can access antenatal and post-natal care including specialist infant feeding support closer to home. The hubs - part of NHS England's Better Births Maternity Transformation Programme, saving babies' lives agenda and Three year delivery plan for maternity and Neonatal aim to bring new families together so that parents have access to antenatal, postnatal, general health and social services all under one roof. The majority of community hubs are in locations in the most deprived areas with the aim to deliver maternity services and targeted support where health inequalities exist.

Community services for Maternity Care have historically been carried out independently in various GP surgeries in the Bedford, Central Bedfordshire areas and Luton. The hubs which were developed on our Luton site as a direct result of the pandemic included; Chaul End community centre, Wigmore Lane Health Centre, Marsh Farm Health Centre, Downside Children's Centre, Dunstable and Ridgeway Court, Leighton Buzzard. At our Bedford site, Stotfold maternity hub serving Central Bedfordshire was launched in response to the pandemic.

In April 2023, the second maternity hub (Bedford hospital) launched at Kings House in Bedford with the first phase of moving antenatal care from GP surgeries into a local hub in Bedford and combining this with postnatal care. We have plans to move to a more suitable premises later this year which will enable us to move other services such as Glucose Tolerance testing and women's Pelvic health in to one location.

Bedford Council has been awarded funding for 3 years to implement Start for life and Family Hubs programme and maternity have been working collaboratively with Bedford Borough Council to move into two new Bedford Family Hubs at Queens Park and Pinecones. This will enable families in the most deprived areas to access antenatal and postnatal care from a Family Hub. Our joint aim is to support all children, young people and families' access to services and resources that support them to build firm foundations for the future, and to deliver this through a strong network of professionals, family, friends and communities who will be empowered to work collaboratively and sensitively with each other. This project will

support the Maternity Building Blocks and will support the Maternity 3 year delivery plan 2023.

Benefits of maternity/family hubs include:

- Ability to create Hub/joint working approach for community midwives
- Improved sharing / safety for antenatal and postnatal pathways of care
- Remove requirement for weekend working and additional unfunded costs.
- Collaborative working across the Bedford Borough and Bedfordshire County
- Longer opening times and 7 day a week to enable families to access midwives
- Location also facilitates staff without transport to be based in a Hub (community)
- Improved attendance and access for our BAME community and our communities experiencing social deprivation due to the location of the Family Hubs.
- Availability of Hot desks so community teams can work from the Family Hubs, which will support with skill mix and staff sickness cover.

1.20.1 PERFORMANCE AGAINST CORE QUALITY INDICATORS

In 2012, a statutory core set of quality indicators came into effect. Eight indicators apply to acute hospital Trusts. All Trusts are required to report their performance against these indicators in the same format with the aim of making it possible for a reader to compare performance across similar organisations.

For each indicator our performance is reported, together with the national average and the performance of the best and worst performing Trusts.

Whilst not listed as a core indictor of the Regulation 4 schedule (NHS Quality Accounts Regulations 2010), it is considered good practice to publish the Friends and Family test for patients, for both inpatients and Accident and Emergency services. These are reported within section 3.17 of this quality account.

Indicator: Summary hospital-level mortality indicator ("SHMI")
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. It includes deaths in hospital and within 30 days (inclusive) of discharge. SHMI had excluded any patient with a Covid-19 diagnosis; from the May 2024 publication, Covid deaths from 1 September 2021 will be included as well as other methodology changes. The SHMI gives an indication for each non-specialist acute NHS Trust in England whether the observed number of deaths within 30 days of discharge was 'higher than expected' (SHMI banding = 1), 'as expected' (SHMI banding = 2) or 'lower than expected' (SHMI banding = 3) when compared to the national baseline.

The Trust is a provider of level 3 neonatal care that cares for the most premature babies and it is acknowledged that SHMI does not adequately risk adjust for a level 3 NICU provided in a District General Hospital.

	Reporting period	BHFT score	National Average	Highest Trust	Lowest Trust	Banding
Value and banding of the SHMI indicator	Published April 20 (Dec 18 – Nov 19	As expected	As expected			2
	Published May 21 (Jan 20 – Dec 20)	As expected	As expected			2
	Published May 22 (Jan 21 – Dec 21)	As expected	As expected			2
	Published May 23 (Jan 22 – Dec 22)	As expected	As expected			2
	Published May 24 (Jan 23 – Dec 23)	As expected	As expected			2
% Deaths with palliative care coding	Published April 20 (Dec 18 – Nov 19)	41	37	59	1	N/A
	Published May 21 (Jan 20 – Dec 20	35	37	61	8	N/A
	Published May 22 (Jan 21 – Dec 21)	35	36	60	9	N/A
	Published May 23 (Jan 22 – Dec 22)	35	40	65	12	N/A
	Published May 24 (Jan 23 – Dec 23)	37				N/A

The Bedfordshire Hospitals NHS Foundation Trust considers that this data is as described for the following reason:

- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived;
- Data is collated internally and then submitted on a monthly basis to NHS Digital via the Secondary Users Service (SUS). The SHMI is then calculated by NHS Digital, with results reported monthly on a rolling year basis.
- Clinical coding of patient records is subject to an annual audit.

The Bedfordshire Hospitals NHS Foundation Trust has put in place the following actions to improve this score, and thus the quality of its services, by:

- On-going use of Structured Judgement Reviews (secondary mortality reviews) by a team of senior clinicians. Cases requiring in depth review are identified by the Medical Examiners who scrutinise each death (primary mortality review). The learning from these reviews is extracted at clinical service line (CSL) level and incorporated in CSL governance meetings.
- The data quality improvement plan which was initiated at the Bedford Hospital site in 2023-2024 in view of the site-based SHMI being ‘above expected’ has demonstrated an improvement. Bedford Hospital site is now within the ‘as expected’ range with a significant improvement trajectory.

Indicator: Readmission within 30 days of discharge

The percentage of patients readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital during reporting period.

	Reporting period	BHFT Score	Peer Value	Best performing Trust	Worst performing Trust
Patients aged 0 – 15 years	2019/20	13.8%	9.2%	Not Avail*	Not Avail*
	2020/21	13.2%	8.9%	Not Avail*	Not Avail*
	2021/22	13.9%	9.1%		
	2022/23	13.5%	8.9%		
	2023/24	14.2%	10.5%		
Patients aged 16 years and over	2019/20	7.9%	8.6%	Not Avail*	Not Avail*
	2020/21	8.8%	9.8%	Not Avail*	Not Avail*
	2021/22	7.3%	8.7%	Not Avail*	Not Avail*
	2023/24	7.4%	8.3%		

The Bedfordshire Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust does not routinely gather data on 28 day readmission rates
- The Trust gathers data on 30 day readmission rates
- The most recent available data on NHS Digital relates to 2011/12 uploaded in December 2013.
- Data taken from CHKS – 2023/24 – is up until February 2024

Indicator: Patient Reported Outcome Measures (PROMs)

PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery. Final annual confirmed PROMs data are planned for release approximately 18 months after the end of each financial year by NHS Digital; therefore, there is a significant time lag in being able to publish data within the Quality Account.

	Reporting period	BHFT Score	National Average	Best performing Trust	Worst performing Trust
Primary hip replacement (EQ-5D)	2017/18	0.43	0.46	0.55	0.36
	2018/19	0.45	0.46	0.52	0.41
	2019/20	0.37	0.45	0.54	0.37
	2020/21	0.39	0.47	0.57	0.39
	2021/22 - updated since 22/23 Quality Accounts published	**0.412**	**0.462**	**0.534**	**0.373**
	2022/23	**Not available on NHS Digital at time of publication**			
Primary knee replacement (EQ-5D)	2017/18	0.31	0.34	0.41	0.25
	2018/19	0.32	0.34	0.39	0.28
	2019/20	0.34	0.33	0.4	0.2
	2020/21	0.23	0.32	0.4	0.18
	2021/22 - updated since 22/23	**0.302**	**0.324**	**0.417**	**0.246**

	Quality Accounts published				
	2022/23	**Not available on NHS Digital at time of publication**			

The Bedfordshire Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has a process in place for collating data on patient reported outcomes
- Data is sent to NHS Digital who calculate PROMS scores and then publish them on NHS Digital
- Data is compared to peers, highest and lowest performers, and our own previous performance as set out above

*Best performing and worst performing are given as provider level data

The Bedfordshire Hospitals NHS Foundation Trust has taken the following actions to improve this score, and therefore the quality of its services, by:

- Ensuring results are reviewed through the organisational service line governance structure in addition to a local clinical governance forum via nominated PROMs lead in the service line
- Use of information to support improved data submission and quality and use of outcome scores at multidisciplinary staff meetings to promote ideas for further quality improvement.

Indicator: Responsiveness to the personal needs of patients

The Bedfordshire Hospitals NHS Foundation Trust has been unable to provide data for this indicator since 2021/22 as it is not available on NHS Digital.

4.2 Responsiveness to inpatients' personal needs - NHS Digital

Indicator: Staff recommendation

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. Question title: *"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."*

	Reporting period	**BHFT Score**	**National Average**	**Best performing Trust**	**Worst performing Trust**
% staff who would recommend the Trust as a provider of care to family and friends	2020/21	70%	74%	92%	50%
	2021/22	64.9%	66.9%	89.5%	43.6%
	2022/23	60.2%	61.9%	86.4%	39.2%
	2023/24	62.02%	63.32%	88.82%	44.31%

The Bedfordshire Hospitals NHS Foundation Trust considers that this data is as described for the following reasons

- The source of the data is the National Staff Survey.

The Bedfordshire Hospitals NHS Foundation Trust has taken the following actions to improve this score, and therefore, the quality of its services, by:

- Expanding its Organisational Development team providing internal consultancy to departments across the Trust supporting service improvement with the uplift of two Culture and OD Consultant posts, and the creation of one People and Culture Practitioner Post.
- Refining the New Consultants' Programme and developing the Clinical Directors' Leadership Programme that focusses on personal development, team engagement and service quality improvement. This programme enables participants to make change in their service to improve standards of care.
- Providing a dedicated ward accreditation and assessment service that allows for the identification and celebration of celebrate excellence in practice, the generation of a culture of continuous improvement and the provision of tailored ongoing support to each area's specific needs.
- The implementation of a Respectful Resolution Pathway to address negative behaviours and create a supportive space where everyone has Freedom to Speak Up.

Indicator: Risk assessment for venous thromboembolism (VTE)

The Bedfordshire Hospitals NHS Foundation Trust has been unable to provide data for this indicator since 2022/23 as it is not available on NHS Digital.

Venous thromboembolism (blood clots) are a major cause of the death in the UK. Some blood clots can be prevented by early assessment of the risks for each patient, which then supports the appropriate delivery of prophylaxis (medication to prevent clots). Over 95% of our patients are assessed for their risk of thrombosis on admission to hospital.

	Reporting period	BHFT Score	National Average	Best performing Trust	Worst performing Trust
% patients who were admitted to hospital and who were risk assessed for VTE. (*Prior to April 2019, the standard related to adult inpatients aged 18 and over. Since this time, the standard relates to inpatients aged 16 and over.)*	2018/19 – Q3	99.0	95.7	100	54.9
	2018/19 – Q4	99.5	95.7	100	74.0
	2019/20 – Q1	99.2	95.6	100	69.8
	2019/20 – Q2	99.0	95.5	100	71.7
	2019/20 – Q3	98.3	95.3	100	71.6
	2019/20 – Q4	NHS Digital data unavailable			
	2020/21	VTE data collection by NHS Digital was paused			
	2021/22	NHS Digital data unavailable			
	2022/23 – Q1	97.4	NHS Digital data unavailable		
	2022/23 – Q2	98.0	NHS Digital data unavailable		
	2022/23 – Q3	97.7	NHS Digital data unavailable		
	2022/23 – Q4	98.1	NHS Digital data unavailable		
	2023/24 – Q1	98.1	NHS Digital data unavailable		
	2023/24 – Q2	96.8	NHS Digital data unavailable		

The Bedfordshire Hospitals NHS Foundation Trust considers that this data is as described for the following reasons

- There is a robust process for capturing the evidence of completion through monthly audit. There has been a national pause on VTE data collection since the Covid-19 pandemic therefore it is not currently possible to compare compliance with other Trusts

The Bedfordshire Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- .
- The electronic risk assessment tool for Luton hospital was updated in 2022 and plans are in place to update Bedford's in the coming year. The Trusts continues to review compliance with VTE risk assessments thought the Trust Thrombosis Group and individual meetings.

Indicator: *Clostridioides difficile* infection rate

The rate of cases of *C. difficile* infection per 100,000 bed days reported within the Trust amongst patients aged 2 years or over during the reporting period.

	Reporting period	BHFT Score	National Average	Best performing Trust	Worst performing Trust
Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two years or over	2016/17	3.6	13.2	0	82.7
	2017/18	3.9	13.6	0	91.0
	2018/19	1.7	12.2	0	79.7
	2019/20	25.0	34.5	0	136.0
	2020/21 HOHA COHA	 8.3 7.1	 17.0 7.7	 0 0	 76.1 33.3
	2021/22 HOHA COHA	NHS Digital data currently unavailable			
East of England data HCAI totals not broken down to COHA or HOHA	2022/2023	19.72	Unknown	11.77	40.88
East of England data HCAI totals not broken down to COHA or HOHA	2023/2024	17.58	Data not available		

- The Trust has a process in place for collating data on C.difficile cases
- Data is collated internally and submitted to Public Health England
- Data is compared to peers, highest and lowest performers, and our own performance as set out in the table above

For 2023/24 cases were reported to the healthcare associated infection data capture system and assigned as follows:

Apportionment category	Abbreviation	Definition
Hospital onset healthcare associated **(counts towards Trust objectives)**	HOHA	Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
Community onset healthcare associated **(counts towards Trust objectives)**	COHA	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
Community onset indeterminate association **(*C. difficile* only)**	COIA	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where day 1 is the specimen date)
Community onset community associated	COCA	**For C. difficile:** Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date) **For bacteraemias:** Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

In 2023/2024 the Health care associated or hospital acquired cases (HA) i.e. Trust apportioned cases included will continue to be the first 2 categories (HOHA & COHA).

To date we have recorded **73** cases of hospital acquired *C.difficile* infections (CDI) against a Trust ceiling of **56** cases for 2022-2023.

Luton Total = 41 (HOHA 29, COHA 12)
Bedford Total = 32 (HOHA 23, COHA 9)

All isolates are typed to enable early warning of clusters or point source outbreaks. Typing to date has not identified any clustering or link between cases, except on one ward where there was a link between two cases.

At Bedford – Ribotype 002 is noted to be the highest, however three of these episodes are from the same patient. At Luton it was 020 with two from the same patient.

There were 12 patients identified to have relapse in 2023 (x8 Bedford, x4 Luton) irrespective of the acquisition type.

All cases of *Clostridium difficile* diarrhoea are subject to a root cause analysis. A practice compliance assessment is also undertaken to establish any “lapses of care or testing”. This then forms the basis of future learning for our organisation. This year we have changed the process with all HCAI cases reported on InPhase (incident reporting system) this will enable learning to be captured in the service line reporting and themes identified.

Proposed interventions for improvement commenced/working towards into 24/25:

- Alert added on medical record of specific patients to avoid Co-amoxiclav as per the recommendation given on post infection review meetings.

- Align IPC risk assessment (admission and every 72 hours thereafter) and launch electronically where possible.
- Bedfordshire Hospital IPC Operational Group meeting continued.
- Commode Audit being completed by Wards/Departments.
- Continue with current weekly C. difficile rounds process with involvement from antimicrobial pharmacist and microbiologist.
- Introduction of new disinfection technologies in Bedford: UV light disinfection or hydrogen peroxide vapour. Process alignment across site.
- IPC dashboard (cross-site) continued – monthly mail out and link – to all wards/units
- Ongoing utilisation of UV gel and torch to audit environmental cleanliness in the wards and feedback provided to respective departments.
- Review if Bristol Stool Chart documentation on NerveCentre can be made mandatory.
- Understand staff barriers to IPC standards when non-compliance is observed and provide on the spot education / reminder when required.

Indicator: Patient safety incident rate

This shows the number and rate of patient safety incidents reported within the Trust during this reporting period. The number and percentage of each patient safety incident shows the results in severe harm and death.

	Reporting period	BHFT score	National Average	Worst performing Trust	Best performing Trust
Total number (n) and rate (r) of patient safety incidents (per 1000 bed days)	Apr 18 – Sept 18	n=3512 r=30.92	44.5	13.1	107.4
	Oct 18 - Mar 19	n= 3841 r= 33.17	46.1	16.9	95.9
	Apr 19 - Sept 19	n=5019 r=43.24	49.8	26.3	103.8
	Oct 19 – Mar 20	BH n= 3551 r=48.05	National comparative data unavailable at time of reporting		
		LDH n=5970 r=50.13			
	Apr 20 – Sep 21	59.1 (Merged data)			
	Apr 22 – Nov 22	n= 10323 (merged data) r=38.65			
Incidents reported to LFPSE via InPhase reporting system	Dec 22 – Mar 23	n=7450 r=53.99	National LFPSE comparative data not available at the time of reporting		
Incidents reported to LFPSE via InPhase reporting system	April 23 – March 24	30,076 r = 72.27	National LFPSE comparative data not available at the time of reporting		
Total number (n) and percentage (%) patient safety incidents	Apr 18 – Sept 18	n=15 0.42 %	0.3	1.3	0

resulting in severe harm or death	Oct 18 - Mar 19	n=12 0.31 %	0.3	1.7	0
	Apr 19 - Sept 19	n=17 0.34 %	0.3	1.6	0
	Oct 19 – Mar 20		0.3	1.4	0
	Apr 20 - Mar 21	n= 17 0.34%	0.3	1.6	0
	Apr 21 – Mar 22	n=37 0.31% (Merged data)	0.3		
	Apr 22 – Nov 22	n=37 0.36% (Merged data)	National comparative data unavailable at time of reporting		
Incidents reported to LFPSE	Dec 22 – Mar 23	n =20	National LFPSE comparative data not available at the time of reporting		
Incidents reported to LFPSE	April 23 – March 24	n=321 1.07%	National LFPSE comparative data not available at the time of reporting		

- The Trust has a local electronic risk management system for staff to report and manage data for patient safety and non-clinical incidents supported by a policy, education and training, and a suite of resources on the Trust intranet.
- Data is collated internally and submitted to the national Learn from Patient Safety Events (LFPSE) platform.
- Data is taken directly from LFPSE reports over 2023/24
- Data should be viewed with caution due to the impact of COVID -19 recovery plans during the reporting period

The number of patient safety incidents reported continues to reflect a positive culture for reporting all patient safety incidents and near misses.

The Patient Safety Incident Response Framework (PSIRF) was implemented in the Trust in October 2023.
The approach, which has been driven by national policy, has shifted the approach from root cause analysis for serious incident investigations – towards a systems approach which recognises that healthcare is complex with multiple interfaces between people, equipment, technology, tasks and the environment.

All incidents are reviewed and validated through governance processes within the Trust. We continue to use the outcomes of learning responses and investigations into patient safety incidents to inform safety and quality improvement work.

3.21 PERFORMANCE AGAINST NATIONAL PRIORITIES

		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Target 20/21
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	5	42	51	64	76	73	
MRSA	To achieve contracted level of 0 cases per annum	1	2	2	1	6	4	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	100%	100%	97.3%	96.9%	94.3%	94.6%	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	87.6%	88.7%	73.7%	70%	59.7%	64.5%	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.8%	93.9%	90.4%	76.7%	84.4%	78.3%	93%
Cancer	Maximum waiting time of 31 days for second or subsequent treatment							
	Surgery	100%	100%	92.6%	94.9%	89.2%	84.7%	94%
	Anti-cancer Drugs	100%	100%	97.4%	99%	99.2%	98.6%	98%
Patient Waiting Times	Referral to treatment - percentage patients waiting so far within 18 weeks - incomplete pathways	91.1%	89.8%	68.6%	64%	58.4	53.1%	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.1%	**	**	**	**	**	95%
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	0.8	1.04*** 0.6 (M1-11)	30.5% ***	27.1% ***	35.8%	39.5%	<1

* The Trust has maintained low rates of MRSA throughout but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
** Data not provided as Trust part of pilot for new Emergency Access Monitoring data
*** 2020/21 & 2021/22 yearly performance adversely impacted by the COVID-19 crisis resulting in cancellation of some diagnostic testing.

GLOSSARY

Term	Description
Acute Kidney Infection (AKI)	A painful and unpleasant illness caused by bacteria travelling from the bladder into one or both kidneys
Antimicrobial	An agent that kills microorganisms or stops their growth
BAME	Black, Asian and Minority Ethnic people
BAUS	British Association of Urological Surgeons
BLMK ICS / ICB	Bedford, Luton and Milton Keynes Integrated Care System / Board (commissioners of care)
BLS	Basic Life Support – the immediate resuscitation given to people who are not breathing and may not have a pulse
BTS	British Thoracic Society
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively
CCG (replaced by ICBs)	Clinical Commissioning Group
CHKS	A commercial organisation that provides healthcare intelligence and quality improvement services. The Trust uses data through systems provided by CHKS to review mortality statistics.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change for improvements
Continence	The ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.

Term	Description
CQUIN	Commissioning for Quality and Innovation – these are quality improvement targets set nationally or by the CCG/ICB where a Trust receives a financial incentive if it achieves the quality targets (see Section 3.4).
Delirium	Delirium is a significant disturbance in mental abilities that results in confused thinking and reduced awareness of the environment.
DME	Division of Medicine for the Elderly
DNA	Did Not Attend – an appointment
DNACPR	A DNACPR decision is usually recorded on a special form. DNACPR stands for 'Do not attempt cardiopulmonary resuscitation (CPR)'. It means that if a person has a cardiac arrest, heart or breathing stops, the healthcare team will not try to restart it. There will be guidance on what action should or shouldn't be taken by a healthcare professional. It does not mean that an individual will not get care and treatment. They will continue to have all other appropriate care, treatment and support.
DQIP	Data Quality Improvement Plan – all NHS organisations must continually review and improve the quality of data they collect, store and use
DQ	Data Quality
EBI	Evidence Based Interventions
Elective	Scheduled in advance (planned) – often referred to for treatment such as surgery.
EOL	People are considered to be approaching the end of life when they are likely to die within the next 12 months, although this is not always possible to predict. End of life care should begin when needed and may last a few days, or months, or sometimes more than a year. End of Life care should help people to live as well as possible until they die, and to die with dignity.
Epilepsy	Disorder characterised by recurrent seizures.
EPMA	Electronic Prescribing and Monitoring Administration system in place.
ESR	Electronic Staff Record. A system which records staff details relevant to their employment.
Grand Round	A lunch time weekly meeting with consultants and junior medical staff to communicate key issues and shared learning – often on a specific topic
Fagerstrom score	This score is calculated by using the Fagerstrom Test of nicotine dependence. It helps to ensure that the prescribing of nicotine

Term	Description
	replacement therapy is appropriate for the needs of the patient
Frailty	Frailty is a common geriatric syndrome that embodies an elevated risk of catastrophic declines in health and function among older adults
GDPR	The General Data Protection Regulation is a regulation in law on data protection and privacy, which came into effect in May 2018.
GIRFT	The NHS Getting It Right First Time (GIRFT) programme targets efficiencies within services, utilising benchmarked outcomes and claims data to improve the quality of care within the NHS
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow
HES	Hospital Episode Statistics - provide definition
HSMR	Hospital Standardised Mortality Rate is an overall quality indicator and measurement tool that compares a hospital's mortality rate
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
ICNARC	Intensive Care National Audit and Research Centre
ICO	The Information Commissioner's Office (ICO) is the independent regulatory office responsible for upholding information rights in the interest of the public.
ICS/B	Integrated Care System/ Board – partnerships across areas form to work collectively to provide better, more joined up care for patients. The Trust ICS covers the areas of Bedford, Luton and Milton Keynes (BLMK)
ILS	Immediate Life Support
Just Culture	In the NHS a Just culture creates the conditions for a culture of fairness, openness and learning by enabling staff to feel confident to speak up when things go wrong, rather than experiencing or perceiving blame.
Laparoscopic	Key hole surgery
Learning Disability	Learning disability and learning difficulties are terms commonly used in the UK. These two terms are often interchangeable when used in the context of health and social care for adults. Some people with learning disabilities prefer the term learning difficulties. There is a view that it includes the presence of: • a significantly reduced ability to understand new or complex information or to learn new skills;

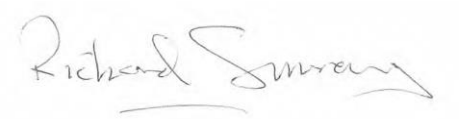
Term	Description
	• a reduced ability to cope independently; • an impairment that started before adulthood, with a lasting effect on development.
LIG	Local Implementation Group
LFPSE	Learn From Patient Safety Events. This replaced the NHS England platform National Reporting and Learning System. LFPSE is an NHS England platform to which NHS Trusts upload the majority of their reported incidents (specified criteria). There is a range of purposes for LFPSE but a key purpose is that the collective knowledge of incidents – for example, an unusual cluster seen in a number of trusts can then inform a National Patient Safety Alert which all trusts are then required to respond to, with the aim of preventing further incidents of a similar type.
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
MDT	Multidisciplinary Team – includes the various disciplines involved in the delivery of care. This includes doctors, nurses, midwives, allied health professionals, pharmacists and clinical support staff.
MRSA (Meticillin-Resistant Staphylococcus areus)	MRSA is a type of bacteria resistant to several widely used antibiotics. This means that infections with MRSA can be harder to treat than other bacterial infections.
Myocardial Infarction	A heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Needs Based Care	Inpatient adult wards are organised by patient need rather than age for example a cardiac ward, respiratory ward
NELA	National Emergency Laparotomy Audit
Neonatal	New-born – includes the first six weeks after birth
NEWS2	NEWS2 is the National Early Warning Score (NEWS), first produced in 2012, and is a system to standardise the assessment and response to acute illness
NICE	The National Institute for Health and Care Excellence (NICE) publish clinical guidelines that recommend how healthcare professionals should care for people with specific conditions. The recommendations are based on the best available clinical evidence
Non Invasive Ventilation (NIV)	The administration of ventilator support for patients having difficulty in breathing

Term	Description
NRT	Nicotine Replacement Therapy is treatment that can be prescribed and administered to help people who smoke or use vapes to avoid or minimise withdrawal effects if they stop use
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	A degenerative disorder of the central nervous system
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment which limits opportunities for rescheduling
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
PPE	Personal Protective Equipment – consists of masks, gloves, aprons, visors which are worn by clinical staff to protect themselves from the risk of infection
PPH	Post-partum haemorrhage – a term used to describe blood loss after childbirth
Prevalence	The proportion of patients who have a specific characteristic in a given time period
PSIRF	Patient Safety Incident Review Framework
RAG rating	Red, Amber and Green ratings are used in the display of some metrics to visually demonstrate whether standards or metrics, are met, partially met, or not met.
Red and Green	The Red: Green Bed day is a visual management system to assist in the identification of wasted time in a patient's journey. If it is red, the patient has not progressed, green they have.
Research Portfolio	Studies which are eligible and have been accepted onto the National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio Database.
Research Non-Portfolio	Studies which do not meet the eligibility criteria to be accepted onto the NIHR CRN Portfolio Database. *(Note: these are worthwhile studies but are usually own account, smaller single centre studies, student research etc.)*
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or associated poisons in the blood stream.

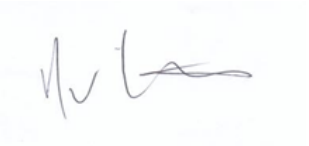
Term	Description
SHMI	Summary Hospital-level Mortality Indicator (SHMI) is a standardised indicator which reports on mortality at Trust level across the NHS in England
Somatosensory	The somatosensory system is a part of the sensory nervous system. It is a complex system of sensory neurons and pathways that responds to changes at the surface or inside the body.
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit.
STEMI	ST Elevation MI (STEMI) – is a specific type of heart attack
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply.
Structured Judgement Review (SJR)	A review methodology whereby trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made which others with the same training would most likely offer similar statements.
SUS	Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England that enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
TEP	Treatment Escalation Plan
Two week wait	Target set nationally for the ideal maximum length of time patients should wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
TRUS	Transrectal ultrasonography – a method of creating an image of the organs in the pelvis, most commonly used to perform a guided needle biopsy of the prostate gland in men.
TTPB	Transperineal Template-Guided Prostate Biopsy
TURBT	Transurethral Resection of Bladder Tumour
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins
WHO	World Health Organisation

Statement of Directors responsibilities for Quality Account

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. By order of the board,



Richard Sumray, Chair



David Carter, Chief Executive

Statement from Bedfordshire, Luton & Milton Keynes Integrated Care Board (BLMK ICB)

Quality Account 2023 – 2024

BLMK Integrated Care Board acknowledges receipt of the draft 2023/2024 Quality Account from Bedfordshire Hospitals NHS Foundation Trust (BHFT) and welcomes the opportunity to provide this statement.

The Quality Account was shared with key members of the ICB and reviewed by members of the ICB's Quality Team as part of developing our assurance statement.

2023/24 was another very difficult year, both locally and nationally, with the on-going work to recover services, system wide pressures, and continuing national industrial action but it is positive to see the progress the Trust has made despite these challenges.

The ICB recognises the work of the Trust and thanks all their staff and volunteers for their efforts and dedication during these incredibly challenging times. It also acknowledges the work the Trust is undertaking to support staff and embed the changes it is making, including the creation of a new People Promise Manager post.

We would like to thank all individuals involved in developing and producing this account.

Due to the requirement to ensure the Quality Account meets the publication date, this statement has been based on information and data which was available within a draft version received from the Trust on 21/05/2024.

The information provided within the draft account is to the best of our knowledge, accurate and fairly interpreted. It is a well-constructed document which highlights the progress and improvements achieved in 2023/2024, the plans to continue to embed and develop the workstreams which are not being taken forward as priorities in 2024/2025 and recognises where further improvements are needed.

Reducing inequalities is a strategic priority for the health and care partnership and it is positive to see that this is reflected in several of the Trusts Corporate Objectives

We are aware of the significant amount of work the Trust has undertaken to implement all relevant requirements within the National Patient Safety Strategy, and in particular the roll out of the Medical Examiners role, the transition from the National Serious Incidents Framework to the Patient Safety Incident Response Framework and the implementation of a new incident reporting system in line with Learning from Patient Safety Events. We thank the Trust for including ICB representation at their Trust Patient Safety Panel and Quality Board and look forward to continuing to collaborate with the Trust on this important work to ensure patient safety is at the heart of organisational culture.

Maternity and Neonatal services remain a key priority nationally and locally. The three-year delivery plan for maternity and neonatal services provides a unified framework for Trusts and ICBs, through the Local Maternity and Neonatal System, to continue to deliver and work collaboratively to oversee quality, safety, improvement, and transformation of these services.

31/05/24

The ICB is supportive of the Trust's 2024/2025 Quality Account priorities, some of which will build on the work already undertaken within the 2023/24 priorities.

Patient participation, engagement and co-production are fundamental to ensuring services are developed which are truly able to meet the needs of the local population, and the Trust has identified a priority to improve responsiveness to feedback. The ICB hope that co-production will be reflected in the development of future Trust Priorities as this work, and the role of the Patient Safety Partners continues to evolve.

Recovery of services, including those for paediatric services, continues to be of on-going importance. We are therefore pleased to see cancer care recovery, in terms of achieving the cancer Faster Diagnosis Standard, is a priority for the coming year.

Digital Maturity is also paramount to improving services and we note the Trust's corporate objective to deliver on their Digital Strategy

We are aware of the work the Trust undertakes to support staff and it is positive to see that this is being reflected in the results from the National Staff Survey which indicates an improvement.

Following the commencement of the Thirlwall Inquiry, embedding and developing the role of the Trust Freedom to Speak Up (FTSU) Guardians and Champions will be imperative to support an open listening culture. The ICB acknowledges the work the Trust has already undertaken and the priorities for 2024/25, with the identification of barriers, and training for all staff being particularly important to ensure all staff feel confident and supported to raise concerns.

The ICB look forward to continuing to work in partnership with the Trust as we strive to achieve our vision for everyone in our city, towns, villages, and communities to live a longer, healthier life.

We hope the Trust finds these comments helpful.

Sarah Stanley Chief Nurse

Bedford Borough Council

Invitation accepted for trust representative to attend the Health Overview and Scrutiny Committee – June 3rd 2024, Quality Accounts on Agenda.
The meeting was held following announcement of the General Election, which restricts NHS representatives from some pre election activity (including discussions).

Follow up response below :

Good Morning Karen

Thank you for your attendance at Monday's meeting of Bedford Borough Council's Health Overview and Scrutiny Committee. Please see the draft minute reference below from that meeting held on 3 June 2024, when the Committee considered the Bedfordshire Hospitals NHS Foundation Trust – Quality Account Report for 2023/2024.

8. BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST – QUALITY ACCOUNT REPORT FOR 2023/2024

The Chair welcomed Karen Sobey Hudson, Deputy Director of Quality and Safety Governance, Bedfordshire Hospitals NHS Foundation Trust who introduced the draft Quality Account for Bedfordshire Hospital NHS Foundation Trust 2023/2024. As part of the Quality Account, local authorities' Health Overview and Scrutiny Committees were invited to comment on them during the draft stage of the process prior to their submission to the Department of Health and Social Care.

The Deputy Director of Quality and Safety Governance advised that the Trust had engaged with the Integrated Care Board (ICB) and HealthWatch for Bedford, Central Bedfordshire and Luton.

In terms of Clinical Quality and Innovation, the Trust had achieved in five areas focussing on patients, particularly eating, drinking and mobilising which were important for patients and would be a quality priority this year.
Corporate objectives included reducing inequalities; patient participation; and digital maturity. There were nine quality priorities for the forthcoming year, relating to patient safety, patient experience, and clinical effectiveness. It was noted that the cancer fast diagnostic standard had already been met and would continue to be a priority going forward.

Work continued regarding the Trust's estates whereby the Chief Executive Officer, Bedfordshire Hospitals NHS Foundation Trust had attended the meeting of this Committee in March 2024 and provided an update.

A national staff survey had identified that the Trust had improved within most areas which was positive for the staff, and it was close to average for being recommended as a place for patients to be treated.

The CQC Maternity Survey had identified improvements within five areas, and since last year, birthing partners had been provided with the opportunity to stay overnight.

In response to Members' questions, the Deputy Director of Quality and Safety Governance, Bedfordshire Hospitals NHS Foundation Trust provided the following answers:

- A significant amount of work had been undertaken to promote flu vaccinations for staff, and there may have been an element of vaccination fatigue. It was an aspirational target which had subsequently been reduced, however the Trust felt that it needed to be pursued and promoted further.
- In terms of the introduction of the Fracture Neck of Femur Improvement Programme, the Trust would investigate the differences between the number of patients receiving surgery within 36 hours at Bedford which was significantly lower compared to Luton and include a narrative within the Quality Account.
- One of the main block lifts was now working at Bedford Hospital, and where patients needed urgent treatment, they would be taken to Luton as a temporary arrangement. In terms of the estate overall, the Trust was concerned and wanted to uplift them for all patients, staff and visitors. It was important for patients to be comfortable and to have a good, accessible environment particularly for their own personal experience.
- Pressure ulcer risks was a one of the corporate priorities for this year whereby a new Tissue Viability Nurse Lead was in place to tackle this matter going forward. It was acknowledged that there had been a gap both in leadership and whilst the Nurse Lead was being appointed regarding pressure ulcers; however, this would improve now that the new Nurse Lead was in place.
- A response was not provided regarding any impacts concerning a lack of staff playing a part in pressure ulcer risks, care, treatment and diagnostics as it was a multi-factorial area of care. As like many other NHS Trusts, Bedfordshire had pressures with staffing which was challenging, particularly with a high volume of patients.
- With the new patient safety framework, all NHS Trusts had been asked to look differently at how it investigated incidents; how they had occurred; and to learn quickly from them. All Trusts had identified national, Trust and local priorities, which for Bedfordshire had chosen insulin incidents, therefore had made it a Trust priority with an Insulin Committee being created to discuss any matters arising regarding insulin related incidents. This also linked into work regarding diabetes and patient safety incidents. With all incidents there were many causes of errors and omissions, human factors etc. and were common across the NHS. Therefore, through the theming of the

new patient safety framework, the Trust had determined to give insulin safety a focus and visibility by monthly meetings via the Insulin Committee.

- A response regarding a question related to the increase in hospital acquired C-difficile cases was not available at the meeting, however it was something that the Trust intended to provide further clarification, explanation, and next steps.
- In terms of the Denny Review, the Trust would continue to work with the Patient Experience Council and Patient Safety Partners whereby some cultural competency workshops had been held with a view to reduce inequalities wherever possible through different approaches. For example, in maternity, there were hubs to assist people who were seldom heard or difficult to access which related to the Trust's engagement with them, by using interpreters and translators to ensure it was being fair and equitable to everyone, including staff.
- Feedback regarding the draft Quality Account, particularly a suggestion of colour coding and assistance to help navigate the document was welcomed. The document would be published on 30 June 2024 on the Trust's website. In terms of the audit, it was a standard requirement of NHS England, where, as an acute hospital trust, Bedfordshire had a lot of audits which needed to be included as part of the Quality Account.

Members also made the following comments:

- The Quality Account had included references to the Denny Review and was one of the Trust's objectives for this year which was commendable.
- The Quality Account was a long document and not an easy read, particularly as it was a public document.
- Whilst it was acknowledged that the Quality Account was in draft format, it needed proof-reading as there were several typographical errors.
- Could the document be colour coded to clearly demonstrate how services were performing and include performance statistics?

The Chair thanked the Deputy Director of Quality and Safety Governance, Bedfordshire Hospitals NHS Foundation Trust for the detailed Quality Account and her attendance at the meeting.

RESOLVED:

i) That the report, be noted.

ii) That the relevant minute of this Committee meeting be submitted as the Council's response to Bedfordshire Hospitals NHS Foundation Trust during the draft stage of the process prior to their submission to the Department of Health and Social Care.

iii) That it be agreed that a report regarding the increase in hospital acquired C-difficile cases at Bedford Hospital *(post meeting minutes update – council acknowledged this referred to Bedfordshire Hospitals NHS Trust – over time)* and how the Trust is looking to resolve it, including next steps, be added to the Committee's Work Programme.

I would be grateful if you can acknowledge receipt of this email.

Kind regards

Lynn McKenna
Senior Democratic Services Officer
Democratic & Registration Services

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Bedford Borough Council
Borough Hall
Cauldwell Street
Bedford
MK42 9AP

Tel: (01234) 228193 (ext. 42193)

For noting, see Section 3.20.6, (page 101) with update on C.Difficile Infection rate, and improvement work.

4/6/24
Central Bedfordshire Council Response to invitation to review Quality Accounts 23/24

Statement from Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee

Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee holds decision-makers to account for improving outcomes and services for the residents of Central Bedfordshire. As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for Bedfordshire Hospitals NHS Foundation Trust.

We would like to start by acknowledging the many highlights and achievements delivered by the Trust during the last year. We make specific reference to the CQC inspection that took place during July and September 2022 and the Trust's overall rating of good for both the service and well-led inspections. It is also encouraging that the Care Quality Commission (CQC) inspection of Maternity services at Bedford Hospital resulted in an improvement in the service rating, albeit with more work needed to further improve.

We welcome the inclusion of the quality priority focused on identification and response to frailty in Emergency Departments given the link between frailty and negative health outcomes. We hope that this work will help ensure that vulnerable patients may be more likely to leave hospital without loss of independence or mobility.

We highlight the following areas of concern and areas for improvement;

- We note with concern that uptake for the flu vaccine by frontline staff with patient contact was lower than hoped given the increased risks of infection for frontline staff and the role vaccination can play in reducing this risk and helping safeguard vulnerable patients. We do however note the increase in overall uptake which was encouraging. We welcome the Trust's continued focus on this issue for the coming year.
- We note with concern the Trust's performance against national targets for maximum waiting time of 62 days from referrals to treatment for all cancers which while it has shown improvement on the previous year remains well below the target.
- It is also a concern that performance against the two week target for waiting time from urgent GP referral to first outpatient appointment also remains below the national target and has declined compared to the previous year.

We would also like to see further information in the future illustrating the ways in which patients and the public were involved with the production of the Quality Account.

In conclusion we welcome the opportunity to consider and comment on the report and we look forward to working constructively with the Trust to support the scrutiny process and our residents.

Cllr Emma Holland-Lindsay, Chair, Central Bedfordshire Council, Social Care Health and Housing Overview and Scrutiny Committee.

9/4/24 Luton Council Response to invitation to review Quality Accounts 23/24

Please email the final document for information of the Chair and members of our Scrutiny Health and Social Care Review Group (HSCRG) when ready.

The draft will not be required, as the Chair has already decided that Luton Scrutiny HSCRG will not comment on any Quality Accounts, as there is no opportunity for the committee to review them. The time lines for comments always fall between the date of the last meeting of the committee in the current municipal year and the first meeting in the new municipal year.

Healthwatch Bedford Borough, Emma Freda, Chief Executive Officer
28/5/24 'The final draft would be preferable please.'
Trust will send final approved copy.

Healthwatch Luton, Phil Turner Chair
9/5/24 Corresponded but no further comment.
Trust will send final approved copy.

Healthwatch Central Bedfordshire
From Diana Blackmun, Chief Executive Officer, 28/5/24

Healthwatch Central Bedfordshire appreciates that the Quality Account is a report about the quality of services offered by an NHS healthcare provider and are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders with 'quality' measured by looking at patient safety, the effectiveness of treatments a patient receives, and patient feedback about the care provided.

We have taken time to review this detailed report and consider the 'new' Trust well and truly a single entity operating across both Bedford and Luton sites.
The NHS states 85% of cancer patients urgently referred by a GP should start treatment within 62 days. But we note from a recent press article that NHS England data shows just 67% of patients, urgently referred by the NHS, who received cancer treatment at Bedfordshire Hospitals Trust in March began treatment within two

months of their referral, which was up from both 63% in February, and 63% in March 2023 last year.

In the same article separate figures show 100,062 patients were waiting for non-urgent elective operations or treatment at Bedfordshire Hospitals Trust at the end of March 2024 – up from 97,012 in February, and 89,195 in March 2023. Of those, 5,332 (5%) had been waiting for longer than a year. Does the Trust have a view?

It appears that the median waiting time from referral at an NHS Trust to treatment at Bedfordshire Hospitals Trust was 17 weeks at the end of March 2024 – the same as in February, and that 20,739 patients were waiting for one of 14 standard tests, such as an MRI scan, non-obstetric ultrasound or gastroscopy at this time. Of them, 8,892 (43%) had been waiting for at least six weeks. Again, does the Trust have a view?

However, we have also taken a forward-looking approach to this Quality Account and note the ten corporate objectives for 2024/25. As an advocate for the people of Central Bedfordshire, we would support all of those plans. And we support the other, 'people' related, initiatives. For example, the uptake of flu vaccination by Trust staff, which absolutely should be a priority for the coming year.

We note measures being taken to improve Patient Experience, in particular – *Supporting Patients to drink, eat and mobilise* after surgery, and will be interested to see how the Trust performs in this area during 2024/25, and will be keen to see results in your supporting the 'Timely Personalised Treatment Escalation Plan (TEP)' conversations and 'Do Not Attempt Cardiopulmonary (DNACPR) decisions'. At the end of this response Healthwatch Central Bedfordshire will be asking questions of the Trust re the wider 'Patient Experience'.

We note the Quality Priorities for 2024-2025; the aforementioned staff flu vaccination programme, consistent recording of NEWS2 score, escalation time and response time for critical care admissions and the reduction in reported *significant harm related to insulin errors* for inpatients.

The Trust states that to improve patient experience they will, further develop the Trust framework to involve Trust employed Patient Safety Partners (PSPs) in the work of the Patient Safety Incident Response Framework (PSIRF), and will do this by carrying out consistent assessment and documentation of pressure ulcer risks for adult in patients (excluding maternity) supported by the National Wound Care Strategy, and also for the pressure ulcer risks for adult in patients (excluding

maternity) as supported by the National Wound Care Strategy, and that you will be responsive to feedback from patients and service users, to support improvements in patient experience. There are no metrics attached but we would expect to see appropriate measurements that show how patient experience will be improved.

We note you will improve clinical outcomes for patients presenting at ED with mechanical lower back pain through re-designed pathway of care, achieve 75%, or greater, of patients receiving definitive cancer diagnosis following urgent referral within 28 days, and support patients to drink, eat and mobilise after surgery – by continuing the regional pilot programme. Healthwatch Central Bedfordshire will be looking to see the positive on-going results.

We also note the Action Plan for Data Quality Improvement, a Trust-wide data quality strategy, that works alongside the Information and Digital Strategies, to allow to adapt and increase the number of indicators available within the Trusts data quality dashboards, ensuring that data is clear and accessible to all that require this to improve and assure the quality of Bedfordshire Hospital Trust's patient data.

Within the QA the Trust has listed the intended improvements. In 2024/5 you will continue to '*Learn from Deaths'* with work continuing to ensure mortality governance is embedded within CSLs, and also that the impact of learning from deaths and resultant quality improvements are captured and shared.

In addition, you refer to 'Learning Lessons' from the Thirlwall Inquiry recognising the value of a positive speaking up and listening culture within the organisation as fundamental to ensuring both patients and staff are safe, identifying barriers to Speaking Up. Healthwatch Central Bedfordshire see this as critical to best practice.

Also, in assisting staff, we note the work you are doing re flexible working in the Trust, and the linked enrolment onto the NHS People Promise pilot programme with a 'People Promise Manager' recruited, ensuring the Trust's efforts in improving staff experience, and subsequently retention, are coordinated effectively in partnership with the wider Integrated Care System (ICS).

The Staff Survey – shows (in comparison to last year) the most improved areas are:

- Disability: the organisation made reasonable adjustment(s) to enable me to carry out work
- Enough staff at the organisation to do my job properly
- Satisfied with extent the organisation values my work
- Organisation is committed to helping balance work and home life
- Satisfied with level of pay

Plus you continue to look at flexible working arrangements and work life balance: We note the NHS People Promise pilot programme with a People Promise Manager working alongside HR and OD teams, improving staff experience, and subsequently retention. This we agree should ensure staff engagement/experience interventions and initiatives are embedded successfully.

We were aware of a number of significant building changes across both sites for example the new Clinical Buildings in Luton providing facilities for Maternity, Neonatal, Theatres and Critical Care, that should open next year. And note the new Energy Centre at the Luton site, which is now more environmentally friendly, and progressing the Hospital's road map to Net Zero Carbon with more efficient and resilient heat and power to the estate.

Other upgrades on the Luton site have delivered an expanded and refurbished ED with increased capacity; a fully segregated Paediatric ED; a CT scanner located within the department; and a re-modelled main entrance. We note that there are other new facilities awaiting finalisation.

We are aware of the 2023 master plan for both Bedford and the L&D Hospital site which brings together capital planning requirements, and creates an aspirational view of how the Trust envisions and needs the sites to be developed over the next 20 years to provide modern healthcare facilities, and to support the enablement of the Trust's Clinical Strategy. We appreciate that it is a long-term strategy and features such things as the Bedford Hospital Maternity Triage providing acute emergency obstetric care to women.

There is much to be said with regard to the information supplied, the data and the statistics but when looking at 'quality' there are some aspects that the Trust might want to refer to in future. Things that impact on how the public view the Trust outside of a treatment room, ward or consultation area but are still part of the patient (and carer/chaperone) experience. For example – across both sites are there safe comfortable waiting areas? What do patients feel about the car parking arrangements and transportation to the hospital (if they haven't driven there)? Is this something that impacts on the patient experience – or indeed staff's workplace experiences too?

Within the report there is no obvious mention of what might be a significant draw on resources at A&E/ED departments, that of mental health cases. We are acutely aware of the challenges that some cases might present and would like to know more about how such instances impact on service delivery. For example, what is the relationship with Mental Health Services like? On a similar theme, linked to patient safety, are there records on the impact on drunkenness and unruly behaviour within such departments as A&E, and how frequently might the police be called to deal with any incidents, plus the knock-on effect on other patients waiting and the Trust's staffs 'time', safety and welfare.

Please find below specific questions raised as a result of our review:

Questions to the TRUST:

PROMS

Primary hip replacement (EQ-5D)	2017/18	0.43	0.46	0.55	0.36
	2018/19	0.45	0.46	0.52	0.41
	2019/20	0.37	0.45	0.54	0.37
	2020/21	0.39	0.47	0.57	0.39
	2021/22 - updated since 22/23 Quality Accounts published	**0.412**	**0.462**	**0.534**	**0.373**

1. Can you please tell us what these figures mean / represent?
2. What are they a measurement of – is higher better or worse?
3. We feel a narrative is needed here – P97 refers.

	Reporting period	BHFT Score	National Average	Best performing Trust
% staff who would recommend the Trust as a provider of care to family and friends	2020/21	70%	74%	92%
	2021/22	64.9%	66.9%	89.5%
	2022/23	60.2%	61.9%	86.4%
	2023/24	62.02%	63.32%	88.82%

1. P98 – 'The Family & Friends Test', we agree this is consistent with national averages, but feel it is well short of 'Best'. Also, we can see that work is on-going in this area, as can be seen on P79 – but when will this figure improve?

	Reporting period	BHFT score	National Average	Worst performing Trust	Best performing Trust
Total number (n) and rate (r) of patient safety incidents (per 1000 bed days)	Apr 18 – Sept 18	n=3512 r=30.92	44.5	13.1	107.4
	Oct 18 - Mar 19	n= 3841 r= 33.17	46.1	16.9	95.9
	Apr 19 - Sept 19	n=5019 r=43.24	49.8	26.3	103.8

1. Can you confirm if these figures are correct and that 'higher rate is better?'
2. What is LFPSE (P101)? It does not appear in the glossary
3. Last pages re national targets CDIF = i.e. not good. We feel this should be explained or elaborated on.

Trust response to Healthwatch Central Bedfordshire specific questions:

Pressure ulcer metrics not included
The data is collected monthly and reported to Trust Quality Committee.

Will Friends and Family Test results improve?
This is very difficult to predict however work is continuous with the clinical teams to understand responses, the sentiments shared and this is triangulated with other sources such as complaints/compliments.

Patient Safety Incidents

- Figures are correct.
- Higher rate is better. It is recognised by Patient Safety Specialists and NHS Trusts, that a positive indicator of a mature patient safety culture, is one where high reporting rates are welcomed, indicative of an open and transparent learning culture.
- LFPSE has been added to the glossary.
- LFPSE is an acronym for 'Learn From Patient Safety Events.' It is a national portal managed by the national NHS Safety Team to enable their access to the majority of incidents which NHS trusts report. The collective data is shared back across trusts through mechanisms such as National Patient Safety Alerts, or learning initiatives.

PROMS

Statistics » Patient Reported Outcome Measures (PROMs) (england.nhs.uk)

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

The two procedures are: hip replacements and knee replacements.

An additional comment was raised by Healthwatch Central Bedfordshire regarding inclusion into the Quality Accounts of 'trip advisor' type feedback.
This comment is noted, and the Complaints, PALS and Compliments feedback, together with Friends and Family feedback, help our understanding of the wider parameters of quality – some of which are included in this document.