Bedfordshire Hospitals
NHS Foundation Trust

# QUALITY ACCOUNT

for the period April 2022
to March 2023

# Quality Account 2022/23

# 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 2022/23 is included in this account alongside our priorities and goals for quality improvement in 2023/24 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 2022/23 against the priorities that we set for patient safety, clinical effectiveness and patient experience.
- Our quality priorities and goals for 2023/24 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 1133 overnight inpatient beds 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 175,000 (including day cases) admitted patients, over 720,000 outpatients and over 250,000 Emergency Department attendees (includes Urgent GP led services) and we delivered over 7,800 babies.

All inpatient services and most outpatient services are provided on the Luton and Dunstable Hospital and Bedford Hospital sites. The Trust provides community muscular-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 getting 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 and limited a lot. 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)
- 74% 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.

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.

| Division | Specialties | |
|---|---|---|
| Medicine | Emergency Department<br>Acute Medicine<br>Ambulatory Care<br>Elderly Medicine<br>Limb Fitting<br>Stroke Service<br>General Medicine<br>Respiratory Medicine<br>Diabetes and Endocrinology<br>Gastroenterology | Cardiology<br>Dermatology<br>Heptology<br>Neurology<br>Neurophysiology<br>Orthotics<br>Genito Urinary Medicine<br>Rheumatology<br>Obesity |
| Surgery | General Surgery<br>- Colorectal<br>- Upper Gastrointestinal<br>- Vascular<br>- Bariatric Surgery<br>Urology<br>Paediatric Surgery<br>Trauma & Orthopaedic<br>Hospital at home<br>Critical Care | Plastic Surgery<br>ENT<br>Cancer Services<br>Medical Oncology<br>Ophthalmology<br>Oral & Maxillofacial Surgery<br>Anaesthetics<br>Pain Management<br>Orthodontics<br>Audiology |
| Women and Children's | Obstetrics<br>Community Midwifery<br>Early Pregnancy<br>General Gynaecology<br>Gynae-oncology | Paediatrics<br>Fertility<br>Neonatal Intensive Care Unit<br>Uro-gynaecology<br>Ambulatory Gynaecology |
| Diagnostics, Therapeutics & Outpatients | Pathology Services<br>- Blood Sciences<br>- Cellular Pathology<br>- Microbiology<br>- Phlebotomy<br>Haematology Care<br>Pharmacy<br>Physiotherapy and Occupational Therapy | Imaging<br>Musculoskeletal Services<br>Dietetics<br>Speech & Language Therapy<br>Clinical Psychology<br>Outpatients<br>Breast Screening |

During 2023/23 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.

For detailed information on related parties see note 27 to the accounts.

# Statement on Quality from the Chief Executive



I am once again delighted to introduce the Quality Account for Bedfordshire Hospitals NHS Foundation Trust in what was a year of continued operational challenge in the aftermath of the Covid pandemic.

Despite these challenges our priority is to ensure the provision of high quality, safe care for all patients, and to learn from our mistakes if we fall short of these standards. We are committed to driving improvement and a culture of excellence throughout the organisation and our staff have worked tirelessly in their efforts to provide high quality services.

Throughout the last year we have maintained momentum in integrating clinical services where there is a tangible benefit for our patients which is helping to drive up quality and efficiency that support our recovery efforts.

As a merged Trust we underwent a Care Quality Commission (CQC) Inspection in July and September 2022. As part of their inspection the CQC inspected Urgent and Emergency Care, Medical care (including older people's care) and Maternity services at both of our hospital sites. In addition the CQC also undertook a Well - Led review.

I was delighted when the Trust received an overall rating of good for both the service and well led inspections. I was particularly proud of the staff in our Maternity services at Bedford hospital where we had previously been rated as Inadequate, they have worked extremely hard continuing with improvement activities already on going and this has resulted in an improved rating to Requires Improvement. We remain committed to ensuring this improvement continues going forward.

Within this account you will note some of the activities both in place and planned to support our staff. In developing these we have listened carefully to feedback and particularly reviewed the information from the staff survey. These remain a high priority for me and the Trust Board as ensuring the health, wellness and safety of our workforce will lead to improved safety and experience for our patients.

Finally, I would like to express my gratitude and thanks to everyone who has supported our work during the past 12 months, including our staff, patients, carers, volunteers, our Charities and our local NHS and social care partners.

I hope that this Quality Account will give you more information about the areas where we are performing well, as well as those where there is still room for improvement, and that you enjoy reading it.

**David Carter**
Chief Executive Officer

# Corporate Objectives 2022/23

The Trust's Strategy underpinned by Corporate Objectives and supported by principles so that each objective will have:

- A work plan and deliverables
- Oversight through the current governance
- Ensure 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**

| Objective 2023/24 | Overview | Strategic Priority | Delivery Work stream |
|---|---|---|---|
| 1. **Support a sustainable workforce through the development of a long term workforce plan** | The plan will take account of health and wellbeing, culture post-merger and integration, education and training and engaging with the workforce of the future through work experience and the Health Care Academy. This will also further embed the Trust values THRIVE throughout the Trust. | Workforce and Culture | Workforce / Attractiveness |
| 2. **Develop the integration plan through the Integrated Care Board and Bedfordshire Care Alliance** | This development will focus on the primary care, community, 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 |
| 3. **Develop the Clinical Strategy aligned to Service Line Strategies** | This will take the Service Line Strategies developed and in development to define a structured clinical strategy that will inform transformation projects and support all of the other work streams and deliver further improved care for patients. | Our portfolio of hospital services | Directions Programme |
| 4. **Embed the approved commercial opportunity proposition** | The focus will be on private patients, propositions for ICB back office functions and developing staff ideas to support development and transformation. | Our portfolio of hospital services | Commercial |
| 5. **Develop the site control plan phase 1 for Bedford and phase 2 for L&D and deliver the current projects** | Following the appointment of master planners, this will focus on developing the site control plans for both sites. 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. | Infrastructure | One Health Estate |
| 6. **Define and execute a digital agenda that provides solutions to enable services to modernise, connect, and transform aligned with the Trusts priorities.** | Digital underpins all elements of the Trusts objectives. The aim is to deliver the Digital Strategy, so we benefit from improved resilience, greater levels of digital maturity, and integration. on resilience and business continuity and implementing the Digital Strategy. | Infrastructure | Digital |

| Objective 2023/24 | Overview | Strategic Priority | Delivery Work stream |
|---|---|---|---|
| 7. **Meet the quality and operational performance targets** | This will focus on the targets and priorities outlined in the National Operational Plan and the Trust Quality Priorities 2023/24. 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, CQUOB, Quality Committee |
| 8. **Achieve financial targets** | 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, FIP |
| 9. **Develop our role as an anchor institution** | 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. | Wider determinants of health | Health and Wellbeing Boards. Workforce Committee |
| 10. **Develop a research strategy** | This will develop the plan for the Trust and consider research and development as an enabler towards workforce attractiveness, training and education and a commercial proposition to set out the parameters of the Trust's ambition in relation to research that will in turn develop its approach. This will encompass current links to the universities and future opportunities. | Our portfolio of hospital services | Task and Finish Group |

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

# Achievements in quality improvement priorities 2022/23

## Priority 1: Deliver Excellent Clinical Outcomes

### 1.1 Cirrhosis and Fibrosis Testing for alcohol dependant patients

#### Why was this a priority?

NICE Guidance recommends that people who are alcohol dependent should receive a test for fibrosis and cirrhosis. In order to help your doctor to understand how much scarring (fibrosis) is in your liver and plan your treatment a Fibroscan is needed. This is a type of ultrasound to measure scarring in your liver.

A UK early diagnosis study found that 39% of cirrhosis patients were abstinent at 30-day follow up, and had a 72% long-term survival compared with 44% for those drinking at 30 days.

This quality priority, based on a national CQUIN, will increase the number of early liver disease diagnoses. This will support changing patient behaviour, provision for effective treatment, better prospects of recovery and improved outcomes for patients.

#### What did we do?

- A cross-site working group was established who met to undertake a review of the requirements and the current pathway at each site.
- Differences in practices were identified due to varying digital systems for referrals.
- The referral process for a Fibroscan is now available via the electronic requesting system for both hospitals.
- A trust wide campaign to increase awareness of requesting Fibroscans via ICE was undertaken at both sites incorporating teaching session aimed at the medical teams.
- At the beginning of the year there was one Fibroscan technician covering both sites and a significant delay in appointments at Luton. We have recruited an additional technician so there is one technician assigned to each site. There has been a subsequent reduction in waiting times for Fibroscan at Luton.

#### How did we perform?

We made some early progress in terms of identifying key areas for improvements, which included ensuring a streamlined referral and requesting pathway for Fibroscans. Implementation for this took longer than anticipated due to varying functionalities of the clinical systems in use and alignment of these.

Despite making some progress, compliance remains poor and we continue to experience challenges with varying levels of referrals from primary and secondary care. The relevant clinical service lines will continue to encourage uptake of referrals amongst clinical teams across the trust.

### 1.2 Treatment of community acquired pneumonia in line with British Thoracic Society (BTS) Care Bundle

#### Why was this a priority?

This key priority supports the CQUIN for adult patients with confirmed community acquired pneumonia (CAP) to be managed in accordance with the British Thoracic Society (BTS) CAP Care Bundle.

The requirements include:

- chest x-ray within 4 hours of admission,
- severity scoring of CAP based on the nationally recognised CURB-65 score
- appropriate antibiotics prescribed in line with national and local guidance
- receive the first dose of antibiotics within 4 hours of admission

#### What did we do?

- A cross-site working group was established who met to undertake a review of the requirements and the current processes on both sites.
- Differences in practices were identified due to varying digital systems and documentation for prompts within clerking and post-take ward rounds.
- A CAP care bundle was devised with the working group and trialled in selected clinical areas with varying degrees of success.
- Stickers were introduced at the Luton and Dunstable Hospital site to prompt clinicians to undertake the CURB-65 score at the post take ward round.
- At Bedford Hospital the post-take ward round documentation was reviewed to incorporate a prompt for the CURB-65 score.
- One of the lead respiratory consultants provided teaching sessions with relevant clinical teams.

#### How did we perform?

Our baseline audit demonstrated key areas for improvement around the documentation of the CURB-65 score. The working group recommended the introduction of a CAP care bundle to support the documentation within key admissions areas, including the Emergency Department and Acute Admissions Areas.

The Luton and Dunstable Hospital instigated a sticker as an

additional prompt to support documentation of the CURB-65 score at post-take ward rounds.

Our percentage compliance is 46%, which just meets the required threshold for conformance.

## 1.3 Elective care recovery

### Why was this a priority?

The impact of the pandemic continues to be most obviously seen in both the size of the Trust's waiting lists and how long patients continue to have to wait for relatively routine treatment.

Recognising that clinical outcomes and experience for patients are improved by minimising long waits for elective care, the Trust adopted the national targets of ensuring no-one was waiting longer than 2 years (104 weeks) for their treatment by July 2022, and then eliminating 78 week waits by April 2023.

### What did we do?

- Building on the hard work of 2021/22, the Clinical Service Line (CSL) teams sought to return to the same levels of productivity that existed pre-pandemic and creating sufficient capacity to be able to meet demand where productivity improvements proved difficult.
- They were supported in these endeavours by the Patient Access team who were responsible for making sure that the list of patients waiting was up-to-date and accurate, and assisted when processes and pathways were more complicated.
- Weekly reporting and PTL (Patient Tracking List) meetings were used to provide teams with oversight of progress and actions at a specialty and patient level.
- Patients were prioritised in terms of clinical need and processes were put in place in ensure that the most urgent requirements were met in as timely a manner as possible.
- Where appropriate, non-face-to-face (telephone or virtual) clinics slots continue to be utilised to help improve efficiency.
- Diagnostic pathways were provided the same level of oversight to ensure patients did not have to wait longer than necessary for a treatment decision.
- At the same time the Trust continued to work on delivering timely cancer care and treatment in line with the national targets.

### How did we perform?

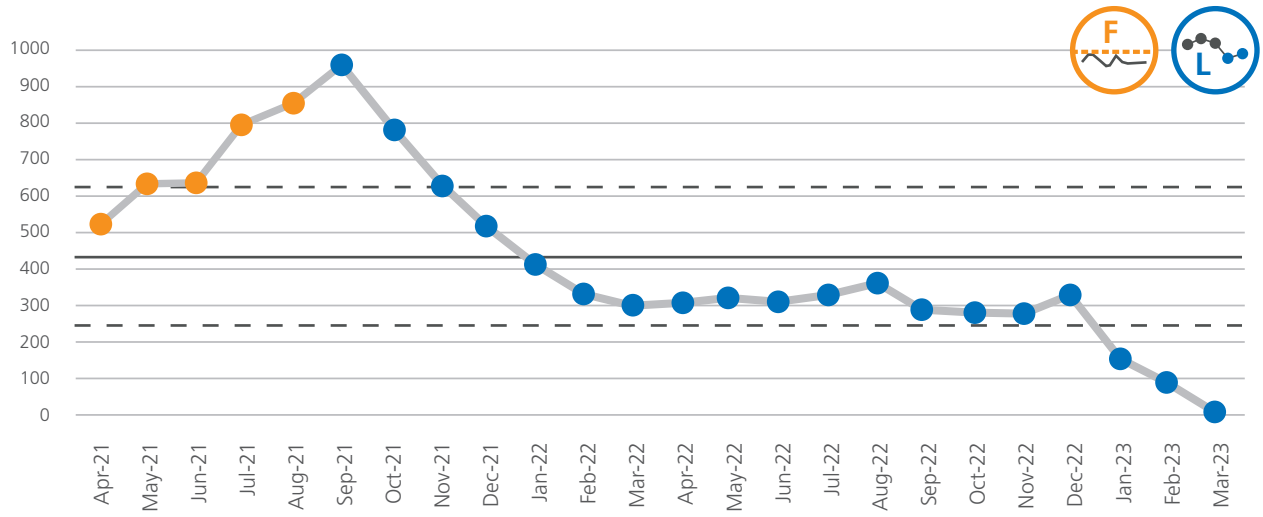
The Trust maintained a zero 104 week wait position from July 2022.

As at the end of March 2023, just 6 patients were on an open pathway over 78 weeks. All 6 patients had recognised reasons for this being the case. This reflected an incredible effort from both clinical and administrative teams to effectively manage a substantial number of treatment pathways during the course of the year.

The chart below shows just what a significant achievement this was, and highlights the step change that was brought about in the final quarter of the year.

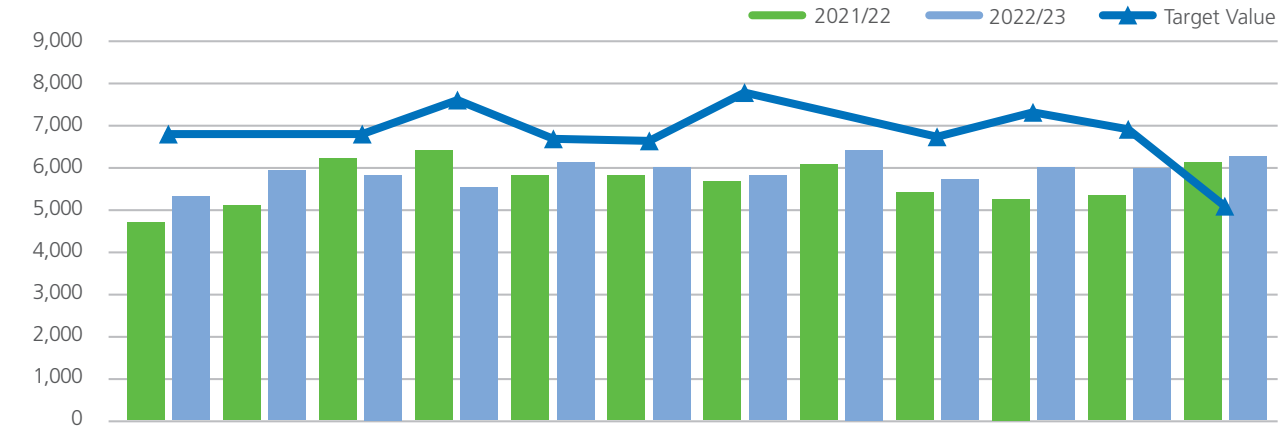
Maintaining this level of performance, and improving on it to make sure no-one is waiting beyond 65 weeks for treatment by April 2024, will require a sustained and concerted focus by Trust staff and colleagues within the wider health and care system.

**RTT Incomplete pathways: Zero tolerance for waits over 78 weeks by Apr 2023**



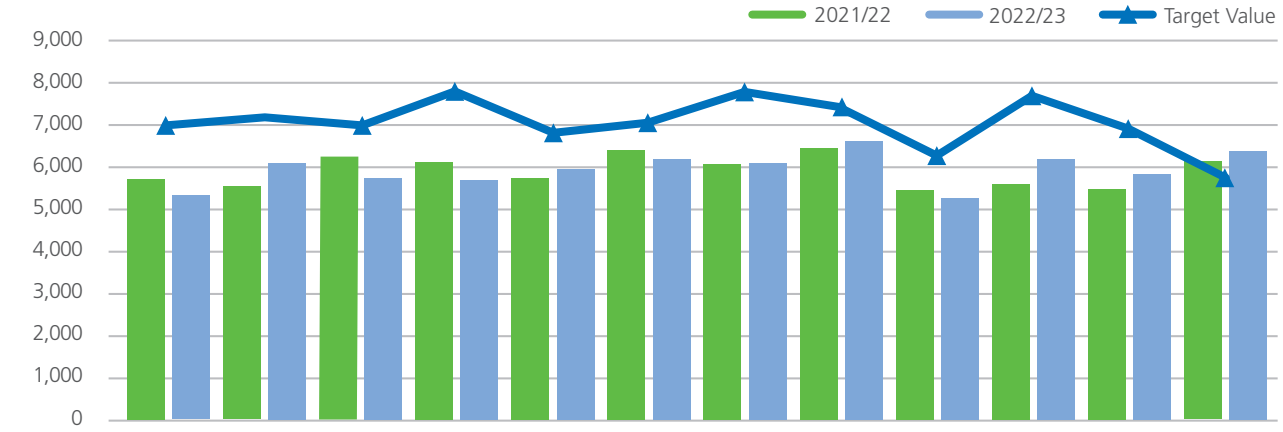
As described above, this was achieved by the CSLs working towards 2019/20 levels of activity across the elective points of delivery (PoD):

### Elective & Day Cases - Bedfordshire Hospitals - All Specialties




| | Apr | May | Jun | Jui | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021/22 | 4,714 | 5,155 | 6,268 | 6,471 | 5,844 | 5,870 | 5.752 | 6,109 | 5,508 | 5,317 | 5,423 | 6,232 |
| 2022/23 | 5,435 | 6,008 | 5,890 | 5,617 | 6,230 | 6,044 | 5,902 | 6,445 | 5,820 | 6,085 | 6,061 | 6,314 |
| Target Value | 6,849 | 6,937 | 6,887 | 7,663 | 6,796 | 6,662 | 7,847 | 7,277 | 6,822 | 7,372 | 6,981 | 5,168 |

### All OP Attendances - Bedfordshire Hospitals - All Specialties

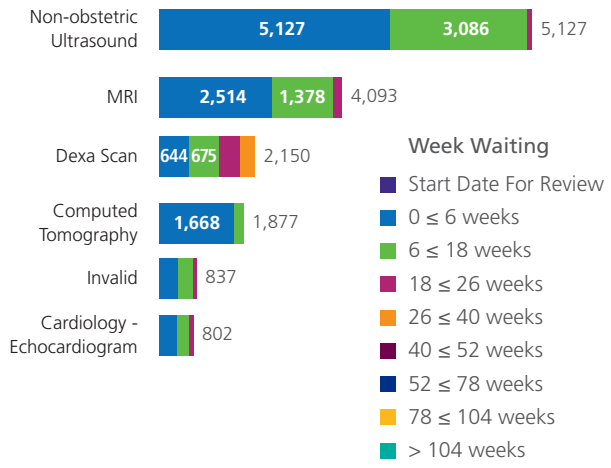



| | Apr | May | Jun | Jui | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021/22 | 57,831 | 56,177 | 63,466 | 61,717 | 57,555 | 64,346 | 61,076 | 65,100 | 54,983 | 56,704 | 55,248 | 61,820 |
| 2022/23 | 53,638 | 61,413 | 57,834 | 56,975 | 59,888 | 62,797 | 62,109 | 67,371 | 53,109 | 62,726 | 59,074 | 64,249 |
| Target Value | 69,656 | 72,274 | 69,623 | 78,090 | 67,911 | 70,896 | 78,209 | 74,326 | 63,560 | 76,929 | 69,007 | 58,232 |

In order to maintain and improve on overall elective waiting times, all elements of a patient's pathway must be working effectively, including diagnostics. The chart below describes the current number of open diagnostic pathways by modality, and by weeks waiting.

Pre-pandemic 100% of diagnostics were being delivered, in line with the national target, within 6 weeks of request; only 66% of requests were within this time-frame at the end of 2022/23.

**Total Pathways by Diagnostic Modality and Weeks Waiting**




## What is the conclusion?

For Bedfordshire Hospitals achieving the key target of zero patients waiting over 78 weeks for their treatment by the end of March 2023 was incredibly important. It was a huge testament to the dedication of the staff that we came so close, and were undoubtedly one of the best performers in the region on this metric.

There remains plenty of scope for further improvement – there is a long way to go before productivity levels are back to or better than 2019/20, and without this transformation, delivering zero 65 week waiting patients will be incredibly challenging. The system will need to build resilience into services that delivers resilient capacity for routine care whilst enabling treatment of patients with highest clinical priority. All parts of the patient pathway need to be working together so that patient experience is not hampered by a gap in diagnostic resource when theatres and outpatient clinics are fully functioning.

This remains a Quality Priority for 2023/24.

## Learning from Serious Incidents

The Trust continues to review all incidents to determine the level of investigation to ensure immediate learning is actioned appropriately and shared learning across both sites where appropriate. The Trust continues to declare those incidents that require a more in depth investigation and we are beginning to incorporate the Patient Safety Incident Response Framework (PSIRF) investigation framework and its tools. This is replacing the previous Serious Incident (SI) framework and will be in place nationally, by the end of September 2023. The Trust continues to work on ensuring actions from incidents are closed in a timely manner and duty of candour compliance monitored in line with statutory requirements.

# Priority 2: Improve Patient Safety

## 2.1 Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.

### Why was this a priority?

The NEWS2 protocol is the RCP and NHS endorsed best practice for spotting the signs of deterioration, including patients with sepsis. This supports prompt interventions and improves patient outcomes, the importance of which has been emphasised during the pandemic.

This key priority focuses on the identification and recording of deterioration, enabling swifter response. Deterioration is linked to 90% of NHS bed days, and data suggests as many as 20,000 deaths in hospital each year could be preventable. By focusing on ensuring appropriate escalation and response time this should support a reduction in the need for higher levels of care, by avoiding ITU admissions and reducing length of stay. These are key indicators in the NHS recovery efforts post pandemic.

This key priority supports the National CQUIN to achieve 60% of all unplanned critical care admissions from non-critical care wards of patients age 18 + having a NEWS2 score, time of escalation and time of clinical response recorded.

### What did we do?

- Established a working group with key stakeholders, including staff from critical care outreach teams to review current working practice to form a baseline.
- Audits were undertaken to measure performance against the key indicators for documentation of NEWS2 score, escalation and response time.
- As part of the Trust's ongoing digitalisation project, the documented clinical review undertaken by the outreach team has been embedded within NerveCentre at the Luton and Dunstable Hospital. This has supported timely documentation of escalation and response times, as well as management of care. The Bedford Hospital continue to record on paper

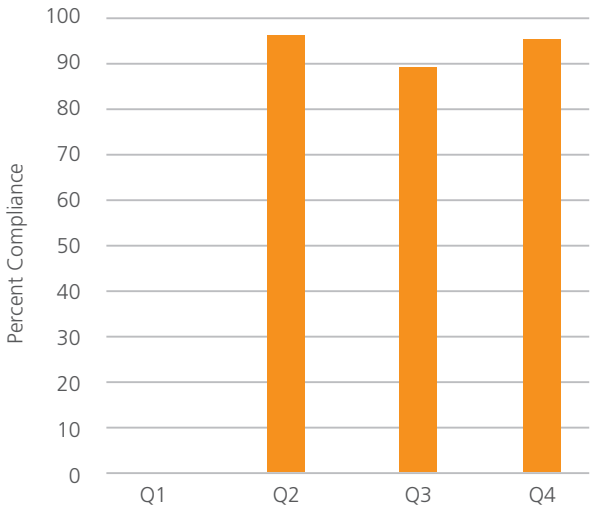
### How did we perform?

A standardised Trust wide escalation protocol for adults aged above 16 years in line with the Royal College of Physicians guidance is in place. This protocol includes the minimum recommended frequency of observations, whilst highlighting the need to perform more frequent observations if there is a concern about a patient's condition. It also incorporates recommended escalation and response time in line with a patients NEWS2 score.

This escalation protocol has been embedded within NerveCentre, our electronic observation system at the Luton and Dunstable Hospital. The protocol is in use at Bedford Hospital on paper charts. NerveCentre is due to be implemented at Bedford Hospital in 2023 standardising the process of recording, monitoring and escalation of observations across the Trust.

We are delighted to have exceeded the required target, achieving a trust compliance to date of 94% and above.

**NEWS2 Percent compliance**




The monitoring of escalation and response time, appropriateness of responder in line with RCP guidance and a documented management plan will remain a key priority for the coming year.

## 2.2 Patient Safety Strategy implementation

### Why was this a priority?

In August 2022, following significant engagement with early adopter sites, NHS England/Improvement published the Patient Safety Incident Response Framework (PSIRF) which replaces the Serious Incident Framework. As well as being a mandatory contractual requirement, the move to PSIRF enables better use of resources, preventing the waste of carrying out multiple investigations of very similar incidents and focusing instead on learning and Quality Improvement. PSIRF promotes meaningful involvement with patients, families and carers and consistent and fair evaluation of staff involved in patient safety incidents.

## What did we do?

- Appropriate governance structures have been established to oversee the implementation of PSIRF.
- Introduced and implemented a risk management and reporting system which is integrated across sites IN October 2022 which also met the requirement to upload all incidents to the NEW national data base called Learning From Patient Safety Events (LFPSE).
- Recruitment of Patient Safety Partners was approved and has commenced.
- Training is being rolled out to Patient Safety Incident Response Leads and Engagement Leads in line with PSIRF Standards
- Stakeholder mapping to enable full engagement of all those impacted
- Gathering and analysis of data relating to incidents, claims, PALs and Staff Survey results to inform Patient Safety Incident Response Plan
- Ongoing delivery against PSIRF Programme Plan

## How did we perform?

We are monitoring and demonstrating progress against a comprehensive PSIRF Programme Plan. A vacancy in Project Management support has led to a delay in some preparatory activities but resource has now been appointed and recovery actions are underway.

### Patient Safety Syllabus

The national patient safety syllabus provides a consistent approach to ensuring that staff across the NHS are trained to an appropriate competency level for their role.

Within the Trust we have implemented the "Essentials for patient safety". Topics within the module include:

- Listening to patients and raising concerns
- The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work
- Avoiding inappropriate blame when things don't go well
- Creating a just culture that prioritises safety and is open to learning about risk and safety

Level two, "Access to practice" is intended for those who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training.

This comprises of two sessions. The first introduces systems thinking (how the way we work can be used to reduce error and improve safety) and risk expertise (how we can identify and manage risk to keep patients safe).
The second session looks at human factors (the science of work and of working together in safely designed systems) and safety culture (the significance of a true learning culture, free of inappropriate blame).

There has been a good response to this training from staff (number of staff to be entered) and we continue to promote the training with the decision to make level one mandatory to all staff and level two to those involved in patient safety investigations. The national patient safety team at NHSE/I are considering making these mandatory in all healthcare organisations.

### Patient Safety Partners

The Framework for involving patients in patient safety was announced as a key priority within the national Patient Safety Strategy.

The document provides guidance on how the Trust can involve people in their own safety as well as improving patient safety in partnership with staff: maximising the things that go right and minimising the things that go wrong. Where patients, carers and other lay people become involved in improving and leading organisational patient safety, they are referred to as 'Patient Safety Partners' (PSPs).

Within the Trust we have been preparing for the appointment of PSPs and this has included presentations to the Trust Board by the Patient Safety Specialist and work to consider what the role description may contain and how PSPs will be supported in their role.

It is anticipated that recruitment for PSPs will be undertaken throughout December-March 2022/23.

### Patient Safety Incident Response Framework (PSIRF)

PSIRF replaces the Serious Incident Framework and advocates a less prescriptive and more proportionate response to patient safety incidents which are focused on learning and improvement.

The four main aims of PSIRF are as follows:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

In order to meet our contractual requirements for PSIRF, the Trust is developing a Patient Safety Incident Response Policy which outlines our approach to responding to and learning from Patient Safety Incidents.

The current approach is being reviewed from the perspective of those involved to identify areas that need to be changed to ensure they are aligned with the Patient Safety Incident Response Standards. Once completed, we will work collaboratively to design processes that enable meaningful engagement with those affected by incidents, focus on understanding what happened rather than who was to blame and identify learning and improvements that can be made.

Patient Safety Incident Response Standards stipulate minimum training requirements for those involved in oversight, engagement and response to Patient Safety Incidents. In order to equip our staff to respond differently to Patient Safety Incidents, we have sourced training in Patient Safety Incident Investigation and Meaningful Engagement in line with the national framework. This training is being delivered throughout Spring 2023. A gap analysis has been undertaken to identify areas where further training may be required.

We are on track to publish our Patient Safety Incident Response Plan by the deadline of Autumn 2023. The plan will be informed by our review of data from multiple sources to define our patient safety incident profile and improvement priorities.

## 2.3 Staff Flu Vaccination Programme

**Quality Priority:** Staff flu vaccination programme
To ensure at least 70% of our frontline healthcare workers with patient contact is provided with the flu vaccination by February 2023.

### Why was this a priority?

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; 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 outcomes and increased staff absence.

Vaccination helps to reduce transmission of flu among staff and patients helping to keep NHS services running and reducing the burden on the NHS during the winter.

It is recommended that health care workers with patient contact are vaccinated annually to protect themselves, their families and patients from getting the flu and is supported by best practice guidance (NICE, NG103).

### What did we do?

- The Trust's occupational health teams led on this key priority, alongside other key stakeholders including human resources, infection control, and the communications team.
- Senior nursing and allied health professional staff as well as our Medical Directors supported the flu campaign and actively participated in the working group.
- A trust-wide communications campaign was put in place to actively encourage our staff to have the flu vaccine and was promoted during various Trust wide events including; the Annual Christmas Staff Engagement event, monthly staff briefings as well as via emails, posters and leaflets.
- Vaccination hubs were set up at each hospital site. Opening times, how to book an appointment using the online system and available appointments were promoted in regular communications as well as details of a drop in service. Vaccinators also visited clinical areas and departments a number of times each week.
- Staff were encouraged to let us know if they had the vaccine elsewhere and share reasons if they chose to abstain.
- Team BEDSFT (the Bedfordshire Hospitals App) launched in the summer of 2022, incorporated a designated section devoted to the flu vaccine including why staff should be encouraged to have the flu vaccine, available appointments etc.

### How did we perform?

Uptake for the flu vaccine remained poor compared to previous years with many staff not booking appointments despite many slots still being available for vaccinations. 50.8% of frontline healthcare workers with patient contact received the flu vaccination. Vaccine 'fatigue' is thought to be a contributing factor for the low uptake on the flu vaccination as booster doses for coronavirus (COVID-19) were also being offered at this time.

There have been fairly low levels of influenza infection activity in the last 2 years because of COVID-19 control measures and reduced contact between people. As social contact and activity picks up it is expected that we will see a resurgence of flu, to levels similar to or higher than before the pandemic.

The uptake of flu vaccination remains important for the

health and well-being of both our staff and patients and is therefore continuing as a key priority for the coming year.

## Priority 3: Improve Patient Experience

### 3.1 Appropriate antibiotic prescribing for Urinary Tract Infection (UTI) in adults aged 16 years or over

#### Why was this a priority?

This quality priority was a CQUIN for 2022/3 with the aim of supporting evidence based improvement and its incorporation into normal clinical practice. National data for 2019 indicated there were over 175,000 admissions where a UTI was the primary diagnosis at a cost to the system of over £450m. A third of all UTI admissions have a length of stay more than 7 days. UTI is a leading cause of healthcare associated Gram-negative bloodstream infections. Improving the management of acute UTI in adults will reduce deterioration and associated length of stay, releasing bed capacity to support NHS recovery activity.

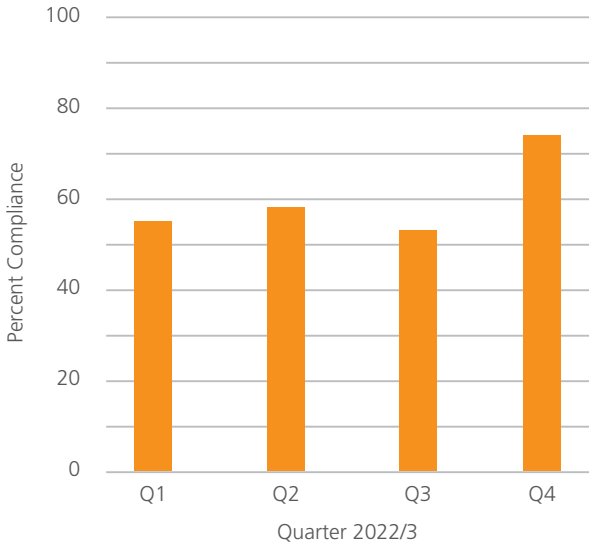
#### What did we do?

- We established a cross-site multidisciplinary working group who met to undertake a review of the requirements and current processes and any changes needed.
- We have established antimicrobial pharmacists at each site; their remit includes supporting clinical staff in the prescribing and ongoing management of patients requiring antimicrobial treatment.
- We reviewed the Trust Microguide and updated the information to align with the recently updated Trust Antimicrobial Guideline. The Trust Guideline incorporated information from the National Institute of Health and Clinical Excellence (NICE) and localised data on microbial resistance.
- We introduced a Trustwide UTI care bundle, which provides guidance on investigations and appropriate antibiotic use.
- We undertook training sessions on areas for improvement such as sending urine specimens for culture, and appropriate antibiotic management.
- The quality priority results and areas for improvement have been shared at the Trust medical teaching forum.
- Posters with the UTI care bundle and information on how to recognise and treat a UTI in line with best practice guidance are on display in clinical areas.

#### How did we perform?

We have audited the quality priority using a randomised sample of 100 patients per quarter. The criteria for compliance included; diagnosis based on signs and symptoms and confirmed by a mid-stream specimen of urine, and antibiotics prescribed in accordance with local/national guidance. Our compliance to date is between 53-74%, which is within the recommended compliance threshold. We have reviewed areas of non-compliance and carried out training within these areas.

**Appropriate antibiotic prescribing for Urinary Tract Infection (UTI) in adults aged 16 years or over Audit of compliance**




Although this is no longer a quality priority or CQUIN for next year the antimicrobial pharmacists will continue to work with clinical teams on supporting clinical staff in the prescribing and ongoing management of patients requiring antimicrobial treatment.

### 3.2 Anaemia screening and treatment for all patients undergoing major elective surgery

#### Why was this a priority?

This key priority was published as a CQUIN for 2022/3 with the aim of supporting evidence based improvement and its incorporation into normal clinical practice. The quality priority draws attention to the importance of screening and treatment of patients who are undergoing major surgery and who have iron deficiency anaemia in accordance with the National Institute of Health and Clinical Excellence (NICE) guidance.

Improved compliance should reduce blood transfusion rates for major surgeries, reducing the occurrence of patient safety risks associated with blood transfusion including fluid overload, infection and incorrect blood

transfusions. Overall, it is estimated that consistent uptake of screening to 60% would deliver savings of around £3m associated with units of blood saved due to lower transfusion rates, reduction in critical care stay, saved bed days and reduction in re-admissions.

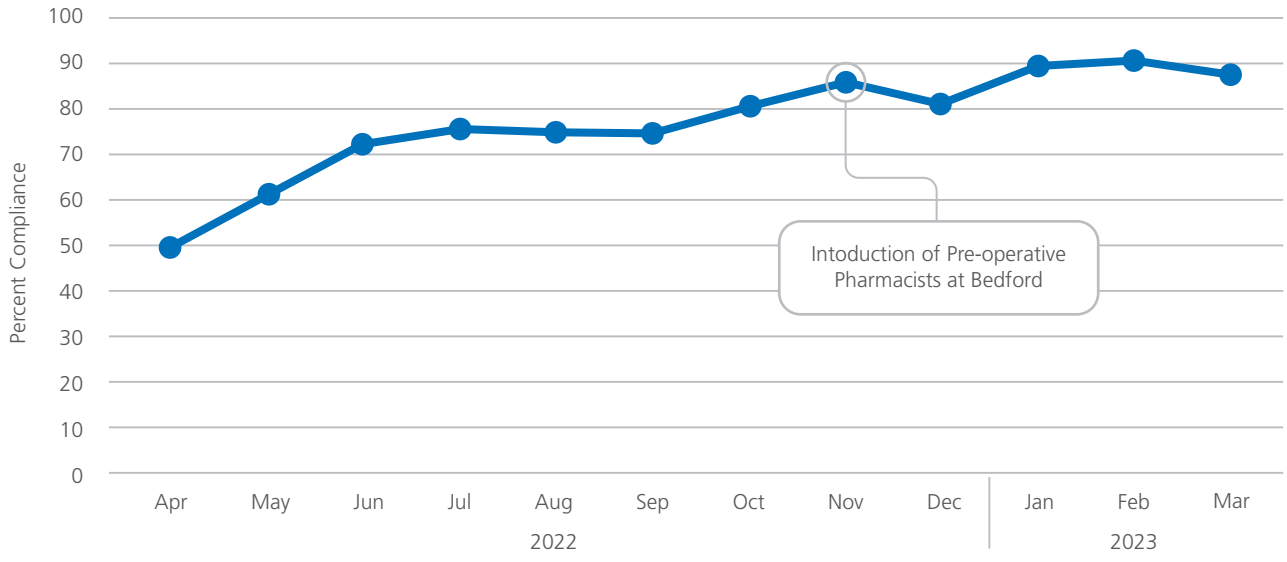
## What did we do?

- We established a cross-site multidisciplinary working group who met to undertake a review of the requirements, current processes and any changes needed.
- We have set up an algorithm on the laboratory systems to ensure all patients tested in pre-operative assessment who have an Hb of <130 g/L will trigger additional testing for ferritin, B12, folate, transferrin saturation and C-reactive protein (CRP) using the same sample.
- We have recruited a Pre-Operative Assessment Pharmacist at Bedford Hospital to mirror the existing Pre-Operative Assessment Pharmacist at Luton and Dunstable Hospital. The pharmacists are able to prescribe treatment for patients with pre-operative anaemia as part of their pre-operative assessment appointment.
- We have updated the Trustwide clinical guideline for the treatment of patients with pre-operative anaemia.
- We have reviewed the provision of intravenous iron replacement therapy at Luton and Dunstable Hospital. This is currently being provided within the newly expanded Day Treatment Unit.

## How did we perform?

We have audited compliance of the priority using a randomised sample of 100 patients per quarter. This has shown compliance between 50-90%. This data is for all elective patients requiring major surgery, including urgent (Priority 2) and 2 week waits. Results by month are shown in the graph below.

**Anaemia screening and treatment for all patients undergoing major elective surgery - compliance with CQUIN criteria**




In the majority of cases there were two main reasons identified for proceeding with surgery for patients who did not receive treatment for anaemia:

- Patients were on a 2-week wait (Priority 2) pathway where the delay imposed by therapy may have led to disease progression
- Patients not on a 2-week wait pathway where the bleeding risk was low, but the surgery deemed urgent in terms of disability / disease

In the above instances, the relevant clinical teams reviewed and agreed that it was in the patient's best interest to proceed with surgery.

The recruitment of a pre-operative pharmacist at Bedford and implementation of a standardised process for screening patients for anaemia prior to major elective surgery has enabled us to improve patient care by delivering timely and appropriate management.

## 3.3 Implementation of the Trust's People Plan

| **IMPROVING PATIENT EXPERIENCE:**<br>Quality Priority 8: Implementation of the Trust's People Plan<br>Key stakeholders: Fiona MacDonald | Period:<br>October 2022 – March 2023 |
|---|---|

**Objectives:**
There is a well-established link between staff wellbeing, team working and patient experience.

| **Aims:** | **Progress:** |
|---|---|
| The Trust will be working as part of the integrated care system to deliver a range of work streams around the following elements of the People Plan<br>Looking after our People<br>Belonging in the NHS<br>Growing for the future<br>New ways of working | Work-streams aligned to the 4 pillars of the People Plan and reflected in the format and agenda of the Workforce Committee.<br>**Looking after our people**<br>Clinical psychologists working with BLMK Keeping well hub, further MHFA training programmes, H+WB strategy staff feedback, FTSU month, take heART project continues to grow, cost of living support with safe spaces and package of measures launched, menopause policy launched, Flu and Covid vaccinations, winter engagement event with wellbeing and staff support focus, THRIVE inaction workshops<br>**Belonging in the NHS**<br>Staff networks – BAME sickle cell event, LGBTQ+ awareness week and Disability and Carers network promoted, WRES and WDES action plan agreed, values based recruitment trialling, new vales based appraisal paperwork and process in place, respectful resolution approach in development, international nursing and midwifery network, Reciprocal mentoring programme funding secured, accepted on cohort 3 of Rainbow Badge 2<br>**Growing for the future**<br>Successful international midwife recruitment, other registered roles pipelines continue, nursing and midwifery retention project, nursing workforce skill mix review and development, leading with values THRIVE masterclasses<br>**New ways of working**<br>Expansion of learning and development opportunities and options to access including e-learning and other platforms, working with BLMK system partners on shared challenges<br><br>Staff survey 2022 results published 9th March<br>Continued focus on increasing Appraisal and Mandatory Training compliance |
| **Areas of concerns/risks:** | **Moving forward: over next 6 months** |
| Staff health and wellbeing with sustained operational pressures and cost of living crisis<br><br>Recruitment and retention across all staff groups due to economic drivers and impact of pandemic on resilience and work life choices<br><br>Achieving Appraisal and Mandatory Training compliance | • Monitor uptake of cost of living support package<br>• WRES/WDES action plan delivery<br>• Reciprocal mentoring programme launch<br>• Further embedding values in recruitment and appraisal<br>• Respectful resolution implementation<br>• Response to 2022 Staff Survey results – in particular flexible working<br>• Continued international recruitment for Nursing, Midwives, AHP and Medical Staff<br>• Scope for Growth Talent management roll out trial<br>• Develop cultural dashboard metrics<br>• Grow Your Own opportunities in conjunction with BLMK strategy<br>• Explore alternative Apprenticeship route opportunities<br>• BLMK support with recruitment and retention initiatives<br>• Working with Education providers commissioning new roles<br>• Maximise e-Rostering opportunities |

| **IMPROVING PATIENT EXPERIENCE:**<br>Quality Priority 8: Implementation of the Trust's People Plan<br>Key stakeholders: Fiona MacDonald | Period:<br>October 2022 – March 2023 |
|---|---|

| **Areas of concerns/risks:** | **Moving forward: over next 6 months** |
|---|---|
| Impact of Industrial Action<br><br>Capacity to keep momentum with delivering initiatives | • Further expansion of eLearning and virtual training<br>• FTSU linking with internal networks including Quality and Clinical Governance, staff side to encourage confidence in raising concerns<br>• Continued focus on Appraisal and Mandatory Training compliance<br>• Rainbow badge assessment and accreditation<br>• EDS 2022 review<br>• Leadership pathways development |

| | | | |
|---|---|---|---|
| | Highly unlikely to achieve current milestones | RAG | |
| | Risks to success | | |
| | Expected to achieve (for CQUIN expected to achieve the milestones for the quarter being reported) | | |

# Quality Improvement Priorities 2023/24

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

The tables below present each of the priorities under these headings together with a rationale for their inclusion, how we will measure success and how we will oversee the progress we make throughout the year. Whilst we have identified priorities for 2023/24,
As we write this account the future still remains uncertain in respect to the global pandemic so we may seek to review and reprioritise as the year progresses.

## Quality Priorities For 2023-2024

| Corporate objective | Improve Patient Safety |
|---|---|
| Quality Priorities | 1. Staff flu vaccination programme<br>2. Recording of NEWS2 score, escalation time and response time for critical care admissions<br>3. Implementation of new Patient Safety Strategy. |
| Rationale | 1. Staff flu vaccinations 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 worse outcomes, and reducing staff absence and the risk for the overall running of safe services.<br>2. The NEWS2 protocol is the Royal College of Physicians and NHS-endorsed best practice for spotting the signs of deterioration, the importance of which has been emphasised during the pandemic. This quality priority will support adherence to evidence-based steps in the identification and recording of deterioration, enabling swifter 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 ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.<br>3. The National Patient Safety Strategy continues to be rolled out across England. There are a number of elements which need to be put in place over the next year, including:<br>• Enhance Just Culture, openness and learning from incidents<br>• Improve timeliness of learning from incidents<br>• Meet national compliance requirements for reporting systems |
| Measures of Success | 1. National Commissioning for Quality and Innovation (CQUINs) target: Achieving 80% uptake of flu vaccinations by frontline staff with patient contact. (This includes a broadened definition of front line staff to include all staff groups that may have contact with patients)<br>2. CQUINs target: Achieving 30% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a timely response to deterioration (T-1), with a NEWS2 score, escalation (TO) and clinical response times (T1) in line with RCP guidance documented in the clinical notes.<br>3. National Safety Strategy requirement: Attendance on 'Thrive into Action' sessions. Improvements to staff survey results which relate to staff feeling safe to raise concerns and confident that the organisation would take appropriate action to address concerns raised by staff, patient's/service users. (Q18 a-d, 19 a&b and Q23b, e & f.)<br>4. Implement Trust wide, the Patient Safety Incident Response Framework (PSIRF) within the year that meets the patient safety standards. As well as ensuring an organisational risk management / incident reporting system is compliant with the national Learning From Patient Safety Events (LFPSE) database. |
| Monitoring Committee | Clinical Quality Operational Board (CQUOB) and the Trust Board Quality Sub- Committee |

| Corporate objective | Improve Patient Experience |
|---|---|
| Quality Priorities | Supporting Patients to drink, eat and Mobilise (DrEaM) after surgery.<br>Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (DMS)<br>Supporting timely personalised Treatment Escalation Plan (TEP) conversations and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions |
| Rationale | 1. CQUINs target: To help prevent Blood Clots and respiratory complications. It supports the NHS's Enhanced Recovery Programme.<br><br>2. CQUINs target: NICE NG5 recommends that medicines-related communication systems should be in place when patients move from one care setting to another. This will support the compliance with the minimum quality requirements described in the NHS Discharge Medicines Service (DMS) Toolkit and will help reduce the number of readmissions and reduce Length of Stay (LOS)<br><br>3. Trust Quality Priority: British Medical Association (BMA), Resuscitation Council UK and the Royal College of Nursing (RCN) advocate decision making around patients care and treatment, including CPR at earliest opportunity. This requires the implementation of a standardised DNACPR and TEP document for use across the trust. It supports an effective way of considering and communicating decisions and plans of care. |
| Measures of Success | 4. CQUIN target: Achieving 80% of eligible surgical inpatients where the primary procedure was a major surgical procedure are supported to drink, eat and mobilise within 24 hours of surgery ending.<br><br>5. CQUIN target: Achieving 1.5% of 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.<br><br>6. Trust Quality Priority: Evidence an improvement in standards in care for End of Life patients and a reduction in cardiac arrest rates and increase our survival to discharge rates with the implementation of a standardised DNACPR and TEP document for use across the trust. |
| Monitoring Committee | Clinical Quality Operational Board (CQUOB) and the Trust Board Quality Sub- Committee |

| Corporate objective | Deliver Excellent Clinical Outcomes |
|---|---|
| Quality Priorities | 1. Identification and response to frailty in emergency departments<br>2. Improving the blood culture pathway<br>3. Optimising time to surgery for patients admitted with a fragility hip fracture |
| Rationale | 1. Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) was asked to provide acute frailty services for at least 70 hours a week. Patients with grades of frailty CFS 6 or above should be assessed for frailty associated syndromes via a comprehensive geriatric assessment and/or be referred to the acute frailty service. It is optimum to have early identification of frailty which can mitigate some of these risks.<br><br>2. Adherence to existing microbiology standards will support the identification of significant bloodstream infection (BSI) in the population. The timely identification of a specific organism will support a more accurate infection diagnosis, guiding specific investigations and a plan of care. Each significant positive blood culture provides an opportunity to improve care and patient outcomes.<br><br>3. NICE guidance CG124 recommend that surgery should take place on the day of admission to hospital or the following day. A prompt time to surgery will mean that post-operative interventions is commenced as soon as possible, improving patient experience, outcomes and reducing length of stay (LOS) |
| Measures of Success | 1. CQUIN target: Achieving 30% of patients aged 65 and over attending the ED or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up<br><br>2. Trust Quality Priority meeting national standards: Evidence an improved adherence to recommended fill volumes of blood culture bottles in line with NHS England blood culture recommendations. This will increase the accuracy of reporting and support antimicrobial stewardship.<br><br>3. CQUIN target: Evidence an improvement in the numbers of patients admitted with a confirmed fractured NOF and considered medically fit have surgery within 36 hours of arrival in Emergency Department (ED). |
| Monitoring Committee | Clinical Quality Operational Board (CQUOB) and the Trust Board Quality Sub- Committee |

# Statements of Assurance from the Board

## 3.1 Review of services

During 2022/23 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 2022/23 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 is a way to find out if care provided is in line with the expected standards. It informs the Trust and its service users where services are doing well and where improvements could be made. The aim is to allow improvements to take place where they will be most helpful and improve outcomes for service users.

Our Clinical service line support team, with our Head of Audit and Quality Governance Manager lead on our clinical audit work, offering guidance and support to our leaders and managers to develop a program of audits (yearly forward audit plan). This includes the audits that every NHS Trust is required to complete (National Audits), those needed to monitor our contractual arrangements, and those requested by our teams to assess and improve the quality of their own work (local audits and quality improvement projects) which include auditing action plans from Serious Incidents and National Patient Safety Alerts.

The registered audits have continuing monitoring throughout the year and their progress reviewed at quarterly Clinical Audit and Effectiveness Committee forums, where learning outcomes and quality improvements then reach a wider audience across the organisation.

Of the 54 National Audits available for the Trust, we participated in 35 in 2022/2023; these are outlined in the table below. Where appropriate, specific hospital sites are listed:

| 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. | Breast and Cosmetic Implant Registry | Not applicable to this organisation. | | | |
| 2. | 2. | Case Mix Programme | Continuous data collection | | Yes | 297 |
| 3. | 3. | Child Health Clinical Outcome Review Programme[1] | Participation in Clinical Outcome Review Programmed 2022/23 listed in table below | | | |
| 4. | 4. | Cleft Registry and Audit Network Database | Not applicable to this organisation. | | | |
| 5. | 5. | Elective Surgery: National PROMs Programme | Continuous data collection | | Continuous data collection | |
| 6. | | Emergency Medicine Quality Improvement Projects: | | | | |
| | 6. | *a. Pain in children V2 21/22* | Yes | 168 | Yes | 113 |
| | 7. | *b. Infection Control V2 21/22* | Yes | 97 | Yes | 127 |
| | 8. | *c. Consultant sign off (Apr-Oct 22)* | Yes | 186 | Yes | 216 |
| | 9. | *d. Infection Control V3 (Oct 22 – Oct 23)* | Yes | 83 (not complete) | Yes | 136 (not complete) |
| 7. | 10. | Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People Epilepsy 12[1] | Yes | 59 | No | Did not participate in cohort 4 |
| 8. | | Falls and Fragility Fracture Audit Programme[1] : | | | | |
| | 11. | *a. Fracture Liaison Service Database* | No service on this site | | Yes | 797 cases |

| 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 |
|---|---|---|---|---|---|---|
| | 12. | *b. National Audit of Inpatient Falls* | Yes | 10 cases | Yes | 9 cases |
| | 13. | *c. National Hip Fracture Database* | Yes | 386 cases | Yes 339 cases | 339 cases |
| 9. | | National Gastro-intestinal Cancer Programme 1, 2, 3, 4 (information only available for 2021/2022) | | | | |
| | 14. | *a. National Oesophago-gastric Cancer* | Continuous data collection | | Yes | 41 (2021-2022 data) |
| | 15. | *b. National Bowel Cancer Audit* | Continuous data collection | | Yes | No results due to errors (2021-2022 data) |
| 10. | 16. | Inflammatory Bowel Disease Audit | Continuous data collection | | Continuous data collection | |
| 11. | 17. | LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme) | Yes | 7 cases | Yes | 8 cases |
| 12. | 18. | Maternal and Newborn Infant Clinical Outcome Review Programme[1] | Continuous data collection | | Continuous data collection | |
| 13. | 19. | Medical and Surgical Clinical Outcome Review Programme[1] | Participation in Clinical Outcome Review Programmed 2022/23 listed in table below | | | |
| 14. | 20. | Mental Health Clinical Outcome Review Programme[1] | Not applicable to this organisation. | | | |
| 15. | 21. | Muscle Invasive Bladder Cancer Audit | Not applicable to this organisation. | | | |
| 16. | | National Adult Diabetes Audit[1]: | | | | |
| | 22. | *a. National Diabetes Core Audit:* | Yes | 5523 cases | Yes | Continuous data collection |
| | 23.. | *b. National Diabetes Foot care Audit* | Yes | 71 cases | Yes | Continuous data collection |
| | 24. | *c. National Diabetes Inpatient Safety Audit* | Yes | 11 cases | Yes | Continuous data collection |
| | 25. | *d. National Diabetes Pregnancy and diabetes Care Audit* | Yes | 66 cases women who went on to deliver NPID completed and 18 miscarriages | Yes | 35 cases |
| 17. | | National Asthma and Chronic Obstructive Pulmonary Disease Audit 1 : | | | | |
| | 26. | *a. Adult Asthma Secondary Care* | Yes | 128 cases | Yes | 178 cases |
| | 27.. | *b. Chronic Obstructive Pulmonary Disease Secondary Care* | Yes | 382 cases | Yes | 621 cases |
| | 28.. | *c. Paediatric Asthma Secondary Care* | Yes | 30 (4/22 to 9/22) | Yes | Closing date 12/5/23 |
| | 29. | *d. Pulmonary Rehabilitation – Organisational and Clinical Audit* | Yes | 140 cases | Yes | 170 cases |

| 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 |
|---|---|---|---|---|---|---|
| 18. | 30. | National Audit of Breast Cancer in Older Patients[1] | Non-participation | | | |
| 19. | 31 | National Audit of Cardiac Rehabilitation | Yes | 1204 cases | Yes | 275 cases |
| 20. | 32 | National Audit of Cardiovascular Disease Prevention (Primary Care)[1] | Not applicable for both sites | | | |
| 21. | 33. | National Audit of Care at the End-of-Life[1] | Yes | 50 cases | Yes | 50 cases |
| 22. | 34. | National Audit of Dementia[1] | Yes | 80 cases | Yes | 80 cases |
| 23. | 35. | National Audit of Pulmonary Hypertension | We do not have either service set up or resources on either site. | | | |
| 24. | 36. | National Bariatric Surgery Registry | Continuous data collection | | No | Not practiced on the site |
| 25. | 37. | National Cardiac Arrest Audit | Yes | 57 cases | Yes | 55 cases |
| 26. | | National Cardiac Audit Programme: | | | | |
| | 38. | *a. National Audit of Cardiac Rhythm Management* | Yes | 230 cases | Yes | 241 cases |
| | 39. | *b. Myocardial Ischaemia National Audit Project* | Yes | 55 cases | Yes | 385 cases |
| | 40. | *c. National Adult Cardiac Surgery Audit* | Not applicable to either site. | | | |
| | 41. | *d. National Audit of Percutaneous Coronary Interventions* | Yes | 430 cases | Yes | Continuous data collection |
| | 42. | *e. National Heart Failure Audit* | Yes | 604 cases | Yes | Continuous data collection |
| | 43. | *f. National Congenital Heart Disease* | We do not have either service set up or resources on either site. | | | |
| 27.. | 44. | National Child Mortality Database[1] | Part of the (Child Death Overview Panel) CDOP process and managed in the community. | | | |
| 28 | 45. | National Clinical Audit of Psychosis[1] | Not applicable | | | |
| 29. | 46. | National Early Inflammatory Arthritis Audit[1] | Yes | 5 cases | No | Not participating due to manpower issues |
| 30. | 47. | National Emergency Laparotomy Audit[1] | Yes | 166 cases (Jan-Dec 22) | Continuous data collection | |
| 31. | 48. | National Joint Registry | Continuous data collection | | Continuous data collection | |
| 32. | 49. | National Lung Cancer Audit[1] | Yes | 212 cases | Yes | 276 cases |
| 33. | 50. | National Maternity and Perinatal Audit[1] | This data is not available as the NMPA receives routinely collected data from NHS England for all English trusts and they have not yet received 2022/23 data from NHS England. | | | |
| 34. | 51. | National Neonatal Audit Programme[1] | Yes | 611 / 100% | Yes | 254 / 100% |
| 35. | 52. | National Obesity Audit[1] | Not applicable | | | |
| 36 | 53. | National Ophthalmology Database | No | Not applicable to this site. | Yes (Moorfields) | All cases were submitted |

| 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 |
|---|---|---|---|---|---|---|
| 37. | 54. | National Paediatric Diabetes Audit[1] | Yes | 233 | Yes | 174 |
| 38. | 55. | National Perinatal Mortality Review Tool[1] | Yes | 21 Stillbirths<br>25 Neonatal Deaths<br>3 Late Fetal Losses<br>Total = 49 | Yes | 14 Stillbirths<br>4 Neonatal Deaths<br>1 Late Loss<br>Total = 19 |
| 39. | 56. | National Prostate Cancer Audit[1] | Continuous data collection | | Continuous data collection | |
| 40. | 57. | National Vascular Registry[1] | Continuous data collection | | Continuous data collection | |
| 41. | 58. | Neurosurgical National Audit Programme | Not applicable to this organisation | | | |
| 42. | 59. | Out-of-Hospital Cardiac Arrest Outcomes | Not applicable to this organisation | | | |
| 43. | 60. | Paediatric Intensive Care Audit[1] | Not applicable to this organisation | | | |
| 44. | | Prescribing Observatory for Mental Health | | | | |
| | 61. | *a. Prescribing the quality of valproate prescribing in adult mental health services* | Not applicable to this organisation | | | |
| | 62. | *b. The use of meltonin* | Not applicable to this organisation | | | |
| 45. | | Renal Audits: | | | | |
| | 63. | *a. National Acute Kidney Injury Audit* | Yes | | Non-participation | |
| | 64. | *b. UK renal Registry Chronic Kidney Disease Audit* | Non-participation on either site managed by Lister hospital | | | |
| 46. | | Respiratory Audits: | | | | |
| | 65. | *a. Adult Respiratory Support Audit* | Yes - data collection ends 31/05/2023 | | | |
| | 66. | *b. Smoking Cessation Audit – Maternity and Mental Health Services* | Organisers advised temporarily on hold | | | |
| 47. | 67. | Sentinel Stroke National Audit Programme[1] | Yes | 713 cases | Yes | 137cases |
| 48. | 68. | Serious Hazards of Transfusion UK National Haemovigilance Scheme | Yes | 21 cases | Yes | 5 cases |
| 49. | 69. | Society for Acute Medicine Benchmarking Audit | Yes | 108 | No | Did not participate in 2022 |
| 50. | 70. | Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment | Not applicable to this organisation | | | |
| 51. | 71 | Trauma Audit and Research Network | Yes | 225 / 100% | Yes | 168 / 100% |
| 52. | 72. | UK Cystic Fibrosis Registry | Not applicable to both sites - applicable to tertiary centres | | | |
| 53. | 73. | UK Parkinson's Audit | Yes | Elderly Care – 34 patient cases<br>Neurology – 33 patient cases<br>Physiotherapy did not participate due to staffing issues | Yes | Physiotherapy – 10 patient cases |

| 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 |
|---|---|---|---|---|---|---|
| 54. | | Urology Audits 2, 3: | | | | |
| | 74. | a. Cytoreductive Radical Nephrectomy Audit | Non-participation | | Non-participation | |
| | 75. | *b. Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)* | Non-participation | | Non-participation | |

Footnotes:
1 National Clinical Audit and Patient Outcomes Programme (NCAPOP)
2 Programme participates in the Clinical Outcomes Publication (COP)
3 Programmed with multiple work streams are listed in HQIP's The Directory

## Participation in Clinical Outcome Review Programmed 2022/23:

| Name of Enquiry | Did Luton and Dunstable Hospital participate? | Stage / % of cases submitted | Did Bedford hospital participate? | Stage / % of cases submitted |
|---|---|---|---|---|
| Child Health Clinical Outcome Review Programme - **Transition from child to adult health services** (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Yes | 100% / 2 cases submitted | Yes | 100% / 8 cases submitted |
| Clinical Outcome Review Programme into Medical & Surgical care - **Crohn's Disease** (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Yes | 33.3% / 2 cases submitted | Yes | 100% / 5 cases submitted |
| Clinical Outcome Review Programme into Medical & Surgical care - **Community Acquired Pneumonia Hospital Attendance** (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Yes | 100% / 8 cases | Yes | 100% / 7 cases |
| Child Health Clinical Outcome Review Programme - **Testicular Torsion Study** (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Yes | 6 (100%) case notes submitted and 2 (33%) questionnaires | Yes | 5 (100%) case notes submitted and 2 (40%) questionnaires |
| Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE) – Perinatal mortality surveillance | Yes | 26 Stillbirths (including 4 Terminations of Pregnancy)<br>31 Neonatal Deaths<br>3 Late Loss<br>Total = 60 | Yes | 18 Stillbirths (including 4 Terminations of Pregnancy)<br>4 Neonatal Deaths<br>1 Late Loss<br>Total = 23 |
| Maternal, New-born and Infant Clinical Outcome Review Programme – Maternal mortality surveillance and confidential enquiry | Yes | 1 maternal death | Yes | 2 maternal deaths |
| Maternal, New-born and Infant Clinical Outcome Review Programme – Perinatal confidential enquiries | Yes | Same as MBRRACE Perinatal Mortality Surveillance | Yes | Same as Perinatal Mortality Surveillance |

## National Audits

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Luton | Anaesthetics | NELA - National Emergency Laparotomy Audit - Eighth Patient Report | • The NELA mortality figures for this site are lower compared to the national average figures; therefore, there are no concerns. The site is achieving the majority of the key NELA targets.<br>• The partially met actions (statements 4.1, 4.2 and 5.3) are currently being worked on for improvement. No further action required. |
| Luton | Acute | Society for Acute Medicine Benchmarking Audit (SAMBA) 2021 Report | • Increase Early warning score calculation and documentation in Same Day Emergency Care (SDEC)<br>• To discuss in acute business meeting Trust has done very well in getting consultants review for patients and discharging patients who do not need overnight admissions. |
| Luton | Breast Screening | National breast screening pathology; non-operative biopsy audit | • All pathologists working within the NHS Breast Screening programme should review the findings of this report and use the results to inform personal development including local audit<br>• The lead breast-screening pathologist should identify an action plan for their department and/or staff based on the findings of this report. The Director of Breast Screening and the lead breast-screening pathologist should present the action plan to the local commissioning programme board.<br>• The Director of Breast Screening should share the results with their biopsy takers<br>Advice and support are available from Regional SQAS. |
| Bedford | Cardiology | National Heart Failure Audit (NHFA) | • We provide echocardiogram for all inpatients suspected of heart failure. We have now secured funding for an In-patient NT pro BNP (natriuretic peptide (BNP) and N-terminal pro b-type natriuretic peptide) service.<br>• Successful Heart Failure nurse and registrar team that identify patients and move them to CCU (Critical Care Unit).<br>• At the Trust, we have a well-established high quality heart failure service/team. We have two specialist heart failure consultants. Heart Failure patients are identified early and moved to the cardiology ward.<br>• Our HF specialist team proactively seek out these patients in the hospital and initiate disease-modifying treatments. The patients are transferred to CCU (Critical Care Unit) and disease-modifying medications initiated and up titrated.<br>• The vast majority of HFrEF (Heart Failure with Reduced Ejection Fraction) patient are reviewed by a member of the heart failure team prior to discharge and follow up is organised in a HF (Heart failure) clinic. |
| Bedford | Cardiology | National Audit of Cardiac Rehabilitation | • Stand-alone programme for Heart Failure patients both Face-to Face and via a home programme using REACH-HF<br>• Functional Capacity testing for Cardiovascular patients and Heart Failure patients both Pre and Post Cardiac Rehab<br>• Plans in progress to start a "Virtual" programme for our cardiovascular patients, and then we will be able to offer a true hybrid approach.<br>• Participating by recruiting patients to the OSPREY study (an NIHR (National institute for health and care research) study run from Sheffield Hallam University), which is looking at cardiac rehabilitation from a patient perspective.<br>• Recruited three new members of staff, allowing a greater provision of current services alongside more timely contact with referred patients. |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Luton | Cardiology | National Audit of Cardiac Rehabilitation | • We currently offer our programme to all priority groups and in the past 12 months have taken on more complex patients including those with SCAD (Spontaneous coronary artery dissection) and a patient with an LVAD (left ventricular assist device) in situ.<br>• We have an excellent MDT (multidisciplinary team) team who work well together under extreme pressure and have a clear record of staff retention.<br>• Additionally, we now undertake functional capacity testing via a six-minute walk test on all our patients attending the face-to-face exercise component of the programme which gives a much better indication of the benefits of the programme |
| Luton | Cardiology | Myocardial Ischaemia National Audit Project (MINAP) | • We provide rapid access to the cardiac catheterisation laboratory for patients that are in hospital when a diagnosis of STEMI is made.<br>• Majority of NSTEMI (Non-ST-elevation myocardial infarction) & STEMI (segment elevation myocardial infarction) patients receive a detailed departmental study during their admission.<br>• All inpatients with T1MI are transferred to our cardiology ward prior to angiogram +/- PCI (Percutaneous Coronary Interventional). If patients are deemed for medical therapy, then they may move to a general medical ward with cardiology input.<br>• Patients are seen at the front door by our Inreach service and if deemed to be appropriate will be moved to the cardiology ward.<br>• We endeavour to perform angiography on all of our NSTEMI (Non-ST-elevation myocardial infarction) patients prior to discharge.<br>• We perform emergent angiography +/- PCI (Percutaneous Coronary Interventional) for all patients with STEMI and high-risk NSTEMI (Non-ST-elevation myocardial infarction) within weekday hours (9am-5pm). |
| Luton | Cardiology | National Audit of Percutaneous Coronary Intervention | • We have run weekend lists over the busiest periods, which has helped us to meet demand.<br>• We have started to use the cardiac Centre to house cardiac patients, so they can get their cardiac catheterisation lab procedure quicker. This reduces the time to discharge and expedites patient flow.<br>• We have started an improved calcium modification service, procuring modern and advanced equipment.<br>• There are plans for new Cath lab equipment to be in place by August, but not enough staff are in post to utilise this and increase capacity. |
| Bedford and Luton | Corporate | National Cardiac Arrest Audit (NCAA) | • Bedford site: Audit of Treatment Escalation Plan 100% compliance with completion. Introduction of weekly MDT (multi-disciplinary team review of cardiac arrests.<br>• Cross-site: Resuscitation and Deteriorating Patient Policy approved. AAR (After action review) training for team completed. QI – for a new standardised cross-site Treatment Escalation Plan in progress.<br>• Luton site: Our ROSC (Return of spontaneous circulation) rate was 71.9% (national average 49.5%). Our STHD 33.3 % (national average 22.7%). Implementation of My Kit Check, an electronic checklist of the resuscitation trolleys that allows timely compliance checks. Implementation of Zoll one-step defibrillator pads, which provide real-time feedback in order to improve CPR (Cardiopulmonary resuscitation) quality. |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Bedford | Corporate | National Inpatient Falls | • When it comes to educating patients about fall prevention, we take highly proactive measures. Patients receive ward orientation and advice by nursing staff as well as relevant informational leaflets on falls prevention.<br>• Patients in the Accident & Emergency department are currently part of the Focus on Falls program as part of an ongoing effort to highlight the risks.<br>• Using the new Risk management system to collate data that highlights potential themes and areas of concern.<br>• To reinstate and develop escalation panels to meet and discuss relevant incidents, these involve Heads of Nursing, Matrons, Ward Managers, Falls Lead and Falls Clinical Nursing Specialists, Physiotherapy Leads as well as Ward Nursing staff.<br>• An improvement of our manual handling equipment has included the introduction of FloJac.<br>• Falls Champions have been reinvigorated and many staff members have been recruited. A robust training/update program has been developed which will take place 4 times a year.<br>• Themed and refresher training modules have been developed for new and existing staff. When working in a particular area and a theme has been recognised, a short training program can be quickly assembled and delivered to staff members to address the theme and provide support.<br>• A staff training video on 'Baywatch bays' in wards is also due to be produced. With staffing levels, a constant challenge and 1 to 1 care with patients at high risk of falls difficult to maintain Baywatch is a pro-active way to help stop patients from falling.<br>• KPIs are being collected on several wards throughout the trust in order to monitor the compliance levels on falls prevention assessments and care plans, this will provide real time evidence-based data to assist in the recognition of successes as well as failures, both of which can be recognized early and acted upon. |
| Luton | Corporate | National Inpatient Falls | • All incidents were reported in a timely manner, 72hr reports generated and presented/reviewed at LIRP (Local incident review panel) and learning taken back to wards. We have been concentrating on raising the profile of falls prevention in the past several months through training and After-Action Reviews (AAR) – we have started seeing results from these measures in weekly falls numbers.<br>• For the future we are working on a more robust auditing system that will help us target themed problem areas within the trust, this will help to improve the number of incidents further. |
| Luton | Diabetes & Endocrinology | National Diabetes Audit | The 3 parameters of particular interests are:<br>• % of pts achieving HbA1c of < 58mmol, the national report headline summary indicates median rate of Hba1c < 58mmol for 2020-21 is 31%. For Luton site, we achieved only 26.6% in 2019-20 but in 2020-21, this is now improved to 29.2%.<br>• % of pts with Hba1c >86mmol, we are still far too high at 18% but I cannot find in the national report what the national mean' expected % is and cannot tell if we are outside of three SD (standard deviation) of the mean.<br>• % of pts receiving all 8 care processes, the England & Wales mean is 28% and we achieved 35.8% so that's better than average |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Luton | Diabetes & Endocrinology | National Diabetes Audit - Adults - National Diabetes Inpatient Safety Audit NDISA | • Joined the Hypo Awareness Week celebration.<br>• Raising awareness on how to spot the signs, learn the symptoms and understand the proper, hypo treatment for health care professionals, patients and/or their family.<br>• Joined the national Insulin Safety Week, campaign to raise awareness on insulin, safety among healthcare professionals, Initiated the Hypo treatment prescription on the nerve centre (10 % Glucose, Glucagon) and recommendation of bedtime snacks PRN (Pro Re Neta). |
| Bedford | Diabetes & Endocrinology | National Diabetes Audit - Adults - National Diabetes Inpatient Safety Audit NDISA (previously Nadia Harms) | • Recommendation 1.NHS trusts should participate in the NaDIA harms audit to review the safety and quality of inpatient diabetes services. This is consistent with the Getting It Right First Time1 (GIRFT-Get it right first time) recommendation that NHS trusts should participate in local and national audits of patient harms. We are fully compliant with the recommendations.<br>• Recommendations 4. NHS trusts should incorporate reduction of DKA (Diabetic ketoacidosis) arising in people admitted under surgical specialties within Quality Improvement programs, focusing on the establishment of processes to ensure that insulin is not stopped in people with type 1 diabetes- We are fully compliant with the recommendations. |
| Luton | DME | NCEPOD - Dysphagia in Parkinson's disease | • Refer patients to SALT (speech and language therapy) if Parkinson disease patients appeared to have swallowing difficulty on screen at ED/acute team - Yes, it is compliant. The current guideline, which was done in 2017 as collaborative work has been already updated in end of 2021 with a special instruction on limitations to use Rotigotine patch on particular group of our patients.<br>• Notify Parkinson disease specialist review in hospital or community when a patient with Parkinson disease admitted if there is any indication that has been a deterioration or progression of their clinical status- Yes Compliant.<br>• Provide written information at discharge on how to manage swallowing difficulties – We are compliant. |
| Luton | Emergency Medicine | Royal College of Medicine (RCEM) –Fractured Neck of Femur QIP 2020/2021 | X-rays are done in good time, when compared nationally. Actions to be completed:<br>• Ensure 95% patients are triaged within 15 minutes and given analgesia<br>• Pain score is recorded when performing observation post fascia iliaca block (FIB). |
| Bedford | Emergency Medicine | Royal College of Medicine (RCEM) – Infection Control (care in emergency departments) | • Standards were met with the department layout of isolating infectious patients, especially COVID patients, from triage and ambulance handovers. Third cycle has commenced. |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Luton | Neurology | UK Parkinson's Audit Neurology | • Documented evidence with patient/ carer and/or provision of written information regarding potential adverse effects for any new medications – 91.2%<br>• Evidence patients taking dopaminergic drugs are monitored re: impulsive/ compulsive behavior – 90.9%<br>• Evidence the patient/ carer has been offered information about, or has set up a Lasting Power of Attorney – 67.6%<br>• Documented discussions regarding end of life care issues/ care plans within 12 months – 66.7%<br>• Access to Parkinson's Nurse – 93.3%<br>• Quality of Service provided by Parkinson's specialist doctor – Excellent 57.1% and Good 42.9%<br>• Enough information given about Parkinson's on diagnosis – 73.3%<br>• Enough information given on new medication prescribed including side-effects – 73.3% |
| Luton | Paediatrics | NACAP: Child and Young Person Asthma 2021 Organisational Audit: Summary report | • Continue training paediatric staff in interpretation<br>• Priority is for specialist respiratory nurse<br>• Await outcome on NSHI funding. If unsuccessful to write business case with support of audit<br>• Formal pathway for transition service |
| Luton and Bedford | Paediatrics | National Diabetes Audit 2017-21 (Adolescent and Young Adult) Type 1 Diabetes | • Hoping to develop a "one stop shop" for complication screening, which should make it easier for outpatients to get all their checks done.<br>• Service users to complete questionnaires to find out what would be helpful.<br>• Potential increase in adult clinician time. |
| Luton | Respiratory | National Asthma and COPD Audit Programme | • National Chronic Obstructive Pulmonary<br>Compared to national, performing well on 4 out of 6 KPI (1 (NIV) not measured due to limited patient numbers).<br>7/7 respiratory service covering acute medical wards which enables a high number of patients to be reviewed within 24hrs.<br>Mandatory O2 prescription successfully discussed at medicines safety committee and approved for change to NerveCentre.<br>• National Asthma audit<br>Performing well on 5 out of 6, KPI compared to national average.<br>Recent improvement project in ED (Emergency department) has helped raise awareness of asthma management and ensure higher compliance with Peak flow and steroids in the first hour but still work ongoing.<br>On World Asthma Day, we ran an all-day event for ED staff (nurses and doctors) on the acute management of asthma including the priorities of peak flow, steroids and nebulisers in the 1st hour |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Bedford | Respiratory | National Chronic Obstructive Pulmonary and National Asthma audit | • We changed our discharge care bundle sheet (which the nurses use to complete when seeing the patients in wards), by removing information we no longer require and adding what is required for the audit,<br>• We have also included on our discharge care bundle sheet 'patient consent'<br>• any patients whom do not consent- we log this on a separate excel spreadsheet (used for internal purpose)<br>• We look back and check an audit database on a weekly basis of any patients that were admitted to the hospital and coded as COPD (Chronic obstructive pulmonary disease) or Asthma against the NACAP (National Asthma and COPD Audit Programme ). |
| Bedford | Respiratory | National Lung Cancer audit | • Undertaken EBUS (Endobronchial Ultrasound) audit – increase in N1 sampling in staging procedure to improve NPV. Otherwise, above average in the region for numbers of cases and sampling rates.<br>• Ongoing commitment to audit outcomes with meeting national targets for 2020/21. Awaiting 2021/22 data outcomes. |
| Bedford | Rheumatology | Fracture Liaison Service Database | • There is an improvement on KPI2 (Identify Spinal Fractures). The success of improving is a result of team effort involving radiology department and FLS (Fracture liaison service).<br>• There is also an improvement KPI 6 (Falls risk assessment) + KPI 8 (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.<br>• On KPI7 (Bone treatment) there is an improvement on patients that after investigation (bloods to check secondary causes for osteoporosis, DXA scan (dual x-ray absorptiometry), based on national guidelines, are on bone strength treatment. |
| Luton | Stroke | Sentinel Stroke National Audit Programme (SSNAP) | • The Luton site have moved from grade E to Grade C in the SNNAP Sentinel Stroke National Audit Programme |
| Luton | Trauma & Orthopaedics | National Joint Registry (NJR) | All standards met.<br>• A Lead Person (SCP) for NJR allocated who supported and completed the pending records on the system resulting to prompt submission of NJR forms of the department.<br>• Having to allocate a designated consultant for Trauma Neck of Femur patients who underwent arthroplasty.<br>Actions to be completed: by Mar-24:<br>• Prompt checking of NJR forms.<br>• Allocated time to check pending records to prevent delays of submission |

## Local Clinical Audits

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Bedford | Acute Medicine | Hospital Acquired COVID Pneumonia | Following actions have been implemented:<br>• Establishing the contact ward to segregate the patients to minimize hospital acquired spread<br>• To reduce the frequency bed transfer in-between the wards particularly during a community or hospital outbreak<br>• To find the ways and steps to expedite discharge after being medically optimised |
| Luton | Acute Medicine | Management of Subarachnoid Haemorrhage | • Improvements made in history taking, clinical examination and avoidance of unnecessary lumbar punctures (LP).<br>• Action to document Ottawa score in notes to avoid unnecessary LP. |
| Luton | Anaesthetics | Factors contributing to General anaesthetic for elective caesarean section | • Currently achieving the standards set by Royal College of Anaesthetists.<br>• Incidences of general anaesthetic for elective cases is 1.8% (Royal College of Anaesthetists recommends <5%) |
| Luton | Anaesthetics | Compliance with Perioperative Diabetic Pathway – Re-Audit | • Pre-assessment hub to upload appropriate pathways when feasible.<br>• Anaesthetists to prescribe post-operative medication.<br>• Posters to be posted in the arrivals area to remind staff to check blood sugars.<br>• Recovery staff in theatres to check whether medications have been prescribed.<br>• Pharmacists to review medications. |
| Bedford | Anaesthetics | Emergency theatre utilisation – June 2021 – 3rd cycle | • Re audit of utilisation of emergency theatre, workload given ongoing work pressures. |
| Luton | Cardiology | COVID 19-CVD Audit | • Key biomarkers predicting COVID 19 outcomes are troponin and creatinine, which are measured in over 95% of admissions. |
| Bedford | Cardiology | An evaluation of the quality, titration and monitoring of GTN (Glyceryl trinitrate) infusion prescriptions for malignant hypertension and acute coronary syndrome | 1. A majority of patients were escalated to GTN (glyceryl trinitrate) infusion before optimising oral medication, however those receiving GTN infusion did have better blood pressure control overall.<br>2. The majority of patients were accurately prescribed<br>3. GTN (glyceryl trinitrate) on their fluid chart.<br>Actions required for improvement:<br>1. Proforma needed to help guide prescription for GTN (glyceryl trinitrate) and record monitor the doses in 3 months.<br>2. Second cycle of QIP (quality improvement project) to assess if any improvement after proforma in 3 months.<br>3. Guideline for indications for starting IV treatment of hypertension, after second cycle3 -6 months. |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Bedford | Cardiology | An assessment of cardiology referrals with views to raise awareness of management and improve patient's length of stay | • There were fewer referrals made over a longer period of 80 days compared to post intervention, when there were 12 more referrals over a shorter period of 36 days.<br>• Despite having fewer referrals, we were not able to achieve our target by simple targeted didactic teaching.<br>• We consistently had patients with AFib (Atrial fibrillation) not under cardiology care.<br>• More patients with HF were referred to specialist nurses and had cardiology outpatient follow-ups arranged.<br>• More patients with AF had cardiology outpatient follow-ups arranged with equal number of them having outpatient investigation, clinic appointment or both. |
| Luton | Critical Care | Documentation of treatment escalation plans in patients admitted to critical care | 1. Policy review - is the time frame for completion unrealistic?<br>2. Integration of escalation plan with Nerve Centre |
| Luton | Critical Care | Prescribing of Antibiotics in Renal Impairment according to guidelines in critical Care (ITU) | 1. Update antibiotic reference sheet.<br>2. Increase accessibility, and awareness of the reference sheet Make reference sheet more accessible in ITU (Intensive Therapy Unit).<br>3. Include fluid diluent within reference sheet. |
| Luton | Diabetes & Endocrinology | Blood Sugar monitoring in ward 12 | • 91 % of diabetic patients had their CBG (Capillary blood glucose) monitored, this should be done in all diabetic patients<br>• 37 % of patient who are non-diabetic had their CBG (Capillary blood glucose monitoring) check, which was not necessary.<br>• 36% of patient on steroid did not have their CBG monitored |
| Bedford | Diabetes & Endocrinology | Indications and safe use of VRIII | • The goal was to maximise the correct responses to a questionnaire that will reflect a better understanding of the Indications and safe use of VRIII. Upon rechecking, the correct response percentage increased from 50 to 80 percent reflective of better knowledge and understanding of the doctors. |
| Luton | DME | Management of delirium - adherence to NICE guidelines | • Delirium is identified early and promptly investigated for underlying causes. The majority of patients with delirium have a behavioural chart and non-pharmacological measures are taken first to manage their behavior. In most cases, the General practice is informed about the diagnosis of delirium via EDL (Essential Diagnostic List).<br>• A pop-up on ePMA (Electronic Prescribing and Medicines Administration) when prescribing lorazepam to remind about guidelines |
| Luton | DME | Anticholinergic Drug Burden | • Daily medication review done well, needs to think about collective anticholinergic burden form polypharmacy; implementation of ACB (Albumin Cobalt Binding) score calculator. |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Luton | DME | Audit of compliance to Parkinson disease management pathway in acute medical and surgical admissions | • ONTIME medication has improved from the previous local audit 2021, which was 58%. Now 63% equivalent to Parkinson's UK figures.<br>• Constant training and emphasis via different platforms should aim 100%. Wrongly, prescribed medication is 11%, which should be 0%, but with improved referrals to Parkinson disease specialist early, constant regular training, widely circulated pathway on poster and vigilance via new EPMA (Electronic Prescribing and Medicines Administration) has achieved it to be low in wrong prescription.<br>• It should further improve with emphasis via this audit (which will be regular audit in future) and via audit poster displayed widely and having a PD specialist pharmacist in future to enhance more pharmacists to support on each ward. |
| Bedford | DME | Compliance to National Neck of Femur Pathway targets on BH | • Some areas were performed particularly well – this included history taking including past medical history, social history and a hip examination. |
| Luton | Emergency Medicine | Improving vascular access device (VAD) education for doctors in the emergency department | • Pre-intervention questionnaire sent out to all doctors working in ED (emergency Medicine) (below the level of consultant) to assess baseline level of knowledge of VAD (ventricular assist device) (how to identify, how to take blood or cultures). Responses analysed and demonstrated a lack of confidence. Although compliance was good - continue to make VAD e-learning module part of induction process for new doctors rotating into the Emergency Department. |
| Bedford | Gastroenterology | An evaluation of the quality and standard of documentation in death verification | • There has been an improvement in all parameters of death verification documentation.<br>• There has also been good uptake of the process of using the sticker system.<br>• Overall 34.9% of doctors used the sticker when verifying death, but this increased to 100% once the pilot stage ended and the sticker was officially implemented. |
| Luton | General Surgery | Acute Testicular Presentation and it's Management | 1. The trust is adhering to the NICE guidelines on management of patients with testicular pain.<br>2. Few scans were booked in the re-audit period as compared to the audit period.<br>3. Recommendations in the audit period was not to book USS (Ultrasound scan) tests in patients suspected with testicular torsion, and we had recommended a surgical exploration in suspected patients with testicular torsion. |
| Bedford | General Surgery | Improving Foundation Year 1/Surgical House Officers General Surgery On-Call Shifts | 1. Clear induction highlighting the structure of different surgical departments, as well as clear roles and responsibility of each team members of the on-call team.<br>2. Induction to include a help sheet for assessing support in emergencies outlining major haemorrhage protocol, trauma protocol, fast bleeping<br>3. Posters outlining on-call team cover for different specialties<br>4. Timetable for on-call junior has now changed in order to better staff both night and weekend on call shift |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Bedford | General Surgery | An Audit Evaluating the Antimicrobial Management of Patients with Uncomplicated Diverticulitis Compared Against NICE Guidelines | 1. Re-audit<br>2. Simplified treatment algorithm to educate junior doctors on the prescription of antimicrobial agents in uncomplicated diverticulitis.<br>3. A short internal guideline/policy on the prescription of antimicrobial agents in uncomplicated diverticulitis. |
| Luton | General Surgery | STARsurg CASCADE Project (Local Feedback) | • Trust is doing well with some aspects of perioperative standards and do not have compliance with CPET (Cardiopulmonary Exercise Testing) as nationally compliance is low as well.<br>• Intraoperative standards are up to mark<br>• Post-operative standards with VTE prophylaxis are above the national level and need more work out on involving specialist input in earlier phases. |
| Bedford | Maternity | Informed Consent - Re: Choice of Place of Birth | 1. Notes printed have been amended to show what midwives input by the midwives at booking.<br>2. Notes changed to evidence discussions as notes not printing inputted information.<br>3. Leaflets to be edited and reprinted<br>4. Further discussions/newsletter with staff to ensure discussions being had and documented |
| Luton | Maternity | Shoulder Dystocia | Re-audit completed. 100% compliance on training, neonatal outcome, call for help. The following actions were completed prior to re-audit:<br>1. Education regarding diagnosis of shoulder dystocia. Delivery of shoulder with gentle traction/next contraction should be attempted before shoulder dystocia diagnosed<br>2. If Royal College of Obstetricians and Gynaecologists (RCOG) sequence of manoeuvres not followed document reason<br>3. Neonatal Unit should be called to assess all babies as per RCOG guideline - even if quick resolution of shoulder dystocia.<br>4. Blood loss should always be weighed to avoid over-estimation<br>5. Cord gas analysis should be attempted in all cases. Document if unable to obtain sample/insufficient sample + handwrite results in notes (as well as sticking in notes)<br>6. Encourage use of documentation tool to ensure more complete documentation<br>7. Regular prompt training should continue within the Trust with use of the shoulder dystocia proforma in the dystocia station to ensure staff awareness. |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Luton | Neurology | Safety of treatment of Multiple Sclerosis patients with Ocrelizumab | 1. Available consent form to commence treatment on medical records (Evolve) 91%. There is no comparator but we should aim for 100%<br>2. MDT (Multi-disciplinary Team) discussion mentioned in medical record 97.7% - NHS England guidance – should be 100%<br>3. Risks discussion in medical records 93%. Aim for >95%<br>4. Patient has had a baseline MRI scan within 3 months 43%.<br>5. Evidence of Varicella Zoster antibodies at screening 93%. Aim for >95%<br>6. Evidence of TB/HIV/Hepatitis B at screening 95.5%. Aim for >95%<br>7. FBC (full blood count)/U&E (Urea and electrolytes)/LFT (Liver function test) at screening 95.5%. Aim for >95%.<br>8. Safety blood tests are collected for all patients. Risks linked with Ocrelizumab are discussed for most patients. |
| Luton | OMFS | To assess the communication of post-operative instructions to parents in Paediatric A&E and the Paediatric Wards following the closure of facial lacerations either under topical, local or general anaesthesia | 1. Its Lacerations were closed in the most appropriate method determined by the child's age and size of laceration<br>2. Majority of lacerations were closed with the help of 'Latgel' placed on by nursing staff before closed by Maxfax team which indicates the good interdisciplinary teamwork the departments in Luton have<br>Actions/improvements:<br>3. Discontinue use of chloramphenicol in paediatrics as antibiotic use not required in non- contaminated wounds.<br>4. Standardise the provision of post-operative instructions in OMFS Implementation of new Trust approved leaflet |
| Luton | Ophthalmology | The Audit of New Cataract referrals redirected to Community Accredited Optometrists and their relevant outcomes | • Over 50% of patients contacted visited Optometrist.<br>• Just under 10% were planned to see one.<br>• 13% decided to go to another provider.<br>• Just under 10% were not contactable. About 5% decided they did not want to proceed with surgery. Actions/improvements:<br>• Trained more optometrists and ran an accreditation evening so that more optometrists in the community are trained to assess patients with cataracts and discuss the merits and risks and directly notify us to wait-list them for surgery.<br>• Re-audit the progress of the direct access to cataract surgery scheme in 1 year. |
| Bedford | Radiology | Timeliness of ultrasound investigation in patients presenting with acute abdominal pain | • Patients presenting to acute care with abdominal pain have timely requests for Ultrasound, which is also performed timely. |

| Site | Specialty | Project Title | Quality Improvements and actions required to improve quality of care |
|---|---|---|---|
| Bedford | Respiratory | An Audit to Evaluate Thoracentesis Performed at Bedford Hospital NHS Foundation Trust and Adherence to British Thoracic Society Guidelines | Correct indication for pleural aspiration<br>All patients had correct pre-procedure investigations<br>1. Actions<br>Promote previously created referral checklist.<br>2. Amend procedure checklist |
| Luton | Rheumatology | Early arthritis service for Psoriatic arthritis | Early arthritis service in line with quality outcome standards |
| Luton | Sexual Health | BASHH National Audit: Post Exposure prophylaxis after sexual exposure (PEPSE) | • 87% had baseline Human Immunodeficiency Virus (HIV) tests done at the time of PEP initiation vs UK average 88%<br>• Completion rate of Post Exposure Prophylaxis with starter pack 63.2% vs UK average 52.6%<br>• Action completed: Availability of full course of Post Exposure Prophylaxis in Luton Sexual Health – HIV pharmacist |
| Luton | Stroke | Assessing the accuracy of patient information on NerveCentre | Utilized NerveCentre for board rounds, jobs lists and clinical plans - Diagnosis, clinical summary/plan and doctor's jobs were updated regularly when checked and were up-to-date - Handovers were more efficient<br>Actions required for improvement.<br>1. Clinician encouragement of NerveCentre use<br>2. Teaching on NerveCentre use during new clinician induction training and Medical Education. |
| Bedford | Therapies | Paediatric Physiotherapy Respiratory | Successful pilot study of four complex community paediatric patients who were frequent flyers to Paediatric Ward, were picked to trial a preventative community respiratory physiotherapy intervention. Actions to be completed:<br>1. Worked with Luton lead to produce summary of admissions for the last year which could have been prevented<br>2. Scope new community respiratory service for complex needs children looking at implementing and reviewing care plans and providing rapid response service to prevent admissions<br>3. Look at it being cross site service to provide robust cover for leave and sickness |
| Bedford | T&O | Short term results of GPS guided reverse total shoulder arthroplasty | • Outcome of GPS navigated reversed polarity total shoulder joint replacement is similar or better than conventional reversed polarity total shoulder joint replacement in short term analysis. Average screw length is also better in GPS navigated reversed polarity total shoulder joint replacement |

## 3.3 Participation in Clinical Research

Participation in clinical research demonstrates Bedfordshire Hospitals Trust's commitment to improve the quality of care we offer and to make 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.

The number of patients receiving NHS services provided by the Trust in 2022/23 recruited to participate in research approved by a Research Ethics Committee was 1755. The Trust was involved in conducting 162 clinical research studies including: oncology; stroke; cardiology; neurology; dermatology; ophthalmology; surgery; midwifery; paediatrics; gastroenterology; rheumatology; infection; orthopaedics; anaesthetics and respiratory medicine. This research can be broken down into 160 Portfolio studies, 2 Non-Portfolio studies.

There have been renewed interest in research across both sites of the Trust. At Bedford a new research midwife has been appointed and is working on a large -scale midwifery study with the potential to provide the evidence for a nationwide change in the care pathway of pregnant women. In Luton bariatrics is also re-establishing research activity after some dormant years with several new trials and the Ear, Nose and Throat department has commenced research assisted by the hospital's first cross speciality clinical trials practitioner.

The Trust has participated in the NIHR Associate Principal Investigator Scheme with several people registering onto the scheme and one has already successfully completed the course.

Bedfordshire Hospitals NHS FT is working on an ongoing inclusion project with East of England CRN, the local clinical research network. This will compare the demographics of participants recruited to clinical trials in the Trust with those of the population using our services.

All articles published as a result of research in the Trust can be found in the Annual Academic Report.

## 3.4 Commissioning for Quality and Innovation payment framework (CQUIN)

Commissioning for Quality and Innovation (CQUIN) is a framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. The CQUIN schemes for 2021/22 continued to be suspended by NHS England due to the COVID-19 pandemic in order to release staff to provide frontline clinical support.

The contract value of CQUIN across all non-specialised commissioner schemes is approx. £6.4M representing 1.25% of the expected annual contract activity.

NHS England did publish CQUIN schemes for 2022/23 and these are reflected in Trust Quality Priorities for the year and some progress was made in implementing some of the schemes, as clinical pressures and availability of staff allowed.

CQUINS RAG rating end of year 2022/3

| CQUIN Ref | Description | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| CCG1 | Achieving 90% uptake of flu vaccinations by frontline staff with patient contact | * | * | * | |
| CCG2 | Appropriate antibiotic prescribing for Urinary Tract Infection (UTI) in adults aged 16 years or over | | | | |
| CCG3 | Ensuring that 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, have a NEWS2 score, time of escalation and time of clinical response recorded in line with NICE NG50 and Royal College of Physician Guidance. | | | | |
| CCG4 | Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways | | | | |
| CCG5 | Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle. | | | | |
| CCG6 | Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24. | | | | |

| CQUIN Ref | Description | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| CCG7 | Achieving 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 | | | | |
| CCG8 | To ensure that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending. | | | | |
| CCG9 | Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis | | | | |

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

*No submission required
**Data not available at time of report

When NHS England rolled out the revised CQUIN schemes in 2019/20 it was to highlight evidence based practice, drawing attention to the benefits for patients and providers, and in doing so, allow those benefits to be spread more rapidly. This revised scheme gives CQUINs a fresh clinical momentum, whilst prioritising simplicity and deliverability. Clinical consensus exists nationally that the selected interventions are in support of the NHS Long Term Plan.

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The CQUINs for 2023/2024 are all national schemes and are listed below:

| CQUINS 2023/24 | Title |
|---|---|
| CQUIN01 | Flu vaccinations for frontline healthcare workers |
| CQUIN02 | Supporting patients to drink, eat and mobilise (DrEaM) after surgery |
| CQUIN03 | Prompt switching of intravenous to oral antibiotic |
| CQUIN04 | Compliance with timed diagnostic pathways for cancer services |
| CQUIN05 | Identification and response to frailty in emergency departments |
| CQUIN06 | Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service |
| CQUIN07 | Recording of and response to NEWS2 score for unplanned critical care admissions |
| CQUIN08 | Achievement of revascularisation standards for lower limb ischaemia |
| CQUIN09 | Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres |
| CQUIN10 | Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway |
| CQUIN11 | Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery |
| CQUIN12 | Assessment and documentation of pressure ulcer risk |

## 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 in August 2022 for the following core services

- Urgent and emergency care at both hospital sites
- Medical Care (including older people's care) at both hospital sites
- Maternity at both hospital sites

The Trust also underwent a well led inspection in September 2022.

Following inspection the CQC rated the Trust as GOOD for well led and the Trust is rated as GOOD overall.

Following inspection in 2018 the Trust was given a Registration with Conditions related to Midwifery and Maternity services at its Bedford Hospital site.

The Trust have requested removal of the conditions on registration following the improved rating from Inadequate to Requires Improvement and the outcome of this is awaited.

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 which is of the highest quality. The COVID-19 pandemic has reinforced the need for access to regularly updated and high-quality data. 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 record and electronic health records on electronic systems.

Data quality is everyone's responsibility. 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.

Standards are essential to ensure that;
- Data collection is consistent throughout the Trust
- National and local comparisons can be made with a confidence that the data is truly comparable
- Data is kept legally, securely and confidentially
- Data outputs can be compared across the organisation and over time

### 2022/23 Data Quality Improvement

Internal monitoring reports have continued to be produced at standard agreed intervals (daily, weekly, monthly and quarterly). These reports monitor key data items such as:

- Valid/Missing NHS Numbers
- PAS missing Data Reports – Demographic missing or invalid records i.e. gender, home addresses, telephone numbers
- Ethnicity Valid completeness
- Postcode assignment
- Purchaser assignment - missing/inaccurate General Practitioner
- Clinical coding completeness
- Outpatient Outcomes or Attendance Reports
- Correct use of Consultant codes/Use of pseudo Consultant codes
- Duplicate Registrations
- A&E Clinical information completeness
- Reports identifying errors in Referral to treatment data

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
- SHMi
- Model Hospital
- Data Security and Protection Toolkit
- External commissioned audits

Over the past 12 months the Trust has continued to adapt and to transition following the merge of the two sites.

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

- A further restructure of the data quality team has taken place. The Trust recognises the importance of data quality and the team has increased in numbers as well as having designated roles to provide better assurance in the quality of our data. This new team are working closely together to identify areas for improvement or areas of good practice.
- Have implemented 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.
- 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 MDS (Minimum data set) is of good quality and supplied within the national deadlines to assist with the national programme of recovery for our elective patients.
- Have supported the type 3 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 which will include the submission of all same day emergency care data by July 2024.
- We have successfully implemented the faster data flows (FDF) submission and continue to work with services to increase the accuracy of the daily flows.
- The team are working even more closely with the digital teams to ensure NerveCentre (Electronic patient record) is compliant with data standards.

Action Plan for 2023/24 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 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.
- To complete more reconciliation from pre and post SUS inclusions to ensure all activity is flowing accurately and in a timely manner.
- To monitor new services providing expert knowledge in data capture so that the service can be reviewed and performance evaluated correctly
- 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.
- Working with the Technical Analytics team to build new data reconciliation reports, thus providing further assurance that all data that is being submitted externally is accurate and timely.
- To create new data quality overview reports for service lines, in addition to the DQ dashboards. These are to be produced monthly and used as a summary for each service line so that they are aware of where data quality needs improvement plans. Tailored individual data quality improvement plans (DQIPS) will be created 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 Technical Analytics and Information services to ensure all reports are produced/remapped to the Trust-wide data warehouse
- To work with Technical Analytics 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)

Education and implementation

- To work closely with IT 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
- Work with IT to standardise systems training across sites, not only to stress the importance of data quality but to ensure we have a consistent approach to data entry which will improve cross site reporting
- 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 review validation processes across site for Referral to Treatment (RTT) – with the increased need to fully understand the patients still waiting for treatment and to provide reassurance to external providers of our recovery plans it is essential that we review the data capture and flows across the Trust. We will have clear and consistent data that can be reported directly from source systems allowing more frequent and reliable reporting locally and nationally.
- To implement a new cross site data quality 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 DQ 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 SystemOne so that we can be assured our patient records are as up to date and accurate as possible.

Audits and system data quality

- To complete a robust audit's the Trust's data warehouse to ensure that the data is consistent and as per clinical systems
- 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

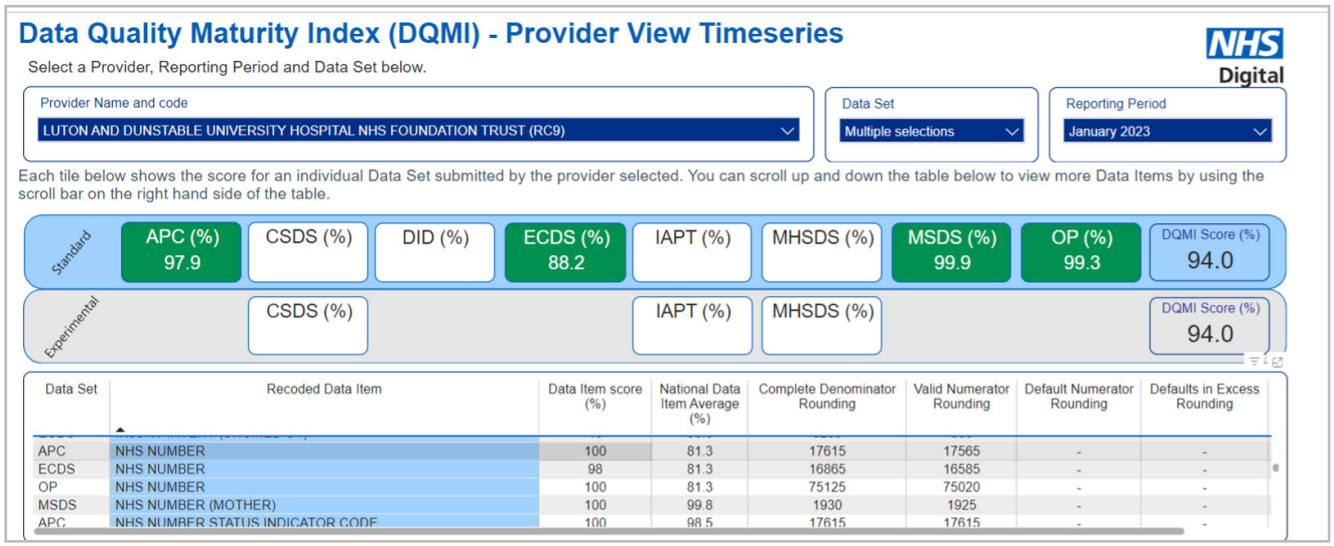
Bedfordshire Hospitals NHS Foundation Trust submitted records during the reporting period 2022/23 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

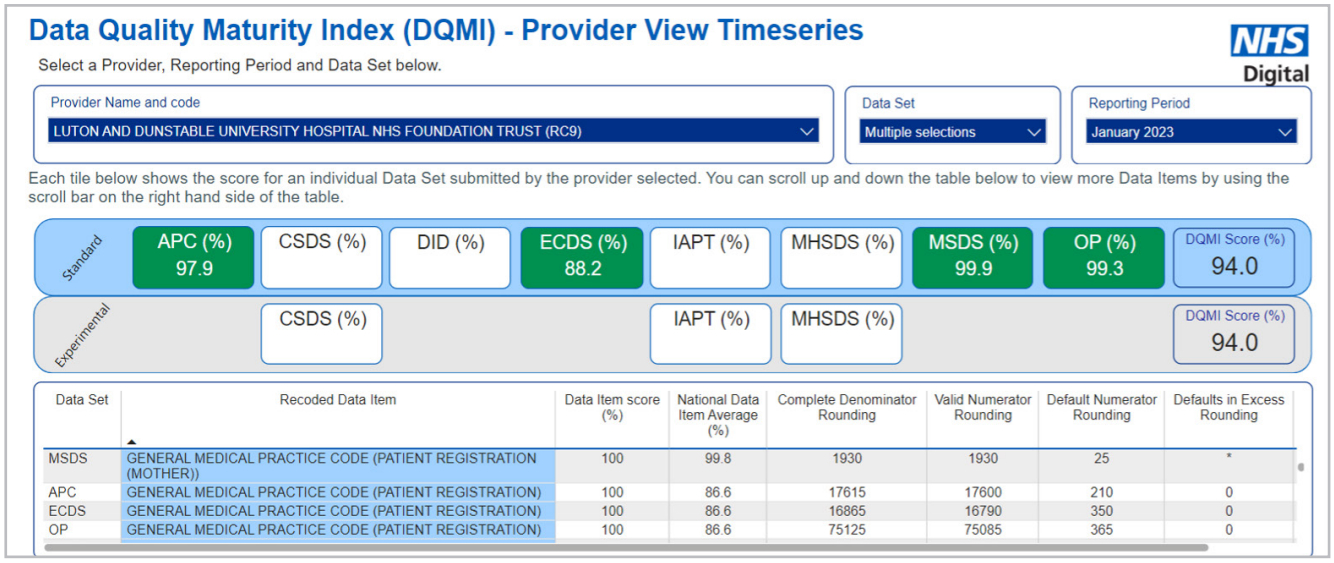
The percentage of records in the published data as at January 2023:

- Which included the patient's valid NHS number was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 98.0% for accident and emergency care
- Which included the patients valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% 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 Trust achieved 94.4% and 92.5% accuracy rates, respectively, for the reporting period April 2021 – March 2022. The accuracy rates reported in the latest published audit for reporting period April 2022 – March 2023 for diagnoses and procedure coding have been sustained with an attainment of 94.4% and 92.5%, 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 2022. 96 of the 109 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 18th July 2022.

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 2023.

**The Trust's current baseline position is: 'Approaching Standards'**

- 93 of 113 mandatory evidence items provided
- 21 of 36 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 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 Offices.

- Password Breach - Under investigation.
- Personal Data Breach - Investigation Complete, awaiting ICO response.
- Personal Data Breach - ICO Decision Notice received, No Further action.
- Unlawful Access – Investigation Complete, awaiting ICO response.

**Audit**

The Trusts external 2023 DSPT audit is scheduled from the 27th of March to the 5th of April.

## 3.10 Learning from Deaths 2022/23

**1.0 Introduction**

Achieving the highest standards in mortality governance, including learning from the care provided to patients who die, is a key priority for the Trust. This includes those deaths that are determined more likely than not to have resulted from problems in care and, in addition, learning from care that was judged as excellent.

The following sections provide a summary of the quarterly reporting to the Trust's Learning from Deaths (LfDs) Board with upward reporting to the Clinical Quality Operational Board and the Quality Committee.

**2.0 Key updates 2022/2023**

Medical Examiner (ME) and Structured Judgement Reviews (SJRs) are shared with the service line triumvirates to inform case discussion at mortality governance forums. Work continues with the clinical service lines to support learning from deaths, this includes identifying themes and highlighting aspects of care for quality improvement.

In addition, a Power BI mortality dashboard is being rolled-out and refined, providing a high-level overview of crude deaths and options to filter by site, month, year (2019 - present) and treatment function. It also incorporates a 'drill through' option, allowing clinical teams to identify patient level detail to support focused mortality governance activities.

Work is ongoing to ensure cross-cutting themes are shared across the clinical service lines and hospital sites, and where highlighted, with system partners.

Opportunities for system learning from deaths is informed by planned reviews, identified through the LfDs Board. Current work streams include case review of end of life patients receiving palliative care, presenting at the Emergency Department (ED) and assessment of the impact of delayed discharge for patients previously deemed medically fit.

In acknowledging the need for timely completion of SJRs to support mortality governance activities, alternative routes of escalation and feedback by the Medical examiner (ME) have been identified. This includes direct feedback to the relevant Clinical Director, with a request for specialist review if indicated. This is considered a proportionate approach and reflects one of the key aims of the Patient Safety Incident Response Framework (PSIRF).

Strategies to engage and support reviewers included establishing a quarterly Mortality Reviewer Forum. In addition, providing individual reports on the number of completed and outstanding assigned SJRs to inform discussion around any barriers to timely completion of allocated cases.

Following implementation of InPhase as the Trust Risk Management System in Q3, the mortality module is now configured to support the mortality review process. Further refinement, including the reporting functionality to meet local and statutory requirements, is ongoing to support learning from deaths.

Review of community deaths commenced in Q4 with an initial three GP practices, this followed a period of training and commissioning of the TTP Systole Community Hub. The pace of further roll-out across the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS) will be dependent on recruitment of GP Medical Examiners (MEs) and completion of the refurbishment of office accommodation.

Recruitment of Medical Examiner Officers (MEOs) is near full establishment across both hospital sites. This role is integral in supporting the work of the MEs and is a core part of the national model, with MEOs acting as a point of contact and source of advice for bereaved families, clinical teams and coroner and registration services.

### 3.0 Monthly mortality reporting

Both hospital site and combined Trust data is reported monthly to facilitate identification of 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 from Q4 Emergency Department (ED) deaths, are reviewed by one Deputy Medical Director and the Associate Medical Director for Mortality Governance and presented at the monthly LfDs Board.

### 3.1 Learning disability deaths (LeDeR)

Monthly reporting also includes learning disability deaths (LeDeR), local governance structure 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 safeguarding leads.

Clinical case review highlights the complexity involved and the opportunities for learning across hospital sites. Key learning and updates identified includes:

#### Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Documentation in the health record of DNACPR decision making and communication of these decisions with the patients' next of kin (NOK) was identified as an area for focus.

Actions arising include (LD) nurse review of DNACPR documentation, to ensure the correct reasoning has been included and to support and inform timely communication with families and carers.

A sustained and significant reduction of concerns raised in respect of DNACPR decision making was noted across the year following implementation.

#### Automated system for identification of LD patients in acute settings

As part of the NHSE National Standards for LD, alongside LeDer reviews locally, organisations have been asked to review systems whereby LD patients can more easily be identified when attending hospital. A system was in place at the Luton and Dunstable Hospital (LDH) site for admitted patients and patients attending appointments in the out-patient setting. This has now been implemented at Bedford Hospital (BH).

#### LD nursing workforce

Both hospital sites are now fully established. This includes a lead nurse and a band 5 nurse for each site. This will support learning, sharing and quality improvement work identified through the LeDeR process.

## 4.0 National data submission

**Table 1: Quarterly breakdown of the number of patients* who died at Bedfordshire Hospitals NHS Foundation Trust by hospital site in 2022/23**

| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| **Bedfordshire Hospitals** | **533** | **530** | **589** | **589** | **2241** |
| Bedford Hospital (BH) | 228 | 247 | 268 | 270 | 1013 |
| Luton and Dunstable Hospital (LDH) | 305 | 283 | 321 | 319 | 1228 |

*Excludes Stillbirth and child deaths: no. 63 Stillbirths (45 LDH, 18, BH), 5 child deaths (aged 2, 4, 6, 10, 11 years, LDH)

**Tables 2a and 2b: Number of completed Primary (a) and Structured Judgement Reviews (SJRs) (b), by quarter, at Bedfordshire Hospitals NHS Foundation Trust and by hospital site in 2022/23**

Primary reviews (2a)

| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| **Bedfordshire Hospitals** | **516** | **511** | **593** | **614** | **2234**** |
| Bedford Hospital | 181 | 197 | 227 | 249 | 854 |
| Luton and Dunstable Hospital | 335 | 314 | 366 | 365 | 1380 |

** Includes non-admitted Emergency Department (ED) deaths

SJRs (2b)

| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| **Bedfordshire Hospitals** | **516** | **511** | **593** | **614** | **2234**** |
| Bedford Hospital | 181 | 197 | 227 | 249 | 854 |
| Luton and Dunstable Hospital | 335 | 314 | 366 | 365 | 1380 |

A primary (first) review was undertaken for 99.7% (2234/2241) of deaths across the Trust in 2022/23, of these, to date, an SJR has been completed in 8.4% cases (187/2234).

An additional 102 SJRs have been requested, allocated and are awaiting completion for deaths occurring in 2022/23 (BH, 22 and LDH, 80 as of 30/04/2023). This equates to a total of 289/2234 (12.9%) SJRs.

There is a 13.9% increase in primary reviews undertaken, with a similar number of SJRs requested when compared to the previous year (2021/22 - 283/2196, 12.9%).

A data refresh is undertaken 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.

Table 3: 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 provide (avoidability judgment score of 2 and 3)

| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| **Bedfordshire Hospitals** | **2** | **6** | **5** | **3** | **16*** |
| Bedford Hospital | 1 | 3 | 1 | 1 | 6 |
| Luton and Dunstable Hospital | 1 | 3 | 4 | 2 | 10 |

The 16 deaths identified represents 0.7% of all deaths in 2022/23 (16/2241).

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

Figures 1 - 3 illustrate the number and percentage of assigned avoidability scores for all SJRs completed in 2022/23 by Trust and hospital site.

**Figure 1**
**BHTs - Assigned avoidability scores for completed SJRs (no. 187)**

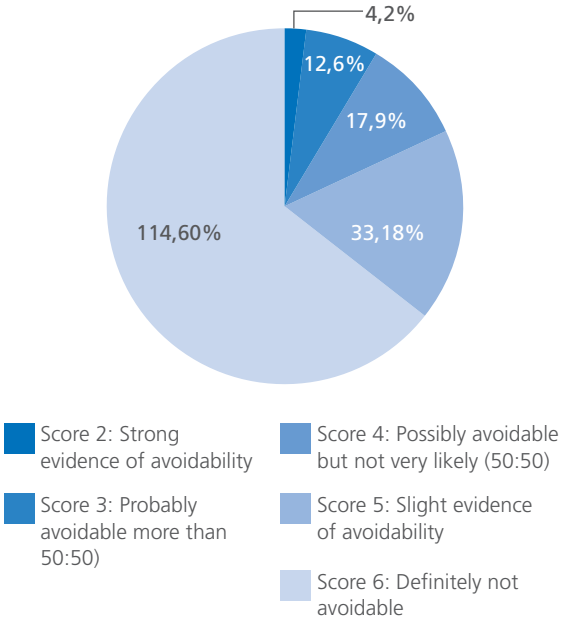


**Figure 2**
**BH - Assigned avoidability scores for completed SJRs (no.91)**

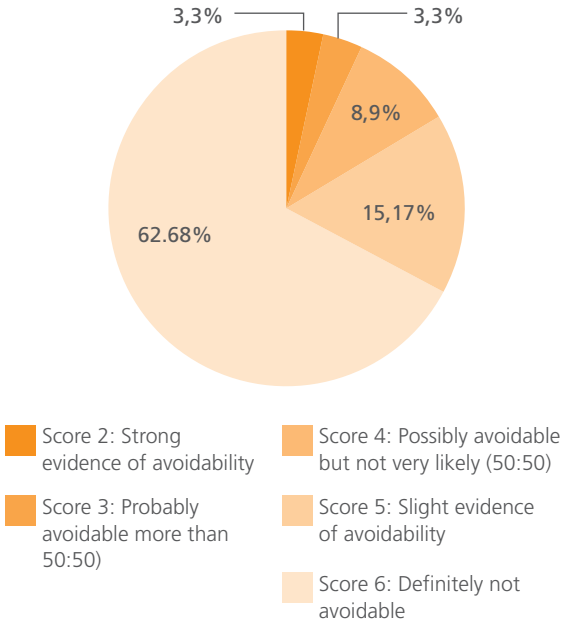



**Figure 3**
**LDH - Assigned avoidability scores for completed SJRs (no.96)**

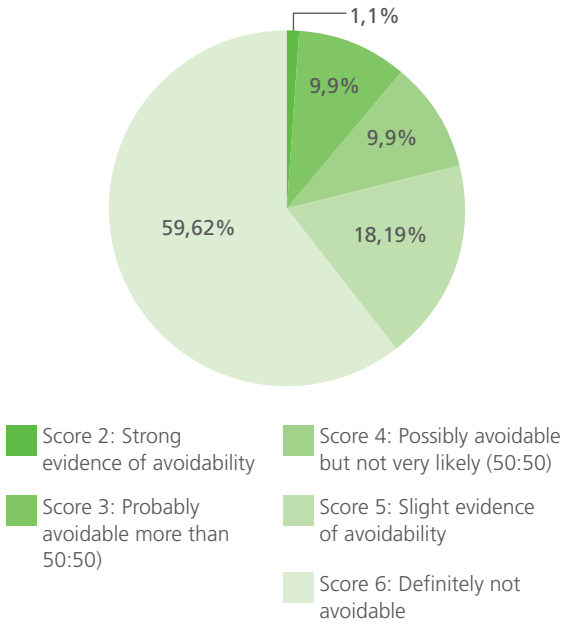
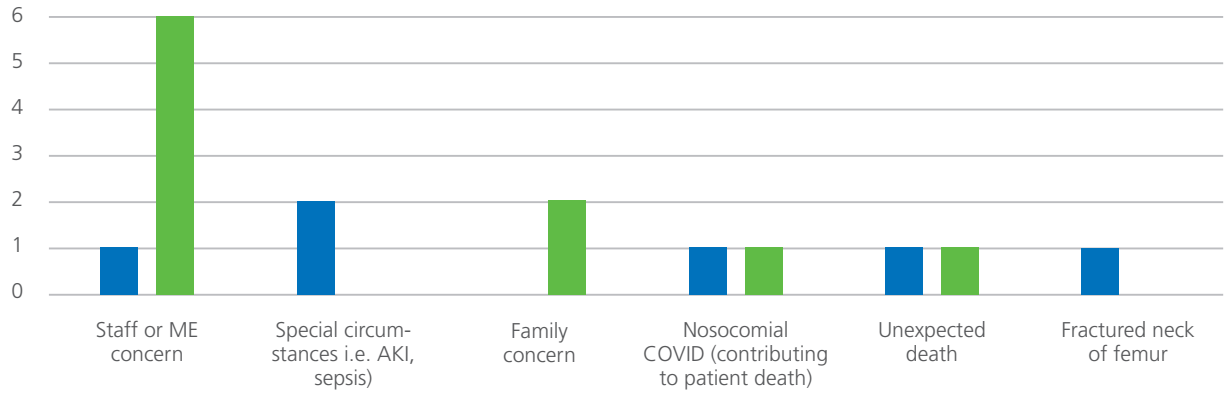



**Figure 4 illustrates the reason for referral for SJR for the 16 cases assigned an avoidability score of 2 and 3.**



### 4.1 Summary learning from SJRs

All completed SJRs are reviewed and approved by the Medical Director and following assignment of an avoidability judgment score of 2 or 3, cases are referred for Post Event Action Review and Learning (PEARL) panel discussion.

The SJR informs this process and, to date, for three cases, a Serious Incident (SI) has been declared and for a further three cases the recommendation was for an After Action Review (AAR). The Patient Safety Incident Response Framework (PSIRF) will replace the current Serious Incident Framework with implementation planned during 2023/24.

**4.1.1 Of the 16 cases with an avoidability scores of 2 (no.4), and 3 (no.12) the following key learning was identified and shared with the clinical teams:**

Phase of Care: Admission and initial management
The need for timely review and documentation of investigation findings.

Phase of Care: Ongoing care
Importance of giving full consideration of the benefits and risks when requesting investigations in patients with impaired renal function.

Consideration of urgent laparoscopy in patients with persistent systemic inflammation, despite broad spectrum antibiotics and unclear intra-abdominal pathology.

Importance of including daily review of all medications prescribed including those placed 'on hold' as part of the daily ward round.

Optimising timely discharge and mitigating delays, in respect of the risk of acquiring a nosocomial infection.

Importance of identifying and managing patients at high risk of falls.
Timely management of sepsis, including fluid resuscitation.

Ensuring optimal management of hepato-renal syndrome.

Timely investigation and correction of severe hyponatraemia and hyperkalaemia.

Phase of Care: Care during a procedure
The need for regular training in managing a major gastrointestinal haemorrhage.

Benefits of simulation training in the management of potential critical post-operative/intervention complications.

Early recognition and intervention of iatrogenic perforation.
Requirement for ease of accessibility and format of clinical protocols.

Phase of Care: End of life care
Timely communication with patients and their families regarding hospital admission avoidance and providing supportive care in a patient's usual place of residence.

Give greater consideration of the appropriateness of requesting investigations in the context of above.

**4.1.2 In addition to problems in care areas of good and excellent practice were also highlighted:**
Phase of Care: Admission and initial management
Timely and thorough assessment and initial management, including investigation requests and antibiotic prescribing.

Phase of Care: Ongoing care
Response to deterioration in condition, frequent updates provided to family.

Multi-disciplinary Team (MDT) involvement and timely specialist review sought

Phase of Care: Perioperative care:
Comprehensive and timely assessment including assessment of risk.

Appropriate antibiotic and anticoagulant prescribing.

End of life care
Timely decision making including DNACPR and ceilings of care, with involvement and documentation of discussion with the family.

## 5.0 2021/22 update

The following section provides an update on the previous reporting period (2021/22)

**Table 4: Number of primary reviews and SJRs completed for the previous reporting period (2021/22)**

| | Total no. Deaths (2021/22) | Primary reviews completed | SJRs completed |
|---|---|---|---|
| Bedfordshire Hospitals | 2196 | 1884 | 283 |
| Bedford Hospital | 998 | 562 | 101 |
| Luton and Dunstable Hospital | 1198 | 1322 | 182 |

Figures 5 - 7 illustrate the assigned avoidability scores for all SJRs completed in 2021/22 by Trust and hospital site

**Figure 5**
**BHT- Assigned avoidability score for completed SJRs (no.283)**

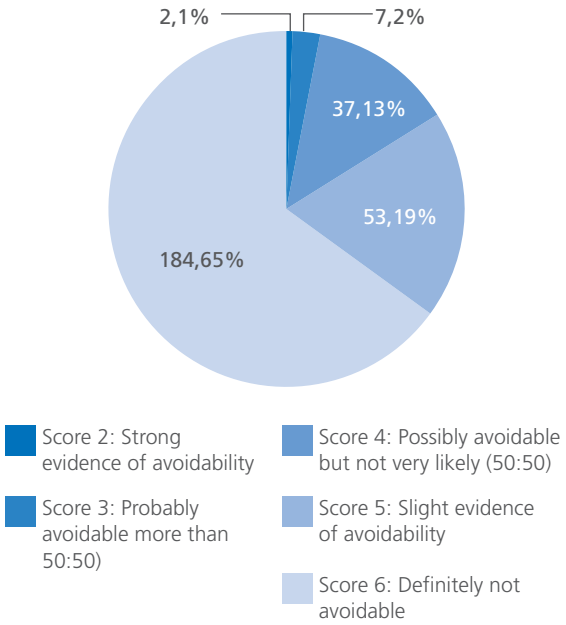



**Figure 6**
**BH - Assigned avoidability score for completed SJRs (no.101)**

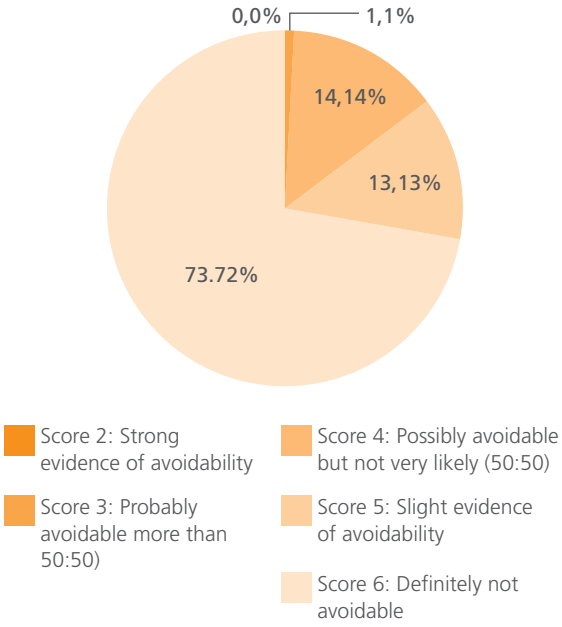
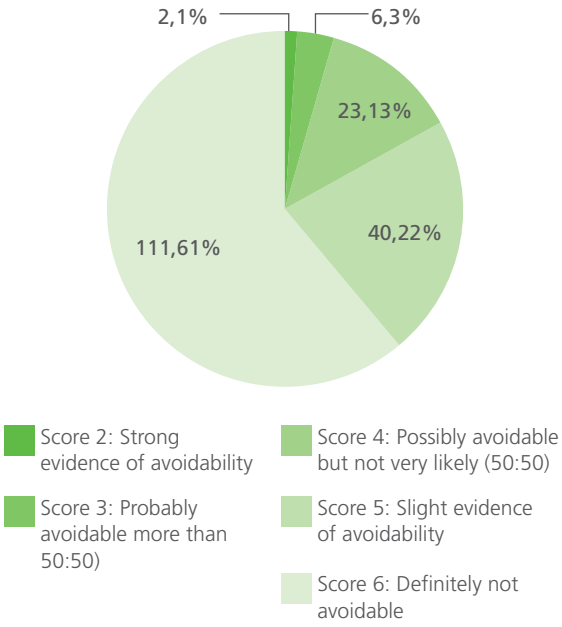



**Figure 7 LDH - Assigned avoidability score for completed SJRs (no.182)**




Following a data refresh for 2021/22 there were 9/283 completed SJRs assigned an avoidability score of 2 or 3, this represents 0.4% of all deaths (9/2196) 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.

6.0 Learning from Deaths - 2023/24 key priorities
Ensure mortality governance is embedded across clinical service lines, including identifying the impact of learning from deaths and resultant quality improvements. This needs to be integrated into the Trust's wider governance learning and sharing strategies. In addition, it should include engagement and involvement of all those affected.

Ensure learning from deaths and the mortality review process is aligned with the key aims of the PSIRF. This includes adopting a system based approach to learning and responding proportionately to balance learning and improvement work.

## 3.12 Freedom to Speak Up (FTSU) and Guardian

Freedom to Speak Up (FTSU) Guardian Quality Report 2022/2023
This report provides an overview of the FTSU activity that took place for the first three quarters of 2022/23 across the Luton & Bedford sites to deliver our Freedom to Speak Up. It includes actions taken to improve speaking up at Bedfordshire Hospitals, an assessment of the number and themes of concerns raised, learnings and priorities for 2023/24.

Background - Raising concerns and FTSU
Freedom to Speak Up in the NHS arose from the tragedies of Mid-Staffs where an atmosphere of fear and futility pervaded. As Sir Robert Frances QC identified in his enquiry, fear about the consequences of speaking up and lack of confidence that concerns would be addressed were deep seated issues in the NHS

The standard NHS contract requires that all trusts and foundation trusts employ a FTSU Guardian. FTSU Guardians are now employed across the health and social care sector including in primary care, health charities, independent providers and health regulators.

The trust has two Guardians: Lana Haslam at the Bedford site and Clive Underwood at the Luton site. They are supported by a network of six FTSU champions on 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 give. 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, we have 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
The purpose of this report is to provide the Board with an overview of the work of the FTSU Guardians, including contacts made and cases opened in the period April 2022-Dec 2022 covering quarters 1 (April-June), 2 (July- Sept and Q3 (Oct-Dec). A more detailed report (split by site) outlines actions the Trust is taking to support a positive speaking up culture in the trust and other demographics relating to the types of cases raised, staff groups raising them and those feeling they may suffer detriment.
There are a number of issues raised by trust staff to either the Guardians or Champions that simply require sign-posting and usually resolved informally. Cases are opened when matters are a bit more complex and requires further action and investigation. Through the signposting process, some cases proceed to formal complaints or being raised through an HR process.

Summary

| Quarter | Concerns raised | Reason for concern | | | | |
|---|---|---|---|---|---|---|
| | | Attitude & behavior | Staff quality and Safety | Patient Quality and safety | Policies & procedures | Other |
| Q1 | 19 | 6 | 9 | 4 | 0 | 0 |
| Q2 | 17 | 6 | 8 | 1 | 2 | 0 |
| Q3 | 25 | 14 | 10 | 0 | 1 | 0 |
| Q4 | 23 | 13 | 7 | 3 | 0 | 0 |
| **Total** | **84** | **39** | **34** | **8** | **3** | **0** |

### Assessment of Cases

The themes and nature of concerns raised continues to be more about matters that concern staff wellbeing rather than patient safety. The extreme operational and national pressures continue to test the resilience of staff on both sites and the majority of concerns are about attitudes and behaviours, often caused by misunderstandings, perceived incivility or poor communications. It is sometimes perceived that staff on one site are treated more favourably than the other. The continued harmonisation of HR policies will help provide more clarity and support when seeking support and guidance.

### Learning and Improvement

From our monthly meeting is key trust stakeholders in discussion of cases/themes and trends, the key learning for 2022/23 were:

- Managers need to be visible to their teams, be open to listening to issues and communicate where action can and cannot be taken
- Managers should hold regular team meetings to ensure staff are aware of local changes and issues, as well as wider Service Line and Trust-wide changes that may affect them.
- Managers must apply policies fairly and consistently
- There is a feeling of inequity and sense of disgruntlement across the two sites regarding the consistently of policies. The revamping of policies to apply cross-site might go some away in remedying this.
- New roles need to be promoted widely to ensure fair access to opportunities as these arise.
- Improved communications about how decisions are taken which affect groups or f staff differently and the rationale behind these decisions. This is to ensure that staff do not feel they are treated differently

### Reporting mechanisms and accountability

### National picture

The National FTSU Guardian requires data to be reported quarterly through a Speak Up data portal. From this emerges 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 suffer detriment if they raised a concern.

As a comparison with our own data,

- 6,677 speak up cases were raised with guardians in Q3 2022/23 according to the figures reported to the NGO; a 15.2% increase in the number of cases reported compared to the previous quarter and a 17.8% increase compared to the same quarter last year.
- Approximately a third of cases (29.0%) included an element of inappropriate behaviours and attitudes (other than bullying and harassment) and over a quarter of cases (27.3%) included an element of worker safety or wellbeing.
- Almost 1 in every 20 cases reported to Guardians are from workers indicating that they have suffered detriment after speaking up.

### 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

### 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 OD. Gordon Johns (Non-Exec Director) is the named FTSU Board Lead who the Guardians contact for support and updates.

There are monthly meetings between the Guardians, the HR Director and the Director of OD. The Guardians find this particularly useful to talk through concerns, review cases raised, themes and lessons learned and debrief where necessary. There have been numerous collaborations between HR, OD, FTSU and Network groups to resolve issues raised by the Speak Up route.

The Guardians continue to work closely with our Organisational Development/HR colleagues to try to resolve staff concerns about behaviours appropriately and sensitively. The objective is to achieve a respectful resolution that arise whenever possible. GMs, HR Business partners and Senior Nurses have involved Guardians and Champions in listening events with staff in affected areas as 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 recently attended an away day to ensure consistency of approach. The Guardians are advocating for a quarterly 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 (and how this can be replicated in areas with similar issues).

### Externally

Guardians are supported by the National FTSU Guardian, who provide initial and top-up training for Guardians, mentorship, Guardian 1:1's The Two Guardians the National Conference in March the National Guardian's Office brings together Freedom to Speak Up guardians and leaders throughout healthcare for a conference exploring how we can make speaking up business as usual. This conference is an opportunity to:

- Explore ways to remove the barriers to speaking up – fear and futility
- Hear from leaders about what Freedom to Speak Up means to them and why it is essential to effective organisations.
- Bring together the Freedom to Speak Up network virtually and in-person for networking and learning.

### Trust induction

The two trust Guardians attend a number of trust induction events including Junior Drs Induction, MDT Preceptorship, speaking to different Year groups on the various undergraduate/post-Graduate Nursing programme to introduce staff to the FTSU process.

### Trust events

October was Speak Up month with a publicity campaign in trust communications, a new FTSU Guardian video, FTSU stalls and events across the trust and a relaunching of the FTSU brochure for staff.

In the December, Event in the tent, which focussed on staff support and wellbeing, 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.

### 2022 Staff Survey- links to FTSU

We have only just received the results of the 2022 Staff Survey and are analysing the results and specific comments pertaining to Speaking Up. Questions 19a and 19b and 23e and 23f refer specifically to Speaking up. Initial observation is that we are tracking near average in comparison to other NHS organisations and this shows there is still work to do across the organisation. We are looking at ways to reassure staff that Speaking Up is positively encouraged, that it should be 'Business as Usual' and this will be emphasised when communicating the Staff Survey results across the trust.

**The specific questions asked are as follows:**

**People Promise elements and theme results: We each have a voice that counts: Raising concerns**

Q19a I would feel secure raising concerns about unsafe clinical practice?

Q19b I am confident that my organisation would address my concern.

Q23e I feel safe to speak up about anything that concerns me in this organisation.

Q23f If I spoke up about something that concerned me, I am confident my organisation would address my concern.

Initial observation is that we are tracking near average in comparison to other NHS organisations and this shows there is still work to do across the organisation.

The results will be analysed with help from the OD team and translate actions needed over the next 12 months.

## CQC Inspection Visit

The Guardians were interviewed during last year's CQC Inspection visit and this provided an opportunity for Speaking Up and the culture within the trust to be considered under the Well-Led domain. There were no concerns raised in the trust Report.

## Actions taken to improve Speaking Up

### Increased resources to hear concerns and raise awareness

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 placed in the Staff Support/FTSU Guardian section of the trust intranet.

So far one new champion has been recruited with at least three more in the process of applying and being interviewed for the role.

### Promoting the Speak Up role

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 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.

## Actions for 2023/24

### Introduction of Training for all workers

The National Guardian Office and Health education England launched a national training programme for all NHS workers in 2021 comprising of three modules: Speak Up (for all staff), Listen Up (for managers) and Follow-up (for leaders- introduced in 2022).
The training modules are informally available for staff but as a starting point and as a commitment from Bedfordshire Hospitals to make Speaking Up Business as usual, We are seeking to make the first module mandatory for all trust in the trust.

We are seeking ways to make the Listen Up module a necessary part of Induction for new Managers. How managers already in post have access to training needs further consideration.

Some senior leaders in the organisation have already completed the 'Follow-Up' module

### Improving our Communications strategy

A lot of good work has been done as a result of staff speaking up and actions taken. However, not all staff are convinced that speaking up makes a difference (particularly if actions taken have come through an Employee relations route and they may never know the outcome. The Guardians intend to use various communication methods (e.g. weekly Team Beds News etc.) to promote the Speaking Up and give staff a flavour the difference speaking up makes for patients, individuals, teams and Departments.

### Shared Learning and closer collaboration with trust colleagues

There will be quarterly meetings between the FTSU Guardians, Staffside Leads, Network Leads, Guardian for Safe Working hours, Directors of HR and OD to discuss the types of issues being raised as a result of speaking up, trends, themes, lessons learned and shared learning, and collaborative working for early and respectful resolution

### Identifying Barriers to Speaking Up- filling the gaps

The two main barriers for staff speaking up are fear and futility. According to Dr Jayne Chidgey-Clarke, the National Freedom to Speak Up Guardian, the silence of missing voices costs careers, relationships and lives. She suggests asking;

- Where is the silence of missing voices in our organisation?
- Are we listening to/for the silence?
- How can we reduce the barriers present?

It's become apparent that one of the areas that could receive more support in speaking up are the large overseas nurse community that work at Bedfordshire Hospitals- both new staff and those who have been here for many years. We will be working with the Overseas Nurse team and Senior Nurses to target the support needed.

The Guardians have pledged to role-model to the rest of the organisation what brave leaders must do when a member of staff speaks up or raises a concern.
A brave leader says:

- Thank you
- I hear you
- I see you
- I don't have all the answers but I will keep exploring and fact finding until we find clarity to try our best to remedy the situation.

**Authors - Clive Underwood & Lana Haslam - Freedom to Speak Up Guardians- Bedfordshire Hospitals. March 2023**

## 3.13 Guardian of Safer Working Hours 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 Safer Working Hours 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

## Bedford site

The following exceptions (150) were reported for April 2021 to March 2022. *

| | |
|---|---|
| Number related to patient safety | 20 |
| Number related to hours of working | 133 |
| Number related to pattern of work | 4 |
| Number related to educational activities | 2 |
| Number relating to service support available to the doctor | 11 |

These were spread across specialities as follows*

| | |
|---|---|
| Medicine | 35 |
| Surgery | 48 |
| Vascular Services | 9 |
| Obstetrics and Gynaecology | 5 |
| Paediatrics | 12 |
| Trauma and Orthopaedics | 8 |
| Geriatric Medicine | 1 |

## Luton and Dunstable hospital site

The following exceptions (434) were reported for April 2022 to March 2023. *

| | |
|---|---|
| Number related to Immediate patient safety | 10 |
| Number related to hours of working/pattern of work | 458 |
| Number related to educational activities | 1 |
| Number relating to service support available to the doctor | 5 |
| Number related to missed break | 6 |
| Number related to missed surgical opportunities | 4 |

These were spread across specialities as follows*

| | |
|---|---|
| Medicine | 259 |
| Surgery | 53 |
| Paediatrics | 13 |
| Emergency Department | 4 |
| Obstetrics and Gynaecology | 21 |
| Ophthalmology | 40 |
| Trauma & Orthopaedics | 0 |
| Ear, nose and throat | 7 |
| Urology | 0 |
| Neonatal medicine | 0 |
| Oral and Maxillofacial surgery | 0 |
| GP | 23 |

*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.

# Review of Quality Performance

## 3.14 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 2022 or 2022/23 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 | National Average |
|---|---|---|---|---|---|---|---|---|
| Number of hospital acquired MRSA Bacteraemia cases (n) | Patient Safety Trust Board Reports (DH criteria) | 1 | 1 | 2 | 2 | 1 | 6 | N/A |
| Hospital Standardised Mortality Ratio* (n) | Patient Safety<br><br>CHKS* | 105.1* | 102.3 | 97.94 | 111.18 | 101.99 | 107.37 | 100 |
| Number of hospital acquired C.difficile cases (n) | Patient Safety Trust Board Reports | 9 | 5 | 42^ | 51^ | 64 | 76 | N/A |
| Incidence of hospital acquired grade 3 or 4 pressure ulcers | Patient Safety<br><br>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<br><br>Trust Internal Report | 5 | 5 | 1 | 2 L&D | 0 | 2 | N/A |
| Cardiac arrest rate per 1000 admissions | Patient Safety<br><br>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<br><br>Trust Patient Administration Information Systems | 3.2 days | 3.0 days | 3.1 days | 3.3 days | 3.9 days | 3.9 days | N/A |
| Rate of falls per 1000 bed days for all patients<br><br>Rate of falls per 1000 bed days for 16+ no maternity*** | Clinical Effectiveness<br><br>Trust Board Report | 3.97<br><br>4.73*** | 4.08<br><br>4.89*** | 4.0<br><br>4.78 | 5.04<br><br>6.32 | Data unavailable | 3.3<br><br>3.94 | <br><br>6.63 |
| % of stroke patients spending 90% of their inpatient stay on the stroke unit | Clinical Effectiveness<br><br>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) | Target of 80% |

| 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 | National Average |
|---|---|---|---|---|---|---|---|---|
| % of fractured neck of femur to theatre in 36hrs [to end Feb '21] | Clinical Effectiveness<br><br>CHKS**** | 76% | 71.3% | 79.8% | 80% LDH<br>40% BH | Data awaited | Data awaited | 69% |
| In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n) | Clinical Effectiveness<br><br>CHKS**** | 50.8* | 63.16* | 67.82 | 94.71 | 80.82 | 78.26 | 100 |
| In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n) | Clinical Effectiveness<br><br>CHKS**** | 100.3* | 76.5* | 74.91 | 69.91 | 96.33 | 120.80 | 100 |
| Readmission rates*: Knee Replacements Trauma and Orthopaedics | Clinical Effectiveness<br><br>CHKS**** | 7.00%* | 5.8% | 6.6% | 6.3% | 5.7% | 6.45% | unavailable |
| % Caesarean Section rates | Patient Experience<br><br>Obstetric dashboard | 31.2% | 31.3%% | 33.09% | 35.4% | 33..2% | 39.8% | 25% |
| Patients who felt that they were treated with respect and dignity** | Patient Experience<br><br>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<br><br>Complaints data and coded discharges | 5.50 | 4.70 | 4.31 | 5.1 | 5.4<br><br>436 - LDH | LDH = 4.6<br>BHT = 4.6<br><br>Trust = 4.6 | Unavailable |
| Patients disturbed at night by staff (n) | Patient Experience<br><br>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<br><br>Audit reported on Board Quality Report | Achieved >95% | Achieved >95% | >95% | 96.5%^^ | 98.4% | 97.8% | 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.

## 3.15 Complaints and Patient Advice and Liaison Service (PALS)

The organisations mandate is to have a robust process that ensures complaints are treated seriously. It is fundamentally important that we listen to what people that use our services tell us, so that we are able to draw some learning therefore implementing positive changes.

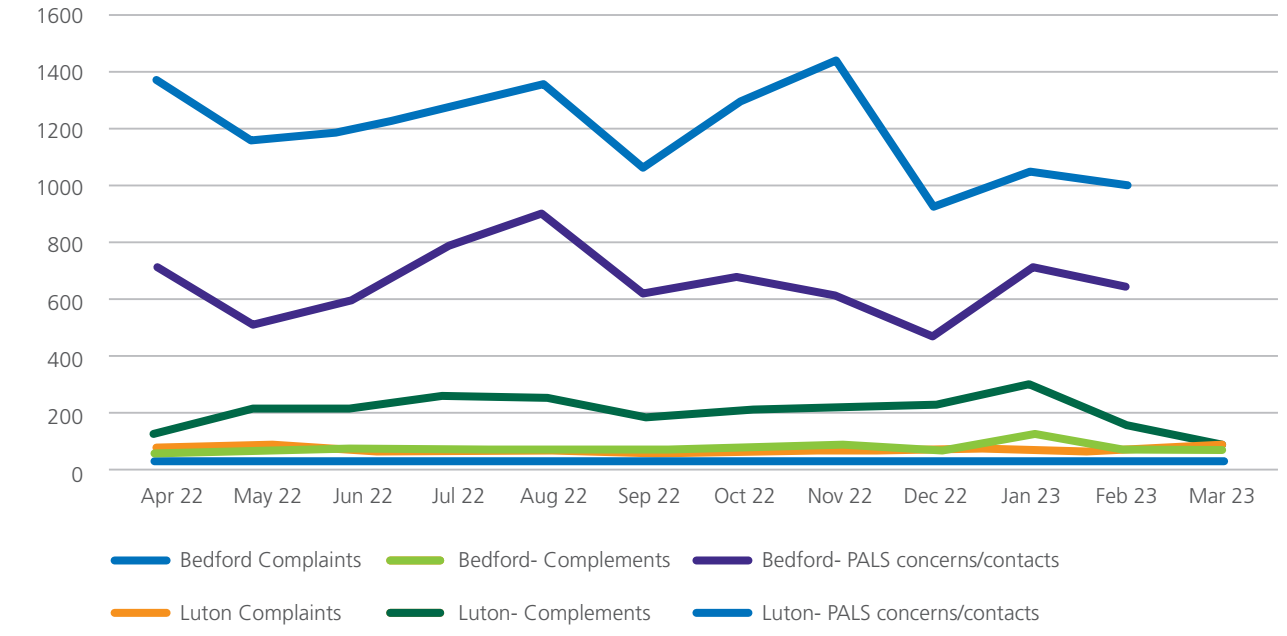
The Trust maintained site-specific teams to deal with complaints and PALS issues. This has enabled the team to focus on providing real time support to patients, families, carers and visitors dealing with issues promptly.
Due to ongoing operational and NHS pressures, the complaints team endeavoured to respond to complaints within the agreed period of 45 working days. The team maintained a complaints tracker, reviewed fortnightly with clinical teams to monitor progress or identify were additional support is required.

The recruitment of a senior complaints officer enabled collaborative working in completing thematic analysis on the learning aspects from complaints The learning aspects shared via the standard governance process aligned to clinical service lines, ensured that learning from complaints focused on quality improvement initiatives. Greater emphasis on learning and service improvement initiatives to improve services provide a framework for delivering best practice.

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.

An increase in demand to support face-to-face contacts with rapid resolutions within the PALS team avoided the need to escalate to formal complaints. Chart 1 below provides the complaints and PALS data

**Luton and Bedford Data**



## Learning from Complaints

Clinical Treatment remains the top theme for complaints followed by communication, patient care, values and behaviours and privacy and dignity.
The majority of complaints were resolved at local level, however, there are four complaints referred to the PHSO from Luton in Q 4 currently open and under investigation and two from Bedford.

Below are some examples of some of the learning and improvements made:

### Case Study 1: Repatriation and medication reconciliation

A patient transferred from a tertiary centre for ongoing care missed dose of medication on critical medicine list. There were issues with communication and handover information about the patient's medication. The admitting team missed prescribing the patient his medication, the pharmacy reconciliation did not pick this up, and as a result, the patient missed his medication, which is on the critical list of medicines.

This complaint resulted in a multidisciplinary approach reviewing the process of admitting patients repatriated from another hospital. The teams involved included Pharmacy, Patient Safety, Medical, Nursing and Patient Experience.

This complaint resulted in system changes where medication on critical medication list are prescribed, administered, with pharmacy reconciliation completed on admission. Further work has continued in relation to training and education for staff in recognising and escalating issues early in order to prevent delays in administration.

### Case Study 2: Acute delirium and Dementia

The son of a patient admitted with acute delirium and managed on a geriatric ward resulted in assumptions being made about his diagnosis because his behaviours were consistent with behaviours normally seen in patients with Dementia. The patient's son attempted to inform the staff that his father did not have dementia but he felt he was not listened to. This led to communication breakdown between the clinical teams and the son.

Learning from this incident result in the clinical teams take an approach where they developed a training package, booked all their staff on this training in order to give them evidence based learning.

### Case study 3: Communication

Patient complained about the care she received on the ward especially in regards to one of the night health care assistant. She overhead the nurse talking about her during hand over which was held in the corridor. The patient challenged the staff advising them it was wrong for them to discuss her care and handover in the corridor. The patient was upset by the experience they decided to self-discharge. She pressed the call bell for someone to take out her cannula, but no one came so she removed it herself.

The ward manager apologised for the distress caused and that it had resulted in her to leave the hospital unexpectedly without completing her treatment. The sister met with the staff members involved and had an extensive conversation about the incident. The manager shared the incident with the team as part of learning and preventing reoccurrence. It was unfortunate that she felt the need to remove the cannula device herself, staff are trained to perform such tasks. The manager apologised that help was not given as promptly as needed and lessons had been learnt.

### Compliments

The Trust maintained a log of complement received via a combination of feedback from patients, staff, and clinical service lines. The Trust site received 3267 compliments as per chart 1 above.

Below are some examples of compliments received:

### Maxillofacial department

*My father was recently urgently referred to the Maxillofacial department at the L&D hospital by his dentist following a routine examination. Having been diagnosed with cancer a short while ago we were surprised how quickly the appointment came through, especially as the junior doctors were on strike. He was seen by a more senior specialist, Mr A, who was thorough, respectful and standing in for the striking staff. After examining his mouth, he made an appointment the next day for a biopsy. Times are a bit fragile at the moment and I cannot thank Mr A, and the staff in the Maxillofacial department, for their professionalism and compassion shown towards my Dad. A pure example of how the NHS works beyond their job description, I have nothing but thanks and appreciation.*

ENT

*I had an appointment with the ENT department on the 16th of March 2023.*

*With Dr B. I just want to pass on how helpful his was. A good ambassador for your hospital. I was very pleased with my appointment.*

Midwifery

*Following the recent birth of my daughter, I would like to offer my sincere thanks and appreciation to all of the midwives and other staff in the Midwife Led Birth Unit. Other than having to wait longer than seemed appropriate for assessment on Ward 31 when I first arrived, I really cannot fault the treatment I received. Particular acknowledgment should go to midwife S (surname unknown), the midwife who was responsible for my delivery. She had an incredibly calming demeanour, had clearly read my birth plan and was very respectful of it, to the extent that she raised items I had forgotten that I had included in it! As a result, my daughter was delivered very quickly, with no complications or intervention and we were able to go home the same day. I was very surprised when midwife S told me after the birth that she was only recently qualified and that this was the first water birth she had done – she seemed to be so much more experienced and confident than her level of qualification would imply.*

*My only constructive feedback is that when another midwife came into the room, presumably to give midwife S any guidance she may need, they were conferring very quietly, which was appreciated in one respect but had the effect of making me worry that something may be wrong. In future, it may be helpful to explain earlier on that colleagues may come in for support but that it is nothing to be concerned about. Otherwise, I can only repeat my thanks to this wonderful team!*

*I would also like to express my thanks to all of the members of the Early Pregnancy team, who provided me with outstanding care and support when I was really suffering with hyperemesis.*

Pre Op Assessment

*I have today been for my Pre Op Assessment in the surgical block.*
*The nurse I saw was called C I believe. I just wanted to say she is such an asset to your team. She was very nice and made me feel at ease when I was told I had to have a blood test (which I hate). She made me laugh so much. She is definitely a people person, and just what you need there. Please pass onto her manager.*

Cardiology secretaries

*Good afternoon,*
*I just wanted to say how wonderful C is, whenever I have a cardiology situation and an anxious patient, she is calm, efficient and friendly, an absolute star! I know a lot of people are quick to complain about people, so I thought I would pass on my gratitude!*

*We have an anxious bariatric patient on the surgical pathway, who needed an echo coordinated with her bariatric appointment, which I was worried would be too short notice, but C has sorted this quickly and efficiently, and the patient is chuffed to bits! She makes me look efficient too, which is a bonus!*

*I have already thanked her for her support, and thought you should be aware of the excellence she provides!*

## 3.16 Friends and Family Test

Bedfordshire Hospitals NHS Foundation Trust in year 2022-2023 continued to collect patient feedback using Friends and Family Test (FFT) survey. This is a national programme used to gather patient feedback.

We continued to use iPads and QR in all departments to enable the collection of patient feedback. QR codes are also now available on patient information leaflets and outpatient letters. FFT texting service for Emergency Department (ED) is active, Maternity are considering at using this service.

Areas within the Trust feedback is collected from are

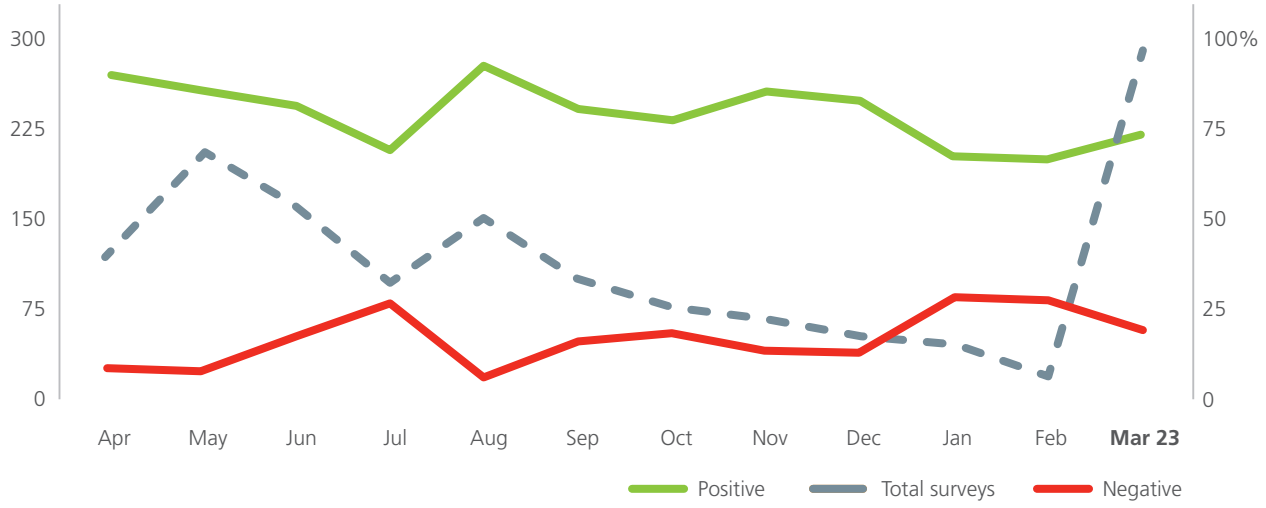
- Emergency Department (ED) and Acute Services
- Women's and Children services
- Inpatient Services
- Outpatient Services

The Patient Experience Team (PET) provide monthly reports to the 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).

Patient Stories continue to be a valued source of feedback, the PET share these with the Quality Committee quarterly.

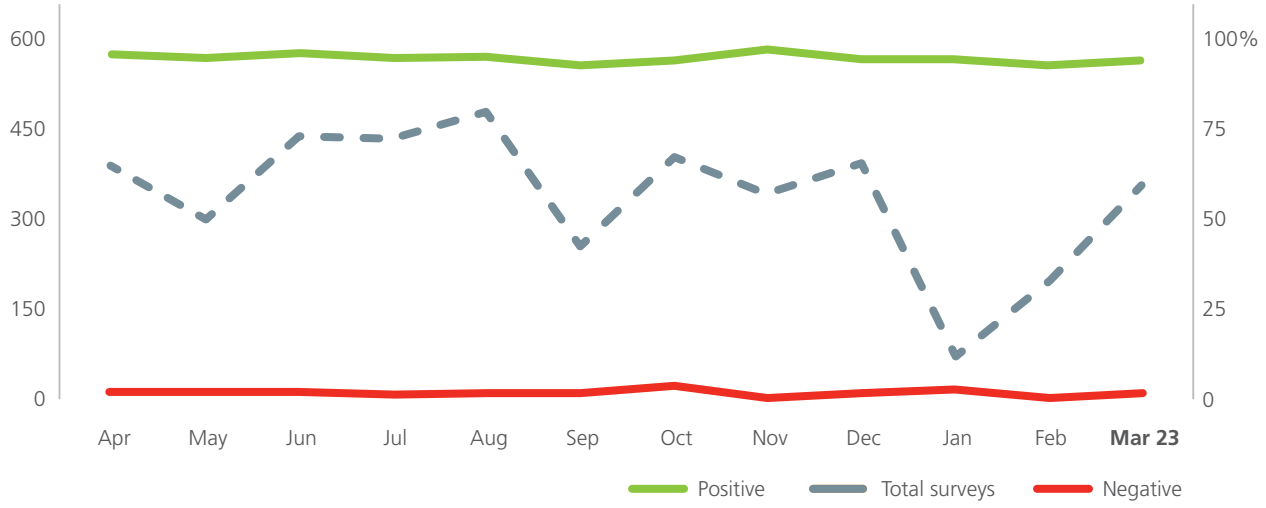
Emergency Department Trust wide FFT results April 2022- March 2023

**FFT ED - Positive vs Negative (3 Trends)**

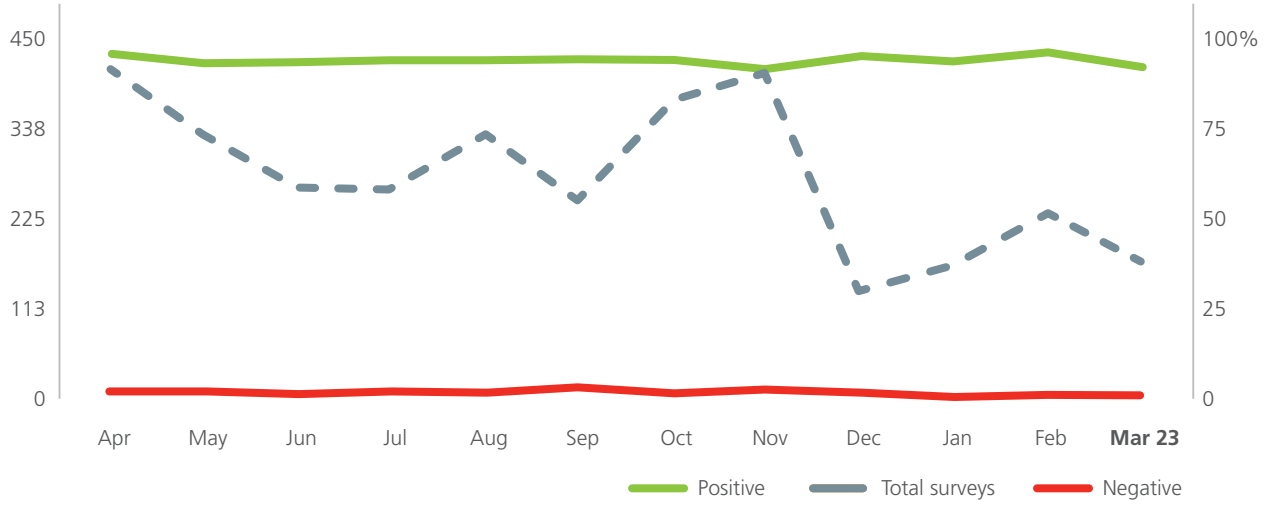



Women's and Children Services Trust wide FFT results April 2022- March 2023

**FFT Maternity - Pos vs Neg (3 Trends)**

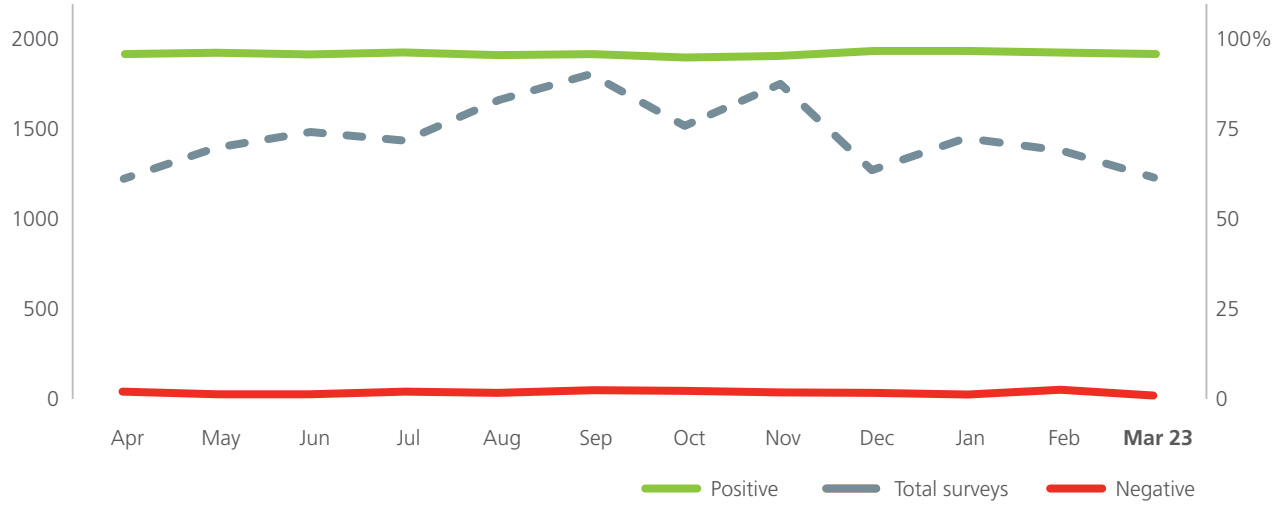



**FFT Paeds - Pos vs Neg (3 Trends)**



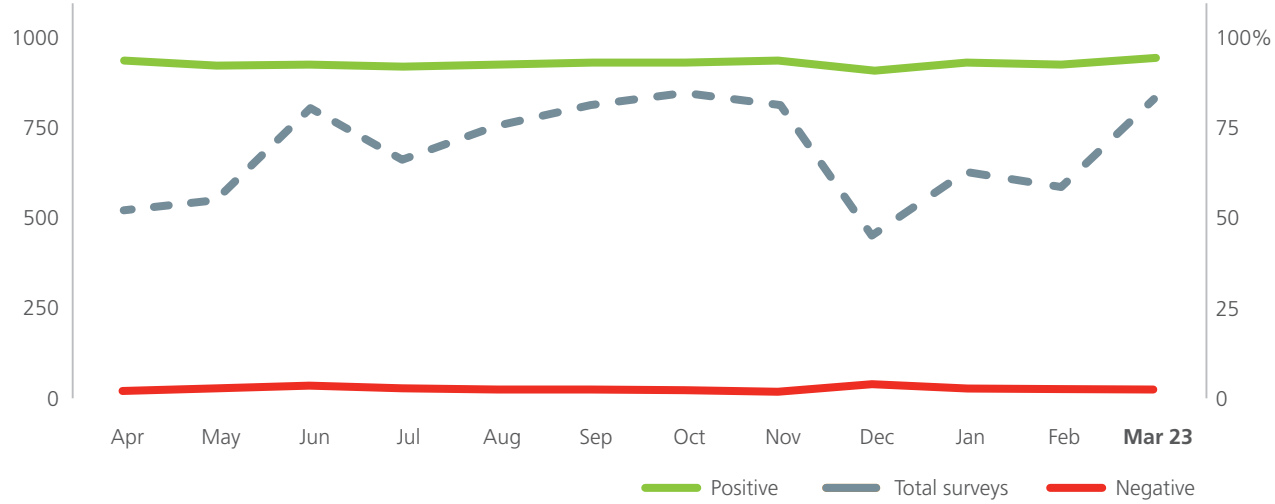
Inpatient Services Trust wide FFT results April 2022- March 2023

**FFT IP - Positive vs Negative (3 Trends)**




Outpatient Services Trust wide FFT results April 2022- March 2023

**FFT OP - Positive vs Negative (3 Trends)**




## 3.17 National Surveys CQC

The Trust undertakes five national surveys, one on alternate years and four annually from April 2022- March 2023: The service lines covered are:

- Adult inpatient Services
- Urgent and Emergency services
- Maternity Services
- Stroke Services
- Cancer services
- Children and Young People (alternate years)

The response rate from the November 2021 adult inpatient survey was 34% a decrease from 38% from the previous year November 2020.

The Trust performed worst for the questions:

- Did you get help from staff to keep in touch with your family and friends?
- Did you have confidence and trust in the Drs treating you?

As part of a quality improvement initiative, an interim in-house survey took place following the publication of the November 2021 inpatient survey in October 2022. This was to understand the Trusts response and position. The

focus will give us reassurance that the work completed for example change in visiting guidance to allow visitors is providing positive experience for our patients. The survey is ongoing, reviewed monthly with a summary provided in future.

The response rate from the National CQC Maternity survey from February 2022 was 45%, a decrease from 56% from the previous 2021 survey.

The Trust performed worst for the questions:

- *Did the staff treating and examining you introduce themselves?*
- *Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?*

These questions are included within the current maternity FFT questions to understand the current Trust position. The maternity team will monitor the results and share via governance meetings. The Patient Experience Midwives invaluable work with the senior midwifery team to improve patient experience and outcomes in maternity will continue. Engagement work is ongoing with external stakeholders for example Maternity Voice Partners (MVP).

The Urgent and Emergency Services survey 2022, results are still pending.

The annual Stroke response survey May-September 2022, results still pending.

### Visiting restrictions

Visiting restrictions continued to have a significant impact upon patient services on both sites. Throughout the year exceptional visiting in certain circumstances continued for example for those patients at end of life or with dementia, learning disabilities or complex care needs. Special exceptions were in place in Maternity Unit and Paediatric wards.
Visiting restrictions were adapted according to local Covid-19 prevalence levels and national guidance.

### Patient Experience Strategy and Council

The Patient Experience Strategy focusing on four key drivers:

- Patient and public involvement
- Measuring and monitoring feedback
- Service Improvement
- Delivering a positive patient experience

The key drivers have underpinned the Patient Experience Team work plan, which is a subject of review and the Patient Experience Council meeting. Key internal and external stakeholders attend the meetings ensuring that the quality improvement initiatives deliver on good patient experience and outcomes. The PEC provide assurance to Board that patient experience and feedback forms a core element of quality improvement.

## 3.18 National Staff Survey

The NHS staff survey is conducted annually. The questions are in to nine themes, the seven People Promises plus Staff Engagement and Morale.

The survey ran from the beginning of October to the end November 2022 and was published on 9th March 2023.

The survey was a full on-line staff survey; with paper copies available for those with no digital access, 2,911 surveys were completed. The response rate for Bedford was 41% and L+D was 34% with an overall response rate of 42%. There was a decrease of 5% points in the response rate compared to last year. The national average response rate for our benchmark group was 44%, down by 2% points on the previous year.

### National Results

The indicator scores are based on a score out of 10 for certain 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.

| | 2022 | | 2021 | | Change from 2021 | |
|---|---|---|---|---|---|---|
| | Trust | Benchmark Group | Trust | Benchmark Group | Trust | Benchmark Group |
| We are compassionate and inclusive | 7.1 | 7.2 | 7.1 | 7.2 | = | = |
| We are recognised and rewarded | 5.6 | 5.7 | 5.7 | 5.8 | ▼ | ▼ |
| We each have a voice that counts | 6.6 | 6.6 | 6.6 | 6.7 | = | ▼ |
| We are safe and healthy | 5.9 | 5.9 | 5.9 | 5.9 | = | = |
| We are always learning | 5.3 | 5.4 | 5.2 | 5.2 | ▲ | ▲ |
| We work flexibly | 5.7 | 6.0 | 5.7 | 5.9 | = | ▲ |
| We are a team | 6.6 | 6.6 | 6.5 | 6.6 | ▲ | = |
| Staff engagement | 6.8 | 6.8 | 6.9 | 6.8 | ▼ | = |
| Morale | 5.7 | 5.7 | 5.7 | 5.7 | = | = |

Overall, the results indicate an "average" set of results but there are areas that do highlight some themes of slightly below average comparisons. It should be noted that the Trust overall average score was identical as the national benchmark group on 5 scores, 0.1 below on three themes and 0.3 below on one theme – "we work flexibly"

## Local Analysis

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

- Received an appraisal in the last 12 months
- Team members often meet to discuss the teams' effectiveness
- Immediate manager gives clear feedback
- Involved in deciding changes that affect work
- Immediate manager listens to the challenges I face

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 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 2022 staff survey results based on NHS People Plan indicators.

### People Promise Elements and Themes: Overview

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.


| | 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 | 7.1 | 5.6 | 6.6 | 5.9 | 5.3 | 5.7 | 6.6 | 6.8 | 5.7 |
| Best | 7.7 | 6.4 | 7.1 | 6.4 | 5.9 | 6.6 | 7.1 | 7.3 | 6.3 |
| Average | 7.2 | 5.7 | 6.6 | 5.9 | 5.4 | 6.0 | 6.6 | 6.8 | 5.7 |
| Worst | 6.8 | 5.2 | 6.2 | 5.4 | 4.4 | 5.6 | 6.3 | 6.1 | 5.2 |
| Responses | 2896 | 2901 | 2873 | 2884 | 2792 | 2893 | 2893 | 2902 | 2901 |

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

| | |
|---|---|
| We are compassionate and inclusive | Continued work embedding our values and developing our people including:<br>• THRIVE in action and master classes<br>• Respectful resolution<br>• Career pathways<br>• Reciprocal mentoring |
| We are recognised and rewarded | Staff focus:<br>• Continued monthly staff awards<br>• Twice yearly physical staff engagement events<br>• Long service recognition |
| We have a voice that counts | A listening focus:<br>• Developing our staff networks<br>• "you said, we did"<br>• Speaking up |
| We are safe and healthy | Maintaining our environment:<br>• Programme of health & wellbeing activities<br>• Promotion of internal and external wellbeing services<br>• Cost of living support |
| We are always learning | Review and continuous improvement:<br>• Values led appraisals with higher completion rates<br>• Respectful resolution and giving and receiving feedback<br>• Sharing learning from development to clinical strategies |
| We work flexibly | Playing to our strengths:<br>• Understand the flexible working gap<br>• Campaign to promote flexible working and work life balance |
| We are a team | Linking directly to our values:<br>• Embed THRIVE in action and master classes<br>• Leadership development offers<br>• Sharing staff survey feedback<br>• Team staff survey action plans |

## 3.19 Site Redevelopment

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;

### 1. New Clinical Buildings at the L&D

£150m investment to improve Maternity, Neonatal, Theatres and Critical Care provision, forecast to complete September 24. 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, critical care and 8 new operating theatres.
The Trust entered into contract with Kier in January 22. The project is progressing well with the buildings clearly visible on site. The Project is adding significant social value to the local community. The structure should complete in March 23, with wrapping of the building to take place shortly thereafter. The final year of the Project will see the fitting out of the buildings, ready for anticipated "go live" September 24.

### 2. Energy Centre at the L&D

The Energy Centre will replace 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. This will provide increased resilience across the whole site, delivering a substantial reduction in energy consumption and reduce carbon emissions. The project is currently in the most complex and final phase of commissioning, expected to complete mid-late 2023.

### 3. Emergency Department upgrades

The Trust secured £21m of external funding to upgrade and expand the Emergency Departments (ED) on both hospital sites, in response to the COVID-19 pandemic. Both projects increase capacity, segregate adult and children's pathways and provide socially distant waiting spaces and imaging facilities.

On the L&D site, the project will deliver an expanded and refurbished ED with increased capacity, a new and fully segregated Paediatric ED, a CT scanner located within the

department, additional waiting room capacity, dedicated mental health facilities, and a re-modelled main entrance and patient drop off area.

Handover of the first phase of the internal fit out took place on 23 May 2022, delivering some additional capacity, which has been received well by the Clinical Teams. The next phases of the programme handing over in the Spring of 2023 include a CT scanning facility supporting rapid access to diagnostics for patients, and thus more rapid decision making on care pathways, and,12 additional cubicles. The main entrance will also re-open. This phase will see the greatest patient and staff benefit being realised.

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

### 1. Urgent & Emergency Care Phase 2 (CT)

Phase 1 of the Emergency Department works completed in 2021. The second phase of the project includes a new CT imaging facility within the department to ensure rapid assessment for patients, and the re-provision of staff facilities.

Demolition works are underway on both the ground and first floor. Works are programmed to complete in May 2023. This will complete the urgent and emergency care construction project to support increased capacity and improved patient flow with earlier access to decision-making and care plans.

### 2. Electrical Infrastructure Phase 1

To allow for the planned strategic developments to take place, developing the infrastructure at Bedford Hospital is fundamental, particularly the electrical capacity.
Works are progressing well on site and this part of the Project will complete in May 23. The scheme provides electrical capacity and resilience to part of the hospital site and aligns to the Net Zero Carbon road map.

### 3. Caudwell Outpatients Departments

At the end of 2021, the Trust was awarded funding to support with COVID-19 elective recovery. This funding was used to convert the first and second floors of Cauldwell Centre at Bedford Hospital into additional Outpatient facilities.

The project is now complete; the official opening ceremony took place on 07 October 2022. The project completed on time and on budget to the expected quality.
Benefits are already being seen in terms of patient access.
To mark the official opening HM Lord-Lieutenant of Bedfordshire, Susan Lousada, joined some of our Outpatients staff to cut the ribbon and officially open the new space.

This new modern area offers flexible clinic space for staff, providing them with a much better working environment, and it will offer patients a comfortable waiting area, whilst they wait for their consultation. The expansion includes an additional 34 rooms.

## Other Projects currently underway at Bedford Hospital include;

### 4. Ophthalmology Theatre

Central funding has been secured to develop a new operating facility on the Hospital site in 2023, to increase operating capacity and help to reduce backlogs that developed during COVID.

### 5. Community Diagnostic Centre (CDC)

The Trust plan to develop Gilbert Hitchcock House, a healthcare building on the North Wing Site. The proposal is to provide a community diagnostic facility for the local population. This facility would increase diagnostic capacity and thus access for patients, and ultimately will streamline care pathways and ensure more rapid access to care plans.

## 3.20 Maternity Improvement

### Maternity Quality Improvement Plan (MQIP)

The Maternity Quality Improvement Plan (MQIP) and provides assurance on the ongoing compliance against key maternity quality and safety indicators and initiatives. The MQIP incorporates the requirements and actions requiring completion from the Maternity Self-Assessment Tool, Ockenden, Kirkup and 60 Supportive Steps visits. Furthermore, the plan includes the recommendations and actions to support national best practice from the HSIB National Learning Reports, MBRRACE and Care Quality Commission (CQC).

### CQC Inspection August 2022

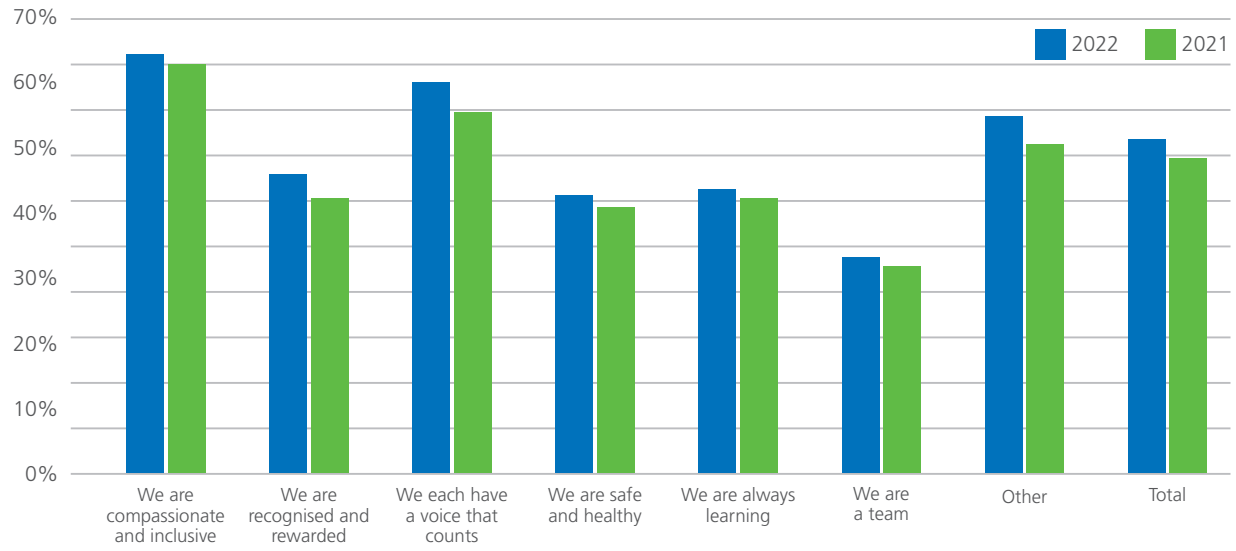
The CQC made an unannounced inspection to Maternity Services on the 2nd and 3rd August 2022. Overall the inspection highlighted that staff were positive about the leadership team and felt well supported and listened to. Positive improvements in the services were recognised and the CQC made some recommendations.

An action plan has been developed to address the inspection findings and is reviewed regularly by the Clinical Directors, Director of Midwifery and Heads of Midwifery in close liaison with the Clinical Leads and Midwives.

### National Staff Satisfaction Survey 2022

The National Staff Satisfaction Survey results were published in April 2023. The chart below presents the results for the Maternity Services for the People Promise element in comparison to 2021.

**National Staff Satisfaction Survey 2022**




Following review of the survey results the triumvirate team and the Heads of Midwifery will be developing plans for culture/morale development. The maternity teams have developed an excellent support package for internationally recruited midwives and a real sense of recognition of the skills that each recruit brings to the team. The team are further exploring a research project to investigate aspects of culture and understand why midwives don't speak out.

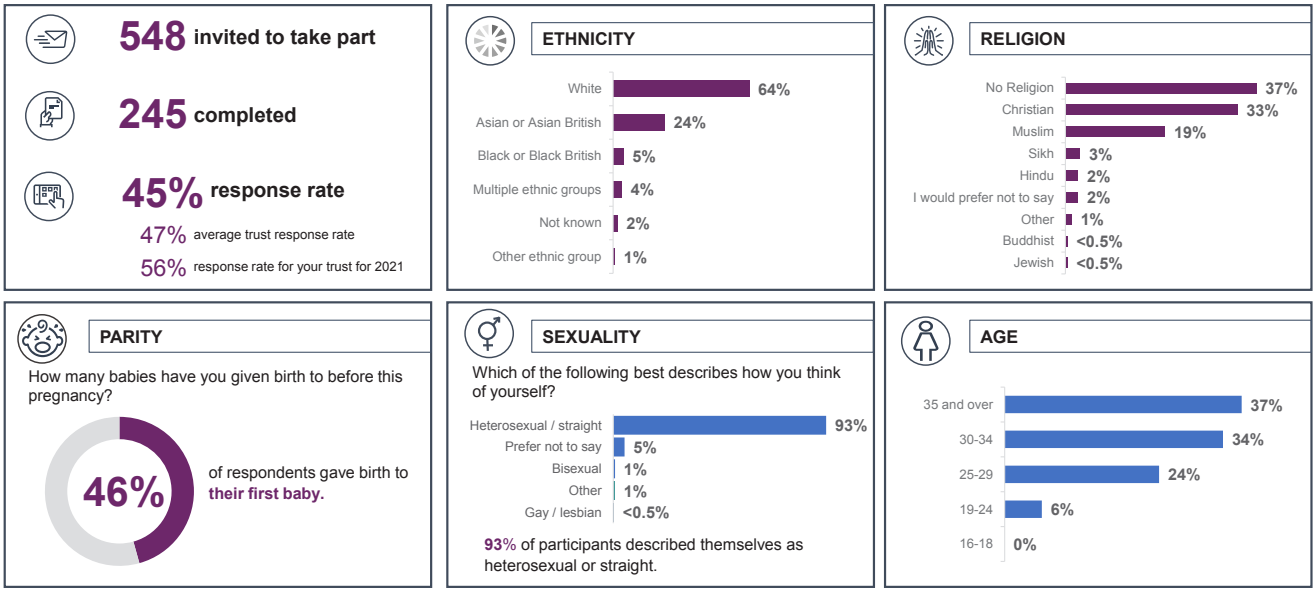
### Maternity and Neonatal Safety Champion Walkabouts

The Board-level Maternity and Neonatal Safety Champion and Non-Executive Director (NED) undertake bi-monthly walkabouts in the maternity and neonatal unit. This provides staff the opportunity to raise any safety issues with the Board-level Maternity and Perinatal Safety Champion and if there are any immediate actions that are required, the Board-level Maternity and Neonatal Safety Champion will address these with the relevant person at the time. Additionally, individuals or groups of staff can raise the issues with the Board champion to support service and quality improvement and ensure patient safety and staff satisfaction. An overview of the feedback from the walkabouts is shared with the staff and there is an action plan to monitor progress on the issues identified. This feedback is also included in the monthly Perinatal Quality Surveillance report which is presented at the Trust Quality Committee.

## CQC Maternity Survey 2022

The 2022 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 April and August 2022. The maternity survey is split into three sections that ask questions about: antenatal care, labour and birth and postnatal care.

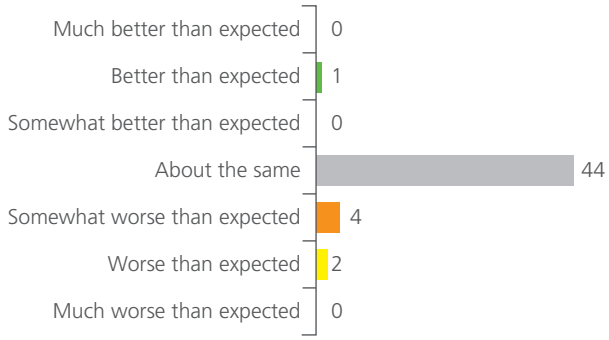
The diagram below summarises the population of mothers who took part in the survey




Overall the Trust scored about the same in comparison to other Trusts in the majority of areas.The charts below show an overview of benchmarking for the Trust

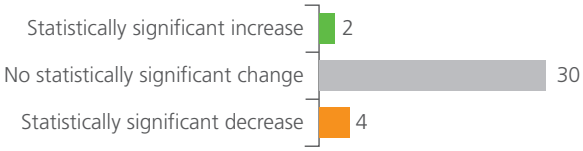
### Comparison with other trusts

The **number of questions** in this report at which your trust has performed better, worse, or about the same compared with most other trusts.




### Comparison with results from 2021

The **number of questions** in this report where your trust showed a statistically signiticant increase, decrease, or no change in scores compared to 2021 results.




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:

- ✔ Mothers being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- ✔ Mothers being spoken to in a way they could understand during theirantenatal care.
- ✔ Midwives or doctors appearing to be aware of the medical history of the mother during labour and birth.
- ✔ Mothers being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
- ✔ At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care.

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:

- Mothers being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- Mothers being spoken to in a way they could understand during theirantenatal care.
- Midwives or doctors appearing to be aware of the medical history of the mother during labour and birth.
- Mothers being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
- At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care.

The Trust's patient experience midwife has been in post since January 2022 and is leading and supporting teams, key partner stakeholders and our users and user representatives in progressing the actions identified from this feedback to support the improvement of the experience of those who use our maternity services.

As part of the development of the new 5 year maternity services strategy Whose Shoes? ® events are taking place In April 2023. This is a transformational way to explore what personalisation really means, and will help us as a Trust to engage peiple through genuine co –production.

## Recruitment Programme for Internationally Educated Midwives

In April 2022 we had a vacancy of 108 WTE Registered midwives across both of our maternity units and there was a high turnover rate of 16- 17%. A detailed workforce plan had been developed by the Director of Midwifery, the maternity team and the Trust recruitment colleagues and this involved the development of a programme to recruit internationally educated midwives to our Trust.

By March 2023 57 midwives have joined our trust and are working in one of our maternity units or are undertaking the comprehensive package to ensure they successfully complete the national OSCE examination and are able to gain full registration in the UK.


We supported two dedicated Clinical Educator posts who created a roadmap which has been revised and updated with feedback from the colleagues who have been on the programme and supported the continued successful outcomes.

While our vacancy rate has reduced significantly we will continue to have a small pipeline of internationally educated midwives as part of our workforce pipeline each year.

Bedfordshire Hospitals NHS FT is now seen as an exemplar for our success in the recruitment and development programme for internationally educated midwives and are helping other trusts through the sharing of approaches and peer support.

## Abigail

I was anxious before my exam, but felt really supported. Our Educators were always there for us and me learning experience was really interactive and hands on, it really boosted my confidence. I have my PIN now and I couldn't be happier I feel safe and confident.

## Raphael

I joined Bedfordshire Hospitals in April '22 and the pastoral support has been excellent and very inclusive. The OSCE preparation helped to improve my confidence and gave me all I needed to pass my exam. It has been a wonderful experience.+

## Khadeeiat

I was worried about the OSCE exam, this exam is known to be the worst nightmare of the migration journey, but I found it the easiest thanks to the unending support, genuine love and motherly care from our educators. Babs and Jodie make it really interesting and not scary at all.

NHS
Bedfordshire Hospitals
NHS Foundation Trust

## Bedford Hospital and Luton & Dunstable University Hospital Maternity Units
## 1 April 2022 to 31 March 2023

We welcomed **7,846** beautiful babies into the world

**136** babies were born at home throughout this time for the L&D and Bedford Hospital

**502** babies were born in the MLBU** at both units

**4,077** boys

**3,769** girls

The average for mothers who began breastfeeding their newborns was **72.1%** at the L&D and **81.41%** at Bedford Hospital

The average IOL rate*** was **28.8%** at the L&D and **30.07%** at Bedford Hospital

Throughout this time, there were:

- **3,701** vaginal births at the L&D and Bedford Hospital
- **925** assisted births at the L&D and Bedford Hospital
- **3,187** caesarean births at the L&D and Bedford Hospital

**81** sets of twins and **3** sets of triplets were born at the L&D and **37** sets of twins were born at Bedford Hospital

**7,144** babies were born on Delivery Suite at both units

**MLBU = Midwifery Led Birthing Unit
***Induction of Labour Rate

## 3.21 NATIONAL CORE SET OF 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 excludes any patient with a Covid-19 diagnosis.

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 Feb 19 (Oct 17 –Sep 18) | As expected | As expected | | | 2 |
| | 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 |
| % Deaths with palliative care coding | Published Feb 19 (Oct 17 –Sep 18) | 36.1 | 33.6 | 59.5 | 14.3 | N/A |
| | 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 |

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.
- A data quality improvement plan was initiated at the Bedford Hospital site in view of site-based SHMI being 'above expected'. This includes improving the depth of coding and ensuring senior coders are used for all deaths to ensure co-morbidity is accurately captured.

## 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 which forms part of Trust 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% | | |
| 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* |
| | 2022/23 | 6.74% | 7.9% | Not Avail* | Not Avail* |

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.

## 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. From 2021, the timescale was due to be reduced by six months, however, in 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data.

At the time of publication of the 22/23 Quality Account, the redevelopment of an updated linkage process between these data is still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs.

| | Reporting period | BHFT Score | National Average | Best performing Trust | Worst performing Trust |
|---|---|---|---|---|---|
| Collection of PROMs for Groin Hernia and Varicose Vein surgery ceased in 2017. | | | | | |
| 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 | Awaited | Awaited | Awaited | Awaited |

| | | | | | |
|---|---|---|---|---|---|
| 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 | Awaited | Awaited | Awaited | Awaited |

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 so the quality of its services, by:
- Ensuring results are reviewed through the organisational governance structure in addition to local clinical governance forum
- 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

This measure is taken from the National Inpatient Survey and is scored based on the response to five key questions:
- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

| | Reporting period | BHFT Score | National Average | Best performing Trust | Worst performing Trust |
|---|---|---|---|---|---|
| Responsiveness to the personal needs of patients | 2017/18 | 66.2 | 68.6 | 86.2 | 54.4 |
| | 2018/19 | 62.9 | 67.2 | 85 | 58.9 |
| | 2019/20 | | 67.1 | 84.2 | 59.5 |
| | BH site | 63.1 | | | |
| | LD site | 60.4 | | | |
| | 2020/21 | 71.7 | 74.5 | 85.4 | 67.3 |
| | 2021/22 | * | * | * | * |

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 In-Patient Survey. 2019/20 data relates to the survey of people who were inpatients in July 2019.

*The data for this indicator for patients responding to the 2021/22 inpatient survey has not yet been published on NHS Digital. It was due for release in March 2023 but has been delayed (as at 22nd May 2023) - 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.

| | 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 | 2017/18 | 72% | 70% | 87% | 60% |
| | 2018/19 | 71% | 71% | 87% | 40% |
| | 2019/20 | 76% | 71% | 87% | 40% |
| | 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% |

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 so the quality of its services, by:

- Engaged with staff about the vision, values and behaviours and have developed our THRIVE values (see FTSU section).
- Provided information and training at the Staff Engagement Event in July and December 2020 to staff, and regular leadership forums to keep staff updated about the ongoing integration and development work within the newly merged organisation.
- Engaged staff in quality improvement across the Trust and shared learning from QI using a wider range of communication methods.

## Indicator: Risk assessment for venous thromboembolism (VTE)

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 | | |

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 2 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<br>HOHA<br>COHA | <br>8.3<br>7.1 | <br>17.0<br>7.7 | <br>0<br>0 | <br>76.1<br>33.3 |
| | 2021/22<br>HOHA<br>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 |

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 2022/2023, 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 23 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 **77** cases of hospital acquired *C.difficile* infections (CDI) against a Trust ceiling of **58** cases for 2022-2023.

Luton Total = 36 (HOHA 28, COHA 8)
Bedford Total = 41 (HOHA 30, COHA 11)

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.

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.

Post Infection Review (PIR) meetings have continued with clinical service line representatives to agree the findings and actions of the requested RCA.

The IPC nurses on each site have undertaken a summary review of the reportable CDI cases, to identify themes and learning. This work has focused on the HOHA & COHA detections from April 2022 and has been shared as a separate report for the JIPCC.

## 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 | | |
| Total number (n) and percentage (%) patient safety incidents resulting in severe harm or death | Apr 18 – Sept 18 | n=15 0.42 % | 0.3 | 1.3 | 0 |
| | 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 | | |

The Bedfordshire Hospitals NHS Foundation Trust has

- The Trust has a process in place for collating data on patient safety incidents;
- Data collated internally and submitted to the National Reporting and Learning System (NRLS) until December 2022 for the Trust when, following the implementation of the new incident reporting system, InPhase, which replaced Datix, reporting then submitted via the Learning for Patient Safety Event (LFPSE) platform instead. All Trusts need to do this by the autumn of 2023.
- Data is taken directly from NRLS/LFPSE reports over 2022/23.
- 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.

All serious incidents are investigated using root cause analysis methodology; although we recognise that this requirement will change when the new Patient Safety Incident Response Framework (PSIRF) is introduced. We work closely with commissioners and the NRLS (now changed to the LFPSE) data system, to ensure that any changes made to incident classifications following a root cause investigation are reported to LFPSE and that data provided here is reviewed and validated against Trust data to ensure it is consistent.

We continue to use the outcomes of investigations into patient safety incidents to drive improvements to the quality and safety of our services.

The Trust continues to implement the PSIRF requirements and publish a plan during 2022/23.

## 3.22 Performance Against National Priorities

| | | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | Target 20/21 |
|---|---|---|---|---|---|---|---|
| Clostridium Difficile | To achieve contracted level of no more than 19 cases per annum (hospital acquired) | 5 | 42 | 51 | 64 | 76 | |
| MRSA | To achieve contracted level of 0 cases per annum | 1 | 2 | 2 | 1 | 6 | 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% (this is for Apr22-Feb23 in arrears – Mar23 in May) | 96% |
| Cancer | Maximum waiting time of 62 days from all referrals to treatment for all cancers | 87.6% | 88.7% | 73.7% | 70% | 61.1% (this is for Apr22-Feb23 in arrears – Mar23 in May) | 85% |
| Cancer | Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment | 95.8% | 93.9% | 90.4% | 76.7% | 84.5% (this is for Apr22-Feb23 in arrears – Mar23 in May) | 93% |
| Cancer | Maximum waiting time of 31 days for second or subsequent treatment | | | | | | |
| | Surgery | 100% | 100% | 92.6% | 94.9% | 89.2% (this is for Apr22-Feb23 in arrears – Mar23 in May) | 94% |
| | Anti-cancer Drugs | 100% | 100% | 97.4% | 99% | 99.2% (this is for Apr22-Feb23 in arrears – Mar23 in May) | 98% |
| Patient Waiting Times | Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways | 91.1% | 89.8% | 68.6% | 64% | 51.4% | 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% *** | 33.8% | <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 your bladder into one or both of your **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 | Bedford, Luton and Milton Keynes integrated care system |
| 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 | Clinical Commissioning Group |
| CHKS | A company that provides healthcare intelligence and quality improvement services. The Trust uses data through systems provided by CHKS to review our 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 |
| Continence | 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. |
| CQUIN | Commissioning for Quality and Innovation – these are quality improvement targets set nationally or by the CCG where the Trust receives a financial incentive if it achieves these quality targets |
| Delirium | Delirium is a serious 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 |
| DNACPR | In the right circumstances, a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order helps ensure that a patient's death is dignified and peaceful. |
| 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 |

| Term | Description |
|---|---|
| Elective | Scheduled in advance (Planned) |
| EOL | End of Life |
| Epilepsy | Recurrent disorder characterised by seizures |
| EPMA | Electronic Prescribing and Monitoring Administration system in place |
| ESR | Electronic Staff Record |
| Grand Round | A lunch time weekly meeting with consultants and junior medical staff to communication key issues and learning |
| Fagerstrom score | This score is calculated by using the Fagerstrom Test of nicotine dependence. It helps to ensure that the prescribing of nicotine 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 **Getting It Right First Time (GIRFT)** programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements |
| HAI | Hospital Acquired Infection |
| HealthWRAP | This is the name of the training which forms part of the national PREVENT strategy, the aim of which is to stop people becoming terrorists or supporting terrorism. The NHS is a key partner in the national counter terrorism strategy. |
| Heart Failure | The inability of the heart to provide sufficient blood flow |
| HES | Hospital Episode Statistics |
| HSMR | Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average 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 in charge of upholding information rights in the interest of the public. |
| ICS | Integrated Care System – partnerships across areas form to work collectively to provide better, more joined up care for patients. Our ICS is across the areas of Bedford, Luton and Milton Keynes (BLMK) |
| ILS | Immediate Life Support |
| Just Culture | Just culture is about creating a culture of fairness, openness and learning in the NHS by making colleagues feel confident to speak up when things go wrong, rather than fearing blame. |
| Laparoscopic | Key hole surgery |
| Learning Disability | A term that includes a range of disorders in which the person has difficulty in learning in a typical manner |
| LIG | Local Implementation Group |
| 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 who are involved in the delivery of care. This includes doctors, nurses, midwives, therapists, pharmacists and clinical support staff. |

| Term | Description |
|---|---|
| MRSA (Meticillin-Resistant Staphylococcus areus) | MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means that infections with MRSA can be harder to treat than other bacterial infections. |
| Myocardial Infarction | 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 latest version of the National Early Warning Score (NEWS), first produced in 2012, which advocates a system to standardise the assessment and response to acute illness. |
| NICE | The National Institute for Health and Care Excellence (NICE) publish clinical guidelines which recommend how healthcare professionals should care for people with certain conditions. The recommendations are based on the best available evidence. |
| Non Invasive Ventilation (NIV) | The administration of ventilatory support for patients having difficulty in breathing |
| NRT | Nicotine Replacement Therapy is treatment that can be prescribed and administered to help people who smoke or vape avoid the withdrawal effects if they stop smoking or vaping |
| Orthognathic | Treatment/surgery to correct conditions of the jaw and face |
| Parkinson's Disease | 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 reducing the chance of rescheduling |
| PEARL | Post Event Action and Review for Learning (PEARL) – this is the name that we use at the Trust for our panels which are used to review incidents to determine if they meet the criteria of a Serious Incident. They were renamed as part of our move towards a just culture to try and eliminate some of the worry that staff feel about a 'serious incident' by focusing on the learning. |
| 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 |
| QSIR | Quality, Service Improvement and Redesign<br>The QSIR programmes are delivered in a variety of formats to suit different levels of improvement experience and are supported by publications that guide participants in the use of tried and tested improvement tools, and featured approaches, as well as encouraging reflective learning |
| RAG rating | Red, Amber and Green ratings are used in the display of some metrics to show whether they meet the standards or not |
| 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. |

| Term | Description |
|---|---|
| Safety Thermometer/Harm Free Care | Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism |
| Seizure | Fit, convulsion |
| Sepsis | The presence of micro-organisms or their poisons in the blood stream. |
| SHMI | Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard |
| Sialadenitis | Inflammation in the salivary glands, usually cause by a virus or bacteria. |
| Sialoendoscopy | A minimally invasive procedure that allows for salivary gland surgery |
| Somatosensory | The **somatosensory** system is a part of the sensory nervous system. The **somatosensory** system 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 based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. |
| SUS | Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which 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 length of time patients have to 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 |

Research – Glossary of terms

**Portfolio** - studies which are eligible and have been accepted onto the National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio Database.

**Non-Portfolio** - studies which do not meet the eligibility criteria to be accepted onto the NIHR CRN Portfolio Database. (Note: these are very worthwhile studies but are usually own account, smaller single centre studies, student research etc.)

# Statement of Directors responsibilities for Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2021/22.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2022 to May 2023;
  - papers relating to quality reported to the Board over the period April 2022 to May 2023;
  - feedback from commissioners dated June 2023
  - feedback from governors dated (suspended requirement);
  - feedback from local Health watch organisations dated June 2023;
  - feedback from Overview and Scrutiny Committee has not been received at the time of publication this year;
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 –
  - the national patient survey
  - the latest national staff survey dated
  - the Head of Internal Audit's annual opinion of the trust's control environment
  - CQC inspection report dated December 2022.

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

June 2023

**Simon Linnett**
Chairman

June 2023

**David Carter**
Chief Executive

# Stakeholder Feedback

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

## Statement from Bedfordshire, Luton & Milton Keynes Integrated Care Board (BLMK ICB) to Bedfordshire Hospitals NHS Foundation Trust (BHFT)

## Quality Account 2022 – 2023

BLMK Integrated Care Board acknowledges receipt of the draft 2022/2023 Quality Account from Bedfordshire Hospitals NHS Foundation Trust (BHFT) and welcomes the opportunity to provide this statement.

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

2022/23 was another very difficult year, both locally and nationally, with the on-going work to recover services affected by the pandemic, system wide pressures, and recent national industrial action.

It is positive to see the embedding of system working within the Integrated Care System (ICS) to ensure the delivery of safe care to our population, both at Place and across the wider ICS footprint.

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.

We would also like to thank all individuals involved in developing and produce 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 22/05/2023

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 which have been achieved in 2022/2023, the plans to continue to embed and develop the workstreams which are not being taken forward as priorities in 2023/2024 and recognises where further improvements are needed.

The Care Quality Commission (CQC) Report published in December 2022 rated the Trust overall as good but safe was rated as requires improvement and there are several areas the Trust, in collaboration with partners, are working to improve within Urgent and Emergency Care, Medicine and Maternity Services

As the demands on services continue to increase, we also acknowledge that there is work being undertaken to ensure a positive experience for patients and their families, such as improvements to discharge processes and the significant site redevelopment work.

We appreciate the amount of work being undertaken to implement all relevant requirements within the National Patient Safety Strategy, and in particular the roll out of the Medical Examiners role and the transition from the National Serious Incidents Framework to the Patient Safety Incidence Response Framework. We look forward to continuing to work 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. We are minded on the many improvements to support these services including the improvements seen in the midwifery workforce following successful recruitment of internationally educated midwives.

We are also aware of the work the Trust are undertaking in relation to supporting children and young people with and without mental health needs on paediatric wards, and we look forward to seeing the impact of this work during the coming year

The ICB is supportive of the Trusts 2023/2024 Quality Account priorities, some of which will build on the 2022/23 priorities and several of which align closely with the National Commissioning for Quality and Innovation (CQUIN) requirements.

Whilst elective and cancer care recovery are not identified as Quality Account priorities the ICB are aware of the joint work being undertaken particularly within diagnostic and imaging services, and that these remain a priority for the Trust.

The National Staff Survey results are the same as or very close to the national benchmark scores, and it is encouraging to see the Trust identifying some themes for improvement, especially relating to flexibility, and linking the results with their Culture and Organisational Development programme and continuing NHS People Promise.

It is reassuring to know that support for staff remains a priority, and that the Trust will continue to build on the work the ICB know is already in place.

It is positive to see the Trust's renewed interest in research and their participation in the inclusion project with the East of England Clinical Research Network

The Trust serves a wide geographical area with a diverse population and joint work needs to continue to ensure equity of service provision. It is also essential that there is a journey towards co-production to reduce inequalities.

2023/24 has seen our transition from a Clinical Commissioning Group to an Integrated Care Board, and we will continue to build on the firm foundations of partnership working to improve health outcomes, reduce inequalities and ensure everyone can live a longer, healthier life.

We hope the Trust finds these comments helpful.

Signed

Sarah Stanley Chief Nursing Director

## Feedback from Healthwatch Central Bedfordshire –

## Bedfordshire Hospitals NHS Foundation Trust's Quality Account 2022/23

Healthwatch Central Bedfordshire thanks the Trust for the opportunity to review their draft and detailed Quality Account for 2022-2023.

It has clearly been an interesting, post COVID/merger of services year for Bedfordshire Hospitals – and we note the current 'political' and on-going industrial positions as are occurring in 2023. We also note the increases in all populations across Luton and Bedfordshire and the likely impact this will have on Trust capacity and services.

The draft report reviewed by Healthwatch had areas that awaited updates and so it should be noted that we are not commenting on a complete report as for example some Trust data for Quarter 4 was still awaited and will impact on overall data completeness and interpretation. That said, in terms of the Trust's continued journey, it is encouraging that following its most recent inspection report (August 2022) the Care Quality Commission (CQC) recognised that the Trust 'scored' Good, and was regarded as 'Well Led'.

We note the three 2022/3 quality improvement priorities and the reasoning behind them and the results and observe that the Trust now supplies 47 clinical services which is a large range of activity to operate and manage and we can see how participation in 35 National Audits and completing 225 Local Clinical Audits must assist its governance and quality assurance.

We can see that the Trust considers three 'golden threads' (Quality and Patient Experience, Sustainability, Equality/ Health Inequalities) but we make comments based on four distinct aspects, 1) Patients, 2) Staff and 3) Performance against Targets and 4) Facilities.

### 1) Patients

We note the references to delivering Excellent Clinical Outcomes, Improving Patient Safety and Improving Patient Experience over the past year, and the on-going commitment in relation to those aspects of care. We support the Trusts use of NEWS2, and its proactivity in mobilising and hydrating of patients, for example.
It is good to see the Trust participating in NCEPOD reviews.

And also, that the Trust is committed to 'Learning from Deaths', including working with families to provide appropriate care at the patient's usual place of residence.

### 2) Staff

It is pleasing to note that despite the national and local challenges on recruitment and retention, good progress has been made in areas such as learning disabilities, and the medical examiners roles which have a significant impact on individuals and their families. The Trust should be congratulated on being an exemplar in the successful recruitment of overseas midwives. We support the 2023/4 objective of creating a sustainable workforce utilising the Health Care Academy and moving forward the development of a research strategy.

It is though, disappointing, to see a clear reluctance of large numbers of staff taking the flu vaccinations.

We note the continued efforts re Information Governance and Data Security.

In relation to 'Seven Day Service' we are unclear as to what the current position is with just three brief paragraphs on this 2015 NHS commitment.

We acknowledge the commitment to 'Freedom to Speak Up' and how it could be considered now as 'business as usual' – with Guardians appointed and the learning (for staff) coming out of this reporting system. And we also note the section and tables relating to 'Safer Working Hours' and accept that these are matters that are probably subject to current 'discussion' within the debate on industrial relations and efforts to recruit more staff.

As ever we appreciate the work of the PALS unit.

The annual staff survey continues to only receive less than half of staff contributing, which is disappointing, though we feel sure all are encouraged and that every effort is made to ensure as many staff as possible can feedback. It is clear that, year on year, the results of the survey are pro-actively worked on.

We can see that mid-wifery services received a CQC inspection this past year and that the Trust has responded to that. The graphics relating to the work of the Maternity Unit(s) was a really clear diagram and explanation of what that unit achieved.

3) Performance against Targets
It is disappointing that limited progress has been made against a number of last year's objectives, for example the treatment of Community Acquired Pneumonia, and Cirrhosis and Fibrosis management.
Additionally, it is disappointing to see that work on antimicrobial prescribing for UTIs (urinary tract infections) is no longer a quality priority, with a performance between only 50%-75%. UTIs are such a significant use of capacity and financial resource, but we do note that ongoing monitoring will take place.

Healthwatch Central Bedfordshire is pleased to see the progress on pre-operative screening for anaemia and the recruitment of a Pre-Operative Pharmacist as it is such a key determinant of patient outcomes and a potential saving on health economy costs.

The results of the Quality Priorities also indicate that there are differences in clinical practices across sites. It is encouraging to see that Service Line Strategies form part of the overall objectives for next year.

The Trust should be congratulated on the excellent results achieved in the Elective Care recovery programme and the aspirations to further improve that position, whilst noting the productivity challenges.

The narrative on Serious Incidents is disappointing because it does not set out any performance data or learning and so it is not possible to assess the impact these events had on individual patients and families, nor what learning has been implemented. However, it is acknowledged that work is ongoing to implement the PSIRF process and Patient Safety Strategy.

In the National Audit data, it is noted that there were three maternal deaths overall which seems a high number, but no narrative or learning is attached to these deaths. It is also noted that there is no quality prioritised for Maternity Services, which given national focus on maternity services, is surprising although the recruitment of the Patient Experience Midwife for maternity is noted and welcomed.

There is no narrative in many of the Audits to assist whether the Trust is compliant with the Audit Standards. It can only be surmised that, where compliance has not been stated, that the Trust is not compliant, which may be incorrect, and it would be helpful to be better able to understand 'compliance levels'.

Whilst it is not possible to comment on every individual Audit undertaken, the general improvement trajectory in a number of the Clinical Audits, for example Verification of Death, Shoulder Dystocia is noted. The further ongoing work to achieve compliance in areas such as Blood Sugar compliance, and the Management of Delirium are also noted.

It is disappointing to read that the DPST standards were not met, but that NHSD have accepted the improvement plan for re-assessment in July 2023 and that there has been an extensive work programme on data transition since the merger, with a Data Strategy planned for this year to ensure consistency.

Finally in relation to Clostridium Difficile - there appear to be a high number of cases against what is the national target.

4) Facilities/IT
We note the (buildings) Development Plan is moving forward, with current capital projects that are on-going, clearly aimed at improving both patient and staff experience. The new clinical building at Luton and the Caudwell Centre in Bedford Hospital being a great example of improvements made. However, it is worrying to see that the new Cardiac Centre and equipment is not able to be utilised due to lack of staffing and it is hoped this can be resolved soon.
We also note the increased concentration on greater use of digital solutions. It would be good if patients only had to supply personal information once during a visit to the hospital(s) – and perhaps the on-going work at the 'Nerve Centre' might assist this.

Format of the Account
Finally, this detailed Quality Account is provided in a clear and readable way for the lay person – although please note the earlier comments re missing data updates still to be seen. We note that a set of challenging objectives have been set for 2023/24, particularly with regard to greater integration of services, workforce, Service Line Plans and the aspiration to deliver further digital solutions and strengthen research to support patient care.

Healthwatch Central Bedfordshire is, as ever, happy to work with our other Bedfordshire based local Healthwatch to assist the Trust in any way we can to ensure that the views of the patients, their families and carers are considered as the Trust works to deliver the improvements needed.

Diana Blackmun
Chief Executive Officer
Healthwatch Central Bedfordshire

# Luton

## Luton Council comment on the Bedfordshire Hospitals NHS Foundation Trust Quality Account 2022/23

Luton Council will not be providing feedback to any Quality Account requests from NHS providers.

BEDFORD BOROUGH COUNCIL

## Bedford Borough Council comment on the Bedfordshire Hospitals NHS Foundation Trust Quality Account 2022/23

The Chair welcomed the Director of Quality, Bedfordshire Hospitals NHS Foundation Trust who introduced the Quality Account for Bedfordshire Hospital NHS Foundation Trust 2022/2023. 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 Director of Quality advised that the Quality Account was a particularly prescriptive document which described Bedfordshire Hospital NHS Foundation Trust's priorities and performance, which were a mixture of both national and local issues and how services could be improved. Bedfordshire Hospital NHS Foundation Trust was also currently implementing the National Patient Strategy whereby one of the key matters to investigate was when matters did not quite go as well as expected, and would include listening to and acting upon feedback from patients and their families regarding their experiences within hospitals; implementing patient safety partners; and looking at processes and priorities to support patients further.

The Director of Quality also reported on Bedfordshire Hospital NHS Foundation Trust's Care Quality Commission (CQC) inspection rating of "Good", since its merger during the COVID-19 pandemic. This was a testament to all the hardworking staff and where good strides forward were being made in terms of improving its performance across the Trust.

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

- Bedfordshire Hospital NHS Foundation Trust's Board was particularly concerned regarding cancer treatment's performance data, including cancer pathway milestones. A written response would be provided to the Committee regarding this performance data and the actions being undertaken.
- If maternity staff could not be appointed to by the Trust through normal recruitment drives, then temporary agency staff were sometimes required, however this was costly. To secure substantive staff was safer compared to employing temporary staff, therefore the invitation to bring in international staff was more cost effective. Maternity services within the Trust had previously been rated as "inadequate" with a vacancy rate of 25% at the time of the CQC inspection. However, services had since improved and been rated as "requires improvement" with a vacancy rate of 2-3%.
- A written response from maternity colleagues would be provided regarding the ages of women giving birth at the hospitals compared to the responses received from the maternity survey results. Cost comparisons of employing international midwives versus agency staff would also be provided.
- The culture within Maternity Units had significantly improved with students wanting to stay and work in Bedford, which demonstrated pride for the organisation and the service.
- A written response regarding an update concerning data sharing set-ups with GP's and pharmacies would be provided.
- The Development Manager of Bedfordshire Hospital NHS Foundation Trust would be requested to provide a written response regarding the capital infrastructure plans for Bedford Hospital.
- The reasons for exceptions, particularly for acute medicine and general surgery was indicative of the issues experienced during the pandemic, with some departments being short-staffed, staff sickness etc and the need to ensure that the service was able to operate safely. Therefore, some departments needed to operate outside of their normal working hours.
- It was anticipated that the data regarding the percentage of fractured neck of femur to theatre in 36hrs would be available by the end of June 2023, as some infographics remained outstanding prior to its publication.
- The types of complaints being experienced within the Trust tended to have similar trends across hospitals in general which related to waiting times for appointments and communications with staff.
- The last four periods of data concerning A&E that were omitted from the Quality Account was attributed to a change in reporting requirements and a pilot scheme to remove the 4-hour waiting time target requirement. Therefore, certain Trusts, including Bedfordshire Hospital NHS Foundation Trust were not required to record this data during the pilot, which was an NHS England mandate, introduced prior to the merger with the Luton and Dunstable Hospital. A written response regarding the current waiting times at A&E would be provided to the Committee for information.

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