



Bedfordshire Hospitals
NHS Foundation Trust



**QUALITY
ACCOUNTS
2020/21**

for the period April 2020
to March 2021



Quality Account

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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 2020/21 is included in this account alongside our priorities and goals for quality improvement in 2021/22 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 2020/21 against the priorities that we set for patient safety, clinical effectiveness and patient experience.
- Our quality priorities and goals for 2021/22 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.

About Our 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 1057 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 153,000 admitted patients, over 700,000 outpatients and Emergency Department attendees and we delivered over 8,100 babies.

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

We serve a diverse population across Luton, Central Bedfordshire and Bedford Borough.

Luton has a population of about 216,800 people in Luton (Luton Annual Public Health Report 2018). Luton is an ethnically diverse town, meeting the criteria to be described as 'superdiverse' with approximately 55% of the population of Black, Asian and Minority Ethnic (BAME) origin, with significant Pakistani, Bangladeshi, Indian, Eastern European and African Caribbean communities (Luton Annual Public Health Report 2018). We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile.

The unemployment rate in Luton has been improving year on year over the past 5 years, but remains consistently behind the regional and national employment rates. The proportion of households earning less than 60 percent of the median wage is 20.7% in Luton compared with 17% nationally. Furthermore, the full time weekly earnings differ between people who simply work in Luton and Luton residents who also work in the town, creating further inequalities for those residing within the locality of the hospital. The health inequalities within our local area are highlighted by the variation in life expectancy across Luton - this varies by 11.6 years for men and 5.6 years for women between the least and most deprived areas in Luton and also shows a strong link with unemployment. Luton Annual Public

Health reports states that in many cases, Black and Minority Ethnic (BME) communities have poorer health outcomes when compared to the overall population and these are linked to infant mortality, access to services due to awareness, language and cultural barriers, early onset dementia and diabetes. The Index of Multiple Deprivation 2010 also indicates that Luton is becoming more deprived. The Luton Annual Public Health Report 2018 (most recent published report) focussed on the implementation of the Luton Investment Framework, which is already providing excellent opportunities to improve the health of the people of Luton. Wellbeing and economic prosperity are closely linked. A thriving economy cannot be achieved without good health, and good health cannot be achieved without a thriving economy.

Central Bedfordshire is a unitary authority serving a growing population of around 274,000. It is a largely rural area with over half the population living in the countryside and the rest in a number of market towns (Central Bedfordshire Website). The area is generally prosperous, with above average levels of employment. This could mask the few areas where there are pockets of deprivation and, greater need in Dunstable and Houghton Regis. 10.3% of people living in the area from black or ethnic minority communities. While Central Bedfordshire has relatively low levels of deprivation overall, these areas face particular challenges relative to the rest of the area. In addition, there are a number of communities (including the areas noted above) with specific issues, that appear in the 10% most deprived nationally when specific aspects of deprivation are considered such as crime, education, skills and training, income, and barriers to housing and services.

Bedford Borough has a population of 173,292 (Office of National Statistics) and 28.5% of the population is from black or minority groups. Nationally Bedford Borough is in the mid-range on overall deprivation this ranking masks areas of significant deprivation affecting many residents in Bedford and Kempston Towns.

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 Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine Respiratory Medicine Diabetes and Endocrinology Gastroenterology	Cardiology Dermatology Hepatology Neurology Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery <ul style="list-style-type: none"> - Colorectal - Upper Gastrointestinal - Vascular - Bariatric Surgery Urology Paediatric Surgery Trauma & Orthopaedic Hospital at home Critical Care	Plastic Surgery ENT Cancer Services Medical Oncology Ophthalmology Oral & Maxillofacial Surgery Anaesthetics Pain Management Orthodontics Audiology
Women and Children's	Obstetrics Community Midwifery Early Pregnancy General Gynaecology Gynae-oncology	Paediatrics Fertility Neonatal Intensive Care Unit Uro-gynaecology Ambulatory Gynaecology
Diagnostics, Therapeutics & Outpatients	Pathology Services <ul style="list-style-type: none"> - Blood Sciences - Cellular Pathology - Microbiology - Phlebotomy Haematology Care Pharmacy Physiotherapy and Occupational Therapy	Imaging Musculoskeletal Services Dietetics Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2020/21 the Clinical Service Line Clinical Directors, General Managers and Lead Nurses and Executive Directors met in the Executive Review Meetings to maintain clinical accountability at specialty level. The Chief Nurse met with Care Units to oversee ward quality and performance.

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

Statement on Quality from the Chief Executive Officer

I am delighted to introduce the Quality Account for Bedfordshire Hospitals NHS Foundation Trust in what has undoubtedly been a challenging year. Not only has this been the first year of merger between the Luton and Dunstable NHS Foundation Trust and Bedford Hospital NHS Trust but we have had to continue to navigate the turbulent waters of the on-going global Covid pandemic.

We are building our new organisation based on a philosophy of strong values and a belief that high quality services are only able to thrive where our staff are able to work in a supportive culture with respect, openness and teamwork. This also allows us to see the diversity of our workforce as a strength and as an enabler of high quality, allowing staff to be comfortable in an environment which values the voices of all individuals equally.

I am delighted that during this year we have continued to build on the successes of our legacy organisations in placing an unrelenting focus on quality and safety. We have used opportunities arising from the merger to improve the care we provide and have begun integrating clinical services to the benefit our patients and look for innovative ways to enhance safety for both hospital sites.

This has all been achieved against a backdrop of the continuing pressures of the Covid pandemic and it would be remiss of me to not acknowledge the incredible efforts of our staff over the past year in the delivery of excellent patient care despite the numerous obstacles. One of the lessons from Covid is the absolute importance of staff wellbeing in creating that supportive environment which allows quality to flourish and we are determined to see this as one of our priorities going forward. In addition I would like to acknowledge the incredible work of our staff in setting up a vaccination hub to deliver vaccine to staff and community.

You will note that within some sections of our Quality Account this year that the significant practical challenges of managing with and around COVID have required a pause to some of activity around last year's quality priorities as well as some national data collection. However, as we look forward to this year's priorities we will be revisiting the improvement activity for some of the important quality and safety initiatives.

A key priority is our work to fully recover our services for patients. We are delighted that the BLMK system partnership has been selected as part of the Covid Recovery Accelerator Programme and the Trust will be fully engaged in the activity to recover elective surgery, diagnostic and outpatient activity during 2021.

Whilst I am always incredibly proud of our staff and their achievements we know there are always things we could do better. Last year we were particularly disappointed with the outcome of the unannounced Care Quality Commission inspection of our Maternity services at the Bedford hospital site which were rated Inadequate.

However the staff have been both resilient and determined in rising to meet the challenge of making improvements and we will be maintaining a sharp focus on the quality improvement plan that is in place throughout the coming year.

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. We look forward to continuing to work closely with you all during the coming 12 months as we move hopefully to recovery.



David Carter
Chief Executive Officer

Corporate Objectives 2021/22

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

1. Attract, value and develop the best people to deliver outstanding care in an environment where people can THRIVE.
2. Measurably improve our quality priorities, meeting the performance targets and financial regime.
3. Achieve full recovery of services and develop the plan for restoration of elective waiting times.
4. Operate in a COVID safe environment.
5. Build on the integration work achieved during the first year of merger and develop the clinical strategy.
6. Commence the construction of the Acute Services Block and continue with the overall redevelopment plan on both sites.
7. Becoming a sustainability exemplar organisation in the NHS.
8. Play a leading role in the ICS and Bedfordshire Care Alliance to increase the integration of services between acute, community, primary care and social services.

Achievements in Quality Improvement Priorities 2020/21

With the merger of the two hospitals taking place in April 2020, amidst the height of the COVID-19 pandemic, it was appropriate to continue into the final year the quality strategy of the Luton and Dunstable NHS Foundation Trust for 2018-2021. The strategy describes four key priority areas based on local, national and Integrated Care System priorities, they are:

- Improving Patient Experience
- Improving Patient Safety
- Delivering Excellent Clinical Outcomes
- Prevention of Ill Health

Quality priorities for 2020/21 listed ambitious programmes of improvement work to ensure that the Trust continues on the journey to become an outstanding organisation for people who both use and work within our hospital. Despite our best intentions to proceed on our improvement journey, there was significant interruption to the work as we faced high levels of staff absence and the need to prioritise clinical activity to ensure a safe environment for patient care and staff alike. However, we are pleased to report that, for some of our quality priorities, we were able to make some progress to be shared in this quality account.

It is worth noting that, whilst we had already included the CQUINs which were published by NHS England for the year 2020/21, our aim was to proceed with these where possible, despite the expectations and payments around CQUIN being suspended by NHS England for the year.

Priority 1: Deliver Excellent Clinical Outcomes

1.1 Treatment of community acquired pneumonia in line with the British Thoracic Society care bundle

Why was this a priority?

This had been published as a CQUIN. Management of community acquired pneumonia has been a priority across the NHS for many years, particularly as part of the strategy for same day emergency care and also as part of winter planning. The care bundle, which is aligned with NICE guidance, sets out discreet steps that the Trust needs to follow with the aim to reduce mortality, length of stay and patient experience. Nationally, it is estimated that £765m spend per year and 29,000 deaths are associated with pneumonia.

What did we do?

Although a team of clinicians started to look at this programme of work, the COVID-19 pandemic rapidly

escalated from the end of March 2020. The guidance distributed from NHS England in support of care and treatment of patients presenting with COVID-19 had to take precedence throughout the year. Guidelines rapidly evolved and new research and evidence based practice for COVID-19 emerged requiring constant review and updating within the Trust. Whilst the focus was not on delivery of antibiotics within 4 hours as this was not always appropriate for patients presenting with COVID-19, we have been carrying out ongoing reviews of patients presenting with signs of sepsis because, for those patients, the importance of administration of antibiotics within one hour remained a priority.

How did we perform?

All new and updated guidance from NHS England to deliver evidence based care to patients presenting with COVID-19 were acted upon swiftly following receipt within the Trust.

In audits of patients presenting as emergency admissions with signs of sepsis and who required antibiotics, of 171 patients audited in quarters 2 and 3, 152 (89%) received antibiotics within one hour.

1.2 Rapid rule out protocol for patients attending as an emergency with suspected acute myocardial infarction (MI) (excluding ST Elevation MI)

Why was this a priority?

This had been published as a CQUIN. High sensitivity troponin tests are recommended as part of a rule out protocol for certain people attending as an emergency with chest pain. Improved compliance with the rapid rule out protocol will lead to improvements in the delivery of same day discharge, reducing length of stay and enhancing patient experience.

What did we do?

- We established a cross-site multidisciplinary working group representing cardiology, emergency and acute medicine and biochemistry.
- Current Trust guidelines were reviewed and differences noted to exist between the two hospitals.
- Teams reviewed the evidence base in light of current practices and reached agreement on a way forward that will ensure that patients receiving two high-sensitivity troponin tests will receive the second within 3.5 hours of the first.
- Development of guidelines for practice was commenced but has been delayed to the impact of COVID-19 upon the availability of key members of the clinical team.

How did we perform?

We did not make as much progress as we would have hoped and so are including this quality priority in our programme for 2021/22.

1.3 Adherence to Evidence Based Interventions criteria

Why was this a priority?

This had been published as a CQUIN. The implementation of the evidence based interventions clinical criteria seeks to reduce the number of inappropriate interventions that patients receive by drawing on best practice guidance. There are 13 conditions where interventions should only be provided when certain clinical criteria are met. Compliance with the clinical criteria will reduce avoidable harm to patients and address unwarranted variation nationally. Robust implementation will ensure the most appropriate use of resources.

What did we do?

- Established our baseline data for the year 2019/20 for both sites.
- Ensured that the Private Patient Unit managers are aware that these interventions should not be offered in the Private Patient Units embedded within an NHS hospital.
- The details for the EBI eligibility criteria have been shared with the managerial and clinical teams for reinforcement, with the details printed and displayed in some key outpatient areas. Discussions regarding compliance with the EBI criteria subsequently led to work to scoping the incorporation of the EBI criteria into the electronic TCI forms allowing subsequent on going audit. Work on this will be progressed in the coming year.
- A review of orthopaedic cases on the in-patient waiting list shows that they were only booked after triage by the MSK service.

How did we perform?

Very few of these cases would have been operated on over the last year due to the impact of COVID on elective surgery. The Trust plans to continue to embed the Evidence Based Interventions over the coming year and is aware that there is a need to implement the requirements of the additional 31 interventions that have been added to the list.

Priority 2: Improve Patient Safety

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

Why was this a priority?

This had been published as a CQUIN. Considerable work has been carried out nationally to improve the identification and treatment of acute illness in order to prevent deterioration and cardiac arrest. This has drawn attention to the importance of timely escalation and the changes planned within this programme of work uses evidence based best practice to improve consistency in the recording and response to deterioration.

What did we do?

- We established a cross-site multidisciplinary working group to review the requirements of this CQUIN. The group included staff from both sites and represented critical care, critical care outreach team, senior nurses, consultants, the GDE programme team and the Trust patient safety team.
- Once it became apparent that CQUINs had been suspended by NHS England (due to COVID-19 pandemic), we took the opportunity to change the focus of this NEWS2 project. We needed to consider implications of the Trust merger upon our protocols, systems and processes around escalation and NEWS2.
- It was identified that the implementation of NEWS2 varied between the two sites. Therefore we established a programme of work to align protocols which could then inform the ongoing GDE programme of work.
- The planning is in place for the NEWS2 protocols to be updated in Nervecentre at Luton and then rolled out in Bedford.

How did we perform?

- We made progress as described above.
- The continuation of the work to embed and sustain the NEWS2 is going to be a Quality Priority for Patient safety for 2021/22.

2.2 Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery

Why was this a priority?

This had been published as a CQUIN. There is detailed NICE guidance setting out the requirements to offer iron before surgery to patients with iron-deficiency anaemia. Improved compliance with this guidance would reduce blood transfusion rate for patients undergoing major

blood loss surgeries, reducing the occurrence of patient safety risks associated with blood transfusion

What did we do?

- We set up a trust wide multidisciplinary working group to review the requirements of this CQUIN.
- An algorithm was set up in the Trust's laboratories to ensure that all patients in pre-operative assessment with an initial Hb of <130g/L have additional testing performed for serum ferritin, B12, folate, transferrin saturation and CRP. The same blood samples will be used for the additional tests, which prevents the requirement for patients to return for additional blood tests and speeds up the pathway thereby enabling swifter access to the appropriate treatment.
- Processes have been put in place within both our pre-operative assessment units to ensure that patients with iron deficiency anaemia commence the appropriate iron treatment.
- At Luton, we needed to identify an appropriate clinical area to treat patients who require intravenous iron infusions. This was already in place at Bedford.
- Trust treatment protocols for intravenous iron infusions have been updated and aligned so that there is one Trustwide protocol for an iron infusion that only requires a short duration of stay and observation.
- Systems have been put in place to provide weekly reports on patients going through the testing process so that audits can be performed when resource permits.

How did we perform?

Having put in place all the above protocols, systems and processes, patients are now being treated through this pathway. The diversion of staffing resources due to the COVID-19 pandemic has impacted on our capacity to undertake audit as yet, although this is planned. However, we can see from the ICE weekly reports that patients with Hb <130g/L are going on to receive the full range of additional tests.

2.3 Implement a programme of work to support patient safety and experience including improve learning from incidents, claims and complaints, and to further progress a 'Just' Culture

Why was this a priority?

The Trust have recognised new requirements following recent publications from NHS Improvement; Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy. These documents reflect considerable changes in previous approaches to governance and the Trust will need to consider new methodologies and processes in response to this.

What did we do?

The Trust Quality and Safety Governance Department has undergone a significant restructuring in order to provide a service that better meets the needs of the newly merged organisation. The Governance Team is now integrated as one, cross-site team and a number of new and novel posts have been created - including the Quality Governance Learning Assurance Coordinator post.

The Clinical Audit function within the Trust has undergone considerable evolution to more closely align the work with an ethos of Quality Improvement. Clinical audit is focused on key concerns/lessons learnt/Key successes and key actions and improvements required. Quality Improvement plans support CSLs with ensuring that clinical audit 'closes the loop', risks are identified and projects prioritised.

Life QI is used for QI projects which may not fit the audit criteria where staff may identify an issue with quality in their area. Projects registered on Life QI are aligned with Trust objectives.

We reviewed governance policies in line with national requirements while at the same time merging policies into a single Trust document.

Supporting patient safety oversight, the trust established two new executive-led boards - Clinical Quality Operations Board and Specialist Committee Oversight Board. Each board is chaired by one of the joint medical directors, and provides oversight for assurances from clinical service lines and patient safety committees.

The Trust has adopted After Action Review (AAR), with an initial cohort of 30 AAR conductors now trained to facilitate this learning process. The first AARs are now being held in our pilot areas of Maternity, Obstetrics, Paediatric and therapies. Further work to more widely adopt the methodology is planned with a train the trainer approach.

We have developed new local review panels to help promote learning and ensure timely review of incidents. In addition the Trust has also commenced a new Sharing Risk Information Group on a cross site basis to improve the collation and sharing of information across patient experience, risk management and safeguarding teams.

The Trust has developed new processes and launched a new database to improve the review of any patient death and ensure all possible learning is identified.

Post-merger the trust established a single clinical guidelines approval board and a policy approval board.

Both groups provide an assurance framework for ensuring both guidelines and policies are updated in line with national guidance and best practice. With exceptions, both guidance and policies are being merged into single trust documents to aid good governance and patient safety.

How did we perform?

Despite a very challenging year operationally, the changes and improvements stated above have been implemented. This provides a firm foundation for ongoing work to embed and sustain the changes which will enable the Trust to more effectively provide an environment, systems and processes which support effective learning and improvement. The work will provide a good starting point upon which to develop and deliver the new National Patient Safety Strategy.

Priority 3: Improving Patient Experience

3.1 Some areas of discharge process can be improved to provide a better patient experience

Why was this a priority?

This work will continue to build upon work started in 2019/20 to improve discharge planning and implementation for patients. Over 2019/20, there was a reduction in the number of complaints and concerns around discharge but a number of work streams had been identified and need further work to embed improvements. Furthermore, changes to the Trust structure, afforded by the merger, means that there is opportunity to expand upon the work cross-site.

What did we do?

This programme of quality improvement work was suspended when clinical staff were redirected to provide frontline clinical care in response to the COVID-19 pandemic.

How did we perform?

Processes around discharge necessarily had to change at pace to provide capacity for patients with COVID-19 and to reduce the risks of nosocomial infection as a result of delayed discharge.

The plan is to include Discharge improvements in the quality priorities for 2021/22.

3.2 Implement a programme of work to support patient safety and experience including improve learning from incidents, claims and complaints, and to further progress a 'Just' Culture

Why was this a priority?

The Trust have recognised new requirements following recent publications from NHS Improvement; Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy. These documents reflect considerable changes in previous approaches to governance and the Trust will need to consider new methodologies and processes in response to this.

What did we do?

See priority 2.3 above. Patient experience is embedded within the overarching governance structures and processes.

How did we perform?

- New governance structures have been developed and incorporated into the new clinical service lines so as to ensure maximum learning from patient experience information.
- Existing policies have been adapted cross-site to reflect the new requirements of national documents and develop new processes accordingly.
- After Action Review has been implemented and will be used to support learning from incidents which impact on patient experience.

3.3 Implement requirements of Smoke Free Hospital

Why was this a priority?

Providing smoke free hospital grounds imparts a clear message to all in society that smoking is harmful to health and provides an environment conducive with quitting. Quitting is not easy and a full package of supportive measures is planned to ensure that patients, staff and visitors are supported to quit or abstain whilst on hospital premises. Cleaner air and a reduction in litter caused by smoking will lead to a more pleasant environment for all people who work in and visit our hospitals.

What did we do?

Involvement and Engagement

- An online survey was created and sent out with our weekly bulletin for several consecutive weeks for staff to respond as to what support would be required. A reasonable number of responses were received from both smokers and non-smokers which resulted in some referrals for stop smoking support as well as helping to shape some of the messaging.
- Wide support has been provided to the preparation for implementation including:
 - Non-Executive Directors
 - Trust Executive Team

- Estates and Facilities Team
- Communications Department
- Trust Respiratory Specialist Nurses, Physio and Consultants
- Director of Redevelopment
- Human Resources Team
- Training and Development Team
- Occupational Health Department
- Pharmacy Team
- Staff Side Chair, Vice Chair and Union Reps
- Patient/service user representatives
- Healthwatch
- Public Health Commissioners - Luton and Bedford
- Stop Smoking Service Providers - Luton and Bedford

Policies

- Trust-wide Smoke Free Policy has been ratified and published on the Trust intranet.
- Trust-wide clinical guideline for smoking cessation therapies is being finalised and due to be published.

Estates

- Estates elements of the programme - included:
 - removal of smoking shelters;
 - installation of new and improved signage including bollard wraps and zoom banners hopefully making it hard to ignore/miss the signs
 - Review of the message spoken out loud by the sensor activated voice messages
 - Contract variation to have the Trust security uphold the no smoking policy and hand out cards which give the 88802 text message
 - Increasing the security patrol routes to include the secret smoker hideouts
 - New bins have been purchased so that all those with integral ashtrays will be removed
 - New landscaping of the area at the front of the hospital is being planned by the landscaping committee

Support for Staff

- NRT was made available to purchase on site for staff and visitors through WHSmith. This requirement will be written into future contract requirements when the retail outlets come up for renewal. NRT is already on sale in outlets at Bedford.
- Briefings and education materials have been developed for clinical staff in further embedding ASK, ADVISE, ACT for inpatients.
- A toolkit has been produced for staff to help them uphold the policy and to help them get support to quit if they smoke.
- A new Smoke-free intranet site has been launched.
- Widely publicised "Text QUIT to 88802"

- Total Wellbeing Luton continues to deliver Stop Smoking Services for Trust staff.
- Specific communications with onsite contractors (building contractors and our laundry and cleaning/ catering staff)
- Inclusion of online learning module on Trust induction with monitoring of uptake
- The policy makes it clear that hospital staff must not smoke in the grounds, must not smoke uniform or whilst overtly recognisable as an NHS member of staff (on or off site). If staff choose to smoke, this must be in designated breaks only, off site and not in uniform or with a hospital lanyard on display. A supportive approach will be offered to those struggling to comply but ultimately, repeated failure to adhere to this policy may result in action in accordance with the disciplinary policy.

Communications

- Communications plan was delivered with regular social media releases to the public via Twitter and Facebook.
- Credit card style cards have been produced to be handed out/available from wards, outpatients, reception areas, diagnostics departments and handed out onsite to people who smoke - includes "This is a smoke free site" type message and includes "For support, text QUIT to 88802"
- Development of bespoke signage for around the site and foam backed, good quality signage for inside the buildings
- A press release was published in Luton to celebrate the launch - including a photo with the Trust Medical Director and the portfolio holders at Luton and colleagues from PHE.
- Dr Syed Tariq, Consultant Respiratory Physician and Clinical Lead for Smoking Cessation at LDH appeared for half an hour on Diverse FM, a local radio channel, on 6th August to talk about smoking, impact on health and how the hospital has gone smoke free.
- Referrals to Stop Smoking Services have been simplified by including the option on our ICE desktop system (in line with referrals to clinical specialities) and all smokers will be referred unless they opt out. We are looking to get this on ICE at Bedford also so we can dispense with paper referrals having to be scanned and emailed.
- The Trust is now actively engaged in the Long Term Plan (LTP) Tobacco Control work being led by BLMK. The funding associated with the LTP work will help us to further progress our work to support patients to abstain or quit smoking, with the first funding expected in 2021 to support work with inpatients (both acute and maternity).

How did we perform?

- A formal launch of the Smoke Free Site at Luton took place on Monday 3rd August
- The hospital sites are both clearly signposted as being smoke free sites.
- The incidence of smoking on site has drastically reduced with it now being seen as unacceptable to smoke on site. There is however, some evidence that

onsite smoking still persists but this is felt to be the exception now.

- Due to the impact of the COVID-19 pandemic on ways of working, it has not been possible to undertake any audits of impact upon patient screening, provision of NRT or referrals.



What did we do?

A UTI prescribing memo was sent out by the antimicrobial pharmacist. Further quality improvement work was unable to progress due to the deployment of all clinical pharmacists during the COVID-19 pandemic and then the reliance on the entire pharmacy team to support the vaccination programme.

How did we perform?

There is no performance data to report.

4.2 Cirrhosis and fibrosis tests for alcohol dependent patients

Why was this a priority?

This had been published as a CQUIN. In 2016/17, more than 50,000 liver admissions nationally were unplanned and avoidable. Improved cirrhosis testing will increase the number of liver disease diagnoses, the aim of which is to change patient behaviour in time for more effective treatment and better prospects of recovering supporting a reduction in the burden that liver disease places on the NHS

Priority 4: Prevention of Ill Health

4.1 Antimicrobial resistance - appropriate antibiotic prescribing for urinary tract infections in adults aged 16 years and over

Why was this a priority?

This had been published as a CQUIN. There is established NICE and PHE guidance for appropriate diagnosis and management of UTI. Improving diagnosis and treatment will reduce treatment failure, risk of healthcare associated bacteraemia and reduce associated length of stay.

What did we do?

- We established a cross-site multidisciplinary working group who met to undertake a review of the requirements and the current processes on both sites. The group included a representative from the CCG.
- It was identified that the laboratory systems could be set up so that an automatic referral for the FIB4 test could be activated for all eligible patients.
- The Audit-C tool which screens for levels of alcohol use has been added onto NerveCentre ready to be fully implemented. This will support the identification of high risk patients who potentially require additional testing for cirrhosis and/or advanced liver fibrosis.
- It was established that the FIB4 test would be used in accordance with the East of England Liver Network guidelines to stratify those patients who require a Fibroscan. This was in place of the enhanced liver fibrosis (ELF) test following agreement with the CCG commissioning manager involved in previous work with the hepatology team.
- Further progress was stalled due to the impact upon availability of key clinical staff due to the COVID-19 pandemic.

How did we perform?

We made some early progress as described above which will be continued into the next year. It has subsequently become evident that the ELF Test will need to be implemented in line with evidence based practice and this will be built into the new quality priority.

4.3 To ensure that at least 90% of our frontline clinical staff are provided with the flu vaccination by February 2021

Why was this a priority?

This had been published as a CQUIN. Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season - a much higher incidence than expected in the general population. Influenza is also a highly transmissible infection and the patient population found in hospital is more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected. It is recommended that healthcare workers directly involved in patient care are vaccinated annually and this is supported by both the General Medical Council and British Medical Association.

What did we do?

- The Trust's occupational health team led on this key priority and ran a successful communications campaign which encouraged our staff to take up the flu vaccine. This was supplemented with the use of multiple opportunities for staff to receive the vaccine in terms of venue and time of day.
- Our Trust Board and other senior staff provided support by actively role modelling behaviour with photographs of the teams receiving their flu vaccination.
- In order to understand reasons for abstaining and also providing an opportunity to "myth-bust" the staff who actively declined the vaccine were asked to sign a declination form.
- Once the COVID-19 vaccination became available, resource was prioritised to focus on vaccinating as many of the Trust staff as possible in line with the national priority.

How did we perform?

This year's flu vaccine uptake by frontline staff was 67.4%.

At Luton and Dunstable, uptake was 70% (compared to 81% last year) and at Bedford, uptake was 63.89% (compared to 74.5% last year). The uptake figures were disappointing and lower than many other acute NHS Trusts. It has been hard to establish reasons for the lower uptake, with a majority of those staff actively declining stating that they just didn't want it, and the second most popular reason was individuals being concerned about side effects.

Quality Improvement Priorities 2021/22

Quality Priorities for Improvement 2021-2022

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.

Our Quality Strategy is due for a refresh during 2021/22 to meet the needs of the new Trust and to reflect the evolving nature of healthcare working within the wider system of health and social care. Furthermore, the publication and implementation of the national patient safety strategy will impact upon the quality improvement work of the Trust.

With the relatively recent Trust merger and the additional work required to integrate clinical and corporate services, it has been established that quality priorities need to be focused on improvements in a considered way in order to manage demands on the time and resources available. Additionally, it has been necessary to reflect the need to

continue with a number of priorities which were unable to proceed as we would have wished for in the last year.

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

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

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 2021/22, the future is currently uncertain so we may seek to review and reprioritise as the year progresses and as we continue to respond to the global COVID-19 pandemic.

Quality Priorities for 2021-2022

Corporate Objectives	Deliver Excellent Clinical Outcomes
Quality Priorities	<ul style="list-style-type: none"> • Cirrhosis and Fibrosis Testing for alcohol dependant patients • Rapid Rule out Protocol for suspected acute MI (excluding STEMI) • COVID recovery
Rationale	<ul style="list-style-type: none"> • Evidence based practice and improved outcomes requires patients to be risk stratified for cirrhosis and fibrosis using the Enhanced Liver Fibrosis (ELF) Test and then referral for Transient Elastography (TE) where required. • Patients undergoing high sensitivity troponin (HST) testing for the rule out of acute MI should receive the second HST within 3.5 hours of the first. The implementation of this evidence based practice will support safe rule out, thus avoiding unnecessary admissions and timely care for this group of patients. • The work to ensure clinical outcomes for patients are enhanced by improving the position for 52 week and 18 week targets. Furthermore, associated work within governance functions to restore services is required, for example to get Serious Incident Investigations back on track.
Measures of Success	<ul style="list-style-type: none"> • The ELF test is available for use within the Trust. • Eligible patients will be screened using Audit C tool and appropriately provided with the ELF test according to score • Appropriate patients receive referral for TE or hepatology referral • Eligible patients having two HST tests receive the second test within 3.5 hours • an audit will be undertaken to assess impact on length of stay • The Trust will be actively engaged in the Covid Recovery Accelerator Programme in partnership with system partners across BLMK. • Achievement of success will be measured against programme targets which include: activity targets for elective surgery; diagnostics; outpatient activity; having a single system PTL; 25% of OP activity being non-face-to-face. • Following return to business-as-usual for governance reporting and activity, relevant targets being met - including 60 day reporting of Serious Incident Investigations.
Monitoring Committee	Clinical Quality Operational Board and the Quality Committee

Corporate Objectives	Improve Patient Safety
Quality Priorities	<ul style="list-style-type: none"> NEWS2 implementation and effective escalation of deteriorating patients Modified Obstetric Early Warning Score (MOEWS) for pregnant women presenting in non-maternity parts of the Trust Patient Safety Strategy implementation
Rationale	<ul style="list-style-type: none"> In 20220/21, there was a CQUIN around NEWS2 and during the early stages of implementation; it became apparent that there were differences in our escalation protocols at Luton when compared with the Royal College of Physicians and the protocol in use at Bedford. This created an urgent requirement to review our escalation protocols at Luton, to have NerveCentre updated, associated with a training need for all clinical staff. The NerveCentre roll out at Bedford would enable the electronic recording and escalation in accordance with best practice following the alignment of the Luton system. The requirement to implement evidence based practice around the observation, detection and escalation of deterioration in women who are pregnant or in the immediate days post-delivery is needed to support patient safety for our women no matter where they are cared for within the Trust. The MOEWS is a nationally recognised system and a significant joint quality improvement programme is needed in partnership with women's services and the acute services. The implementation of MOEWS in non-maternity acute care is a recommendation of MBRRACE. The new National Patient Safety Strategy is being rolled out across England. There are a number of elements which need to be put in place over the next year, including the implementation of Patient Safety Partners, an extensive education programme and preparing to introduce the Patient Safety Incident Response Framework.
Measures of Success	<ul style="list-style-type: none"> The escalation protocol on NerveCentre will be fully aligned to the Royal College of Physicians NEWS2 criteria Ongoing audit will be in place to measure the impact upon effective observation frequency and escalation and direct QI work MOEWS is in place and used for pregnant and immediate post-partum women in acute hospital services outside maternity non-maternity staff are trained in MOEWS audit will be available to demonstrate impact upon the escalation of pregnant women The new "essentials" training is being rolled out to all staff across the Trust and is measured, with a plan in place to have all staff trained by April 2023 There is a clear implementation programme for The Framework for Involving Patients in Patient Safety and this is being delivered in line with national timescales A gap analysis will have been undertaken to understand skills, capability and capacity to undertaken patient safety incident investigations in line with the new Patient Safety Incident Response Framework. After Action Review is embedded across the organisation with a programme of training for AAR conductors in place.
Monitoring Committee	Clinical Quality Operational Board and the Quality Committee

Corporate Objectives	Improve Patient experience
Quality Priorities	<ul style="list-style-type: none"> • Safe and effective discharge arrangements • End of Life Care • Staff culture and organisational development
Rationale	<ul style="list-style-type: none"> • The quality priority work in 2020/21 was put on hold as key staff were redirected to frontline clinical roles. It is recognised that issues with discharge lead to potential patient safety and patient experience problems. A reduction in safeguarding alerts raised and complaints around discharge processes will be monitored as well as the implementation of evidence base that supports best practice around discharge. • With the recent publication of the CQC report around DNACPR and our own experiences of gaps in care demonstrate that this is an area due some quality improvement focus. The timely decision making around end of life care and our ability to give the best possible care so that people can die a dignified death in the place of their choice. • There is a well-established link between staff wellbeing, team working and patient experience. Implementation and embedding of the new Trust values and a broader series of organisational development opportunities will be used to make impact on patient experience.
Measures of Success	<ul style="list-style-type: none"> • Learning and improvement is implemented with the support of the Emergency Care Improvement Support Team • Targets will be set to monitor and improve the number of patients with an Expected Date of Discharge recorded within 14 hours of admission • An increase in the proportion of discharged patients leaving the Trust by midday each day • Reduction in LOS in Bedford moving towards LDH performance with further plans for ongoing improvement in place • Reduction in complaints relating to a poor discharge experience • A monthly discharge steering group has been meeting over the year and utilises performance targets; patient experience; complaints; incidents; safeguarding data to drive improvement • Learning from the CQC report on DNACPR has been implemented and embedded • There is an improvement in the quality of end of life care conversations as perceived by patients and their families - measured through complaints; patient experience feedback • Feedback indicates that more patients are dying in the place of their choice • Completed a review of the Bedford Peer to Peer Listening Service and progressed implementation at Luton and Dunstable • Recruited additional Freedom to Speak Up Champions • Increased the diversity of the P2P Listeners and FtSU Champions • THRIVE values embedded in recruitment and appraisal processes • Improvements monitored through national staff survey
Monitoring Committee	Clinical Quality Operational Board and the Quality Committee



Statements of Assurance from the Board

3.1 Review of services

During 2020/21 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 2020/21 represents 100% of the total income generated from the provision of relevant health services by the Bedfordshire Hospitals NHS Foundation Trust.

We are committed to participating in relevant national audits and national confidential enquiries to help assess quality of healthcare nationally and to make improvements in safety and effectiveness.

During 2020/21, we took part in 40 (93% of those applicable) national clinical audits at Luton and Dunstable Hospital and 39 (95% of those applicable) at Bedford Hospital; three national confidential enquiries at LDH and three at BH (100%).

The information provided also includes the percentage of cases submitted as required by the terms of that audit or enquiry. In many cases, where a number of cases for submission is specified, the Trust has submitted more than the number required and so these audits are shown below as having submitted >100%. For some audits, the number is not confirmed until later in the year or the audit is still in progress.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2020/21 are shown in the tables below.

Participation in some national audits is lower in 2020/21 due to COVID-19 pandemic and some audits being suspended at national level as well as staff being redeployed to focus on clinical care.

3.2 Participation in Clinical Audits and National Confidential Enquiries

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

Participation in national clinical audits 2020/21

No	Audit Title	Participated at LDH	LDH	BH	
			Stage/number or % of Cases submitted	Participated at BH	Stage/number or % of Cases submitted
1	Antenatal and new-born national audit protocol 2019 to 2021	Yes	100% 18	Yes	100% 3
2	BAUS Urology Audits - Female Stress Urinary Incontinence Audit	Audit stopped running Dec 2020			
3	BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Audit closed in Dec 2020 as per BAUS team			
4	BAUS Renal Colic Audit	Yes	25 cases submitted	No	N/A
5	BAUS Urology Audits -Nephrectomy audit	Audit stopped running Dec 2020			
6	Breast Cancer in Older People national audit (NABCOP)	Yes	*Continuous data collection	Yes	168 cases submitted between 1 April 20 - 31 Mar 21 - Continuous data collection

No	Audit Title	Participated at LDH	LDH	Participated at BH	BH
			Stage/number or % of Cases submitted		Stage/number or % of Cases submitted
7	Case Mix Programme (CMP) (Intensive Care National Audit & Research Centre (ICNARC))	Yes	961	Yes	430
8	Child Health Clinical Outcome Review Programme - Transition from child to adult health services	No - Postponed due to COVID-19			
9	Elective surgery (National PROMs Programme)	Yes	*Continuous data collection		
10	Emergency Medicine QIPs- Pain in Children (care in emergency departments)	Yes	Data submission extended to October 2021 82 cases submitted	Yes	54
11	Endocrine and Thyroid National Audit	Yes	*Continuous data collection		
12	Falls and Fragility Fractures Audit programme (FFFAP) INPATIENT FALLS	Yes	*Continuous data collection	Yes	565 cases submitted
13	Inflammatory Bowel Disease (IBD) Service Standards The annual IBD Service Standards is the organisational element of the full IBD Audit	Yes	Organisational surveys submitted		
14	Inflammatory Bowel Disease (IBD) Audit - Inflammatory Bowel Disease (IBD) Biological Therapies Audit	Yes	157	Yes	244
15	Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Reviewed on case by case basis both sites		
16	National Asthma and COPD Audit Programme (NACAP) - Paediatric - children and young people asthma secondary care	Yes	100% 40 cases	Yes	1
17	National Asthma and COPD Audit Programme (NACAP) - Pulmonary rehabilitation	Yes	100% 139 cases	Yes	125
18	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	Yes	44% (audit data collection and submission suspended April to October 2020)	Yes	Audit data collection and submission suspended April to October 2020
19	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	65% Audit data collection and submission suspended during COPD audit between April to June 2020	Yes	27 Audit data collection and submission was suspended during COPD audit between April 2020 and June 2020

No	Audit Title	Participated at LDH	LDH	Participated at BH	BH
			Stage/number or % of Cases submitted		Stage/number or % of Cases submitted
20	National Bariatric Surgery Registry (NBSR)	Yes	*Continuous data collection	Not applicable	
21	National Bowel Cancer (NBOCAP)	Yes	*Continuous data collection		
22	National Audit of Cardiac Rehabilitation	Yes	100% 922cases	Yes	*Continuous data collection
23	National Cardiac Arrest Audit (NCAA)	Yes	100%	Yes	100%
24	National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	Yes	100% 168cases	Yes	218 cases
25	National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	51 cases submitted. Due to staff redeployment full data for MINAP has not been entered. Number of eligible cases approximately 300.	Yes	*Continuous data collection
26	National Cardiac Audit Programme (NCAP) -National Heart Failure Audit	Yes	100%	Yes	100% 365 cases
27	National Audit of Care at the End of Life (NACEL) -	No cases submitted due to COVID			
28	National Cardiac Audit Programme (NCAP)-National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	100%	Yes	*Continuous data collection
29	National Comparative Audit of Blood Transfusion - 2021 Audit of Blood Transfusion against NICE Guidelines	No - project postponed due to COVID-19			
30	National Comparative Audit of Blood Transfusion - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	No - project postponed due to COVID-19			
31	National Comparative Audit of Blood Transfusion - re-audit of the medical use of blood	No - project postponed due to COVID-19			
32	National Comparative Audit of Blood Transfusion - National Comparative Audit of Blood Transfusion programme - use of FFP, cryoprecipitate, PCC and fibrinogen concentrate	No - project postponed due to COVID-19			
33	National Audit of Dementia	The NAD commenced in 2020 was part of a 'pilot' in preparation for round 5 of the nation audit.			
34	National Diabetes Audit - Adults -National Core Diabetes Audit	Yes	*On-going data collection	Yes	*On-going data collection

No	Audit Title	LDH		BH	
		Participated at LDH	Stage/number or % of Cases submitted	Participated at BH	Stage/number or % of Cases submitted
35	National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDIA)	National audit did not run in 2020 due to COVID 19			
36	National Diabetes Audit - Adults -NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	16 NaDIA Harms submitted from 1st of April 2020 to 31st of March 2021. Not all cases may have been captured due to COVID pandemic demands.	Yes	*Continuous data collection
37	National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Yes	100% 58cases	Yes	*Continuous data collection
38	National Diabetes Audit Integrated Specialist Survey	Yes	Survey Submitted		
39	National Early Inflammatory Arthritis Audit (NEIAA)	Trust did not participate.			
40	National Emergency Laparotomy Audit (NELA)	Yes	172 cases submitted Jan 2020-2021	Yes	60 cases submitted between 1 April 20 - 31 Mar 21 - Continuous data collection
41	National hip fracture database	Yes	Continuous data collection	Yes	100% 291
42	National Joint Registry (NJR) Operates continuous data collection	Yes both sites	Continuous data collection		
43	National Lung Cancer Audit (NLCA)	Yes	100% 176cases	Yes	100% 96 cases
44	National Maternity and Perinatal Audit (NMPA)	Yes	100% 5047 cases	Yes	*Continuous data collection
45	National Neonatal Audit Programme (NNAP)	Yes	100% 614 cases	Yes	100% 248 cases
46	National Oesophago-gastric Cancer (NOGCA)	Yes	*Continuous data collection		
47	National Ophthalmology Database Audit 2	Did not participate at LDH due to IT issues		Not applicable to BH	
48	National Paediatric Diabetes Audit (NPDA)	No	N/A	Yes	*Continuous data collection
49	National Prostate Cancer Audit	Yes	192 recorded at LDH - 350 across both sites	Yes	158 recorded at BH - 350 across both sites
50	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	80 and organisational questionnaire	Yes	3% 1 and organisational questionnaire
51	National Vascular Registry	Participate at Bedford continuous data collection			

No	Audit Title	Participated at LDH	LDH	Participated at BH	BH
			Stage/number or % of Cases submitted		Stage/number or % of Cases submitted
51	Perioperative Quality Improvement Programme (PQIP)		Trust decision not to participate because there are some aspects of the audit and data inputting which would be difficult to fulfil e.g. anaemia pathway		
52	RCEM Emergency Medicine QIPs -Fractured Neck of Femur (care in emergency departments)	Yes	101	Yes	71
53	RCEM Emergency Medicine QIPs - Infection Control	Yes	126	Yes	141
54	Sentinel Stroke National Audit programme (SSNAP)	Yes	SSNAP database suspended because of the pandemic, data submitted from January to March 21 are yet to be validated (1 case)	Yes	45% 97 cases
55	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100% 13	Yes	100% 5
56	Society for Acute Medicine's Benchmarking Audit (SAMBA) - Acute Internal Medicine / General Internal Medicine	Yes	Audit delayed due to run again June 2021 both sites will be participating		
57	Surgical Site Infection Surveillance - Public Health England	Yes	Continuous data collection	Yes	Continuous data collection
58	The Trauma Audit and Research Network (TARN)	Yes	All relevant cases	Yes	All relevant cases

*due to the complexity of the information to ascertain the full sample, it is not possible to determine the % case ascertainment without undue resource implications.

**partial data was submitted for all cases, but resource to complete the submission was unavailable due to the amount of data required.

Participation in national confidential enquiries 2020/21

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))		Study to commence 2021		
Maternal, New-born and Infant Clinical Outcome Review Programme - Perinatal confidential enquiries		No data collection during FY2020/2021		
Maternal, New-born and Infant Clinical Outcome Review Programme - Perinatal mortality surveillance	Yes	100% 40	Yes	*continuous data collection
Maternal, New-born and Infant Clinical Outcome Review Programme - Maternal mortality surveillance and confidential enquiry	Yes	100%	Yes	*continuous data collection
Medical and Surgical Clinical Outcome Review Programme - Dysphagia in Parkinson's disease	Yes	1 organisational questionnaire, 4 sets of patient notes submitted but no completed patient questionnaires	Yes	
Medical and Surgical Clinical Outcome Review Programme - Epilepsy study (National Confidential Enquiry into Patient Outcome and Death (NCEPOD))		Data submitted to NCEPOD for 2021 study		

National clinical audits

The reports of 19 national clinical audits published were reviewed during 2020/21 at the Trust, and the following provides an overview of the actions that have been, or are being, put in place to improve the quality of the healthcare we provide

Site	Specialty	Project Title	Quality Improvements
LDH	Anaesthetics	National Emergency Laparotomy Audit (NELA)	<ol style="list-style-type: none"> 1. NELA is now discussed at the Emergency Surgery Board and there is a dedicated NELA Quality Improvement group. 2. A Locum Ortho Surgical Geriatrician to be appointed to surgical and orthogeriatric frail patients. 3. Emergency Department NELA lead to be appointed. 4. A NELA recommendation was to hold a NELA multi-disciplinary team to include Radiologists to increase the rate of consultant reported scans. This was a national recommendation which the Trust currently meet. 5. Numerous audits /Quality Improvement team are complete and all actions have been implemented 6. Issuing NELA passwords to all Anaesthetists & Surgeons at all levels so that access to NELA is not an issue. 7. Improved awareness of NELA data at Luton and Dunstable (via department and joint Clinical Governance meeting with Colorectal Surgeons - reinforcing the need to input accurate NELA data post operatively and log cases). 8. We have created a process where the emergency theatre team email the NELA anaesthetic team weekly re: laparotomies performed in the emergency theatre.
LDH	Breast Surgery	National Audit of Breast Cancer in Older People (NABCOP)	The data does not reflect our practice within the Trust. The Luton screening unit is one of the largest in the country and refers to 6 or 7 hospitals all of which will be represented in this data. The matter was raised with the NABCOP administration but it does not appear to be resolvable at this stage.
LDH	Cardiology	National Audit of Cardiac Rehabilitation (NACR)	Aiming to reduce the wait time. However, this can be impacted by reduced staffing and during the audit period the staffing levels within the team were reduced. Action plans include a review of the process timeline from referral to start cardiac rehabilitation (CR) to identify areas of delay, weekly review of clinic wait times, a full review of the clinic process - in some instances this can be classed as start of Core Cardiac rehabilitation. If > 3 weeks wait for clinic additional clinics to be implemented if able. All staff has undertaken further NACR training and has a better understanding of the audit.
LDH	Cardiology	National Cardiac Audit Programme (NCAP) -National Heart Failure Audit	Heart failure guidance has been updated, currently in process; this will address areas where we need to improve.
LDH	Corporate	National Cardiac Arrest Audit (NCAA)	<ol style="list-style-type: none"> 1. Increase in survival to hospital discharge from 5.3% - 9.4%. 2. Resuscitation is being attempted on a higher proportion of patients in the 85+ age group 3. Patients who achieve return of spontaneous circulation >20 minutes are more likely to have a final destination of ward/mortuary.

Site	Specialty	Project Title	Quality Improvements
LDH	Elderly Medicine /DME	UK Parkinson's Audit 2019 Elderly Medicine	No integrated service as no therapist available in the clinic is same as national standard which is only 21% in Geriatric Parkinson's clinic has integrated service. Over and above national standard in all domains with 100% in most 90 or 95% in few.
LDH	General Surgery	National Bariatric Surgery Registry (NBSR)	We need to invest in a more granular version of this database and are appealing to the Trust to help fund this.
LDH	General Surgery	National Bariatric Surgery Registry (NBSR)	We need to invest in a more granular version of this database and are appealing to the Trust to help fund this.
LDH	Maternity	Perinatal Institute Report - missed SGA and SGA detection rate	The national report produced by Perinatal Institute show that our detection rate for small for gestational age babies for the quarter June to September 2020 was 47.3% which is higher in comparison to a national average of 39.9%. This is particularly remarkable as it is part of a six month period where our antenatal pathway was amended due to COVID 19. The national average detection rate dropped during this period but the Trust's detection rate was maintained despite the challenges that COVID has presented. These national findings are confirmed by our local monthly audit of missed Small for Gestational Age babies. Previous audits have highlighted a need for late gestation scans which have been implemented this year as a result, and these scans have contributed to this success.
LDH	Respiratory	National Chronic Obstructive Pulmonary Disease (COPD) Secondary Care - COPD Clinical Audit 2018/ 2019	Action plan is in place to improve time to non-invasive ventilation (NIV) and to improve access to spirometry. Also, actions in progress to ensure smokers are identified and offered smoking cessation.
LDH	Respiratory	National Adult asthma clinical audit 2019/2020 data	Action plan is in place to improve time to measurement of peak flow to within 1 hour and to improve time to administration of systemic steroids to within 1 hour of arrival to hospital
LDH	Stroke	Carotid endarterectomy (CEA) Prospective Re- Audit	Though we are below national average, there is considerable improvement in reviewing referrals and early surgery (within 2 weeks). There is no risk to patient safety. There was considerable increase in reviewing patients within one week and surgery within one week. Action plan is in progress including improvement actions such as new pathway for outpatient CEA referral, improving communication between stroke and vascular colleagues, joint stroke -vascular MDT, continuous education to GP's and public, same day Computed Tomography angiogram / Magnetic Resonance angiogram for eligible patients.
LDH	Stroke	Snapshot Audit of DNACPR and TEP - Re-audit	2018: 98% of patients with do not attempt resuscitation (DNAR) had Treatment Escalation Plan (TEP) 2019: Improvement of correct DNAR form completion to 73% (16% increase), improvement of correct TEP form completion to 50% (48% increase).

Site	Specialty	Project Title	Quality Improvements
LDH	Trauma & Orthopaedics	National Hip fracture database Neck of Femur (NOF)	<ol style="list-style-type: none"> 1. Improvement to Patient Safety Creation and implementation of NOF pathways (Fast track 1 & 2) Day 0 review Day 1 review Creation of 'Neck of femur (NOF) bleep' Dedicated slot and presentations in orthopaedic clinical governance Personal feedback to doctors for improvement Prioritisation of NOF fracture patients Specialised anticoagulation/Direct Oral Anticoagulation guidelines for NOFs Dedicated doctor covering the ortho geriatric patients on the weekend 7 day board round NOF steering group - monthly meetings to address issues and formulate solutions 2. Improvement to Patient Experience (caring/responsive domain) Rapid surgery Reduced numbers of patients having post op delirium. 3. Improvement to Clinical Effectiveness (effectiveness domain) <36 hour target 4 hour to the orthopaedic ward NOF bleep and pathways Improvement in NICE Compliance to surgery
BH	Emergency Medicine	Assessing Cognitive Impairment in Older People (Care in Emergency Departments) 2019/2020	<p>The following improvements were identified:</p> <ol style="list-style-type: none"> 1. Compulsory DEP for 4AT bundle added to Symphony system. 2. Re Audit to be carried out in 2 months' time <p>follow up scheduled for <i>30 June 2021</i>.</p>
BH	Emergency Medicine	Care of children (care in emergency departments) 2019/2020	<p>The following improvements were identified:</p> <ol style="list-style-type: none"> 1. Teaching/Education/Email to be disseminated for further education of the staff 2. HEADSSS tool to be in cooperated in Symphony after liaising with safeguarding and IT teams. <p>follow up scheduled for <i>31 October 2021</i></p>
BH	General & Upper GI Surgery	National Gastro Intestinal Cancer Programme (National Oesophago-gastric Cancer (NOGCA))	<p>The following improvements were identified:</p> <ol style="list-style-type: none"> 1. Ensure that clinical staging is recorded and entered onto Somerset Cancer registry at local and specialist Multidisciplinary Team (MDT) 2. Multidisciplinary Team (MDT) co-ordinator to ensure that PET Computed Tomography (scan) is recorded on Somerset Cancer Registry <p>follow up scheduled for <i>31 May 2021</i></p>
BH	Neonates	National Neonatal Audit Programme Annual Report 2020	<p>The following improvements were identified:</p> <ol style="list-style-type: none"> 1. Better thermometers are required for more accurate temperature reading for premature infants. 2. Use of Trans warmers for use during transit from Delivery Suite to Neonatal where there is no other heat source 3. Introduction of regional thermoregulation project in collaboration with midwifery teams (delayed due to COVID) back on track April 2021 4. Reintroduction of ATAIN (Avoiding Term Admissions into Neonatal Units) project on hold due to COVID now restarted. <p>follow up scheduled for <i>1 June 2021</i></p>

Site	Specialty	Project Title	Quality Improvements
BH	Respiratory	Adult asthma clinical audit 2019/20	<p>The following improvements were identified:</p> <ol style="list-style-type: none"> 1. Peak flow to be recorded within 1 hour of hospital arrival (Asthma) with provision of peak flow meters in ED and education of need to staff in ED 2. Respiratory review within 24 hours (Asthma & COPD) with RNS team to increase surveillance of ED arrivals and to raise profile of RNS team in ED and AAU 3. Systemic steroids administered within 1 hour of arrival to hospital (Asthma) and education of need to RNS team and staff in ED 4. Increase smoking cessation referrals for both in patients and out patients by Re engaging with Bedford Borough Council to re start in house service 5. Re Launch Asthma / COPD discharge bundles to ensure key indicators and best practice through a meeting with RNS Team to discuss 6. Increase uptake to ARAS service by Re launching the service to primary care / EOE ambulance service <p>follow up scheduled for <i>31 October 2021</i></p>
BH	Respiratory	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care - COPD Clinical Audit 2018/ 2019	<p>The following improvements were identified:</p> <ol style="list-style-type: none"> 1. Improve the prescribing of oxygen in the trust 2. Improve smoking screening of patients on admission 3. Increase numbers of patients in type 2 respiratory failure receiving NIV within 2 hours of presentation <p>follow up scheduled for <i>1 January 2021</i></p>

LOCAL CLINICAL AUDITS

The reports of 53 local clinical audits were reviewed by the provider in 2020 and Bedfordshire Hospitals intend to take the following actions to improve the quality of healthcare provided [description of actions. Listed below is a selection of the 53 local audits reviewed.

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	Anaesthetics	Continuing nasogastric feeding in critically ill patients who are being ventilated in prone position (audit and Re-audit)	<ol style="list-style-type: none"> 1. Locally adapted best practice guidance was implemented after discussion with intensive care consultant group and nutrition team. 2. Education of the intensive care staff. 3. Poster of the policy was displayed in all critical care areas for ease of referral.
LDH	Anaesthetics	Documentation of treatment escalation plans (TEP) in patients admitted to critical care- reaudit cycle	<ol style="list-style-type: none"> 1. Patients to have Treatment Escalation Plan completed prior to leaving critical care. Junior doctors should check and bring this to attention of senior doctors to fill TEP. 2. If for full escalation, still document on TEP forms to make ward teams aware of plans. 3. Encourage documentation of family/Next of KIn discussion on 2nd page of form.
LDH	Breast screening	Evaluation of the value a mammogram contributes to the triple assessment approach when routinely performed on symptomatic women aged 35-39yr	<p>The evaluation highlighted that a routine mammogram of women aged 35-40 years on attendance to the breast symptomatic clinic did not detect any cancers that were not detected upon on clinical breast examination and ultrasound. There had been 4 cases in which the mammogram was reported as normal but malignancy was present. Also a stereotactic biopsy performed for incidental findings reported on mammography did not detect any additional cancers. However, the use of a mammogram in evaluation the extent of disease in cases of multifocal cancer proved beneficial.</p> <p>As a consequence of this evaluation routine mammography for women aged 35-40 was stopped bringing the service in line with the Royal College of Radiologists.</p>
LDH	Dermatology	A Quality Improvement Project evaluating patient and clinician experience of video consultations in outpatient dermatology	<p>A Quality Improvement Project evaluating patient and clinician experience of video consultations in outpatient dermatology. The Attend anywhere platform has been well received by patients (>90% 'positive' or 'very positive' in most domains) and clinicians. We demonstrate that Attend anywhere (video consultations platform) is a patient-friendly platform that can have a pivotal role in the short and long-term in the dermatology outpatient setting. Improving accessibility to dermatology care for vulnerable groups is vitally important to minimise the substantial indirect impact of the pandemic on patients' lives.</p>
LDH	ENT	ENT Record Keeping Audit (inpatient only)	Ensure high standards of record keeping continue. Re-audit next year. Potential for consideration of a ward round sticker to improve on missed areas. Initiate Ward round sticker

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	General Surgery	Reaudit impact of COVID-19 pandemic on approach to patients with suspected appendicitis	Patient and GP education is crucial for early hospital presentation, to avoid delay in diagnosis and decrease the overall morbidity/mortality rates. Construction of pathways for such pandemic events is helpful.
LDH	Hepatology	Identification of and re-engagement with diagnosed but not in care hepatitis C patients using a laboratory database (IREEN-C): a multi-agency East of England audit	<ol style="list-style-type: none"> 1. Majority of Hepatitis C patients were being referred to specialist services in the region. 2. 55 “un-referred” Hepatitis C Virus patients were identified from 2012-2016. Their General Practitioner was contacted encouraging re-engagement & referral. 3. Phase 2 of the audit identified 9 more “un-referred” HCV patients from 2017-2018. Their General Practitioners have been contacted too, as above. 4. Stakeholders (Hepatology, Microbiology, and Public Health) at all 3 sites (Luton & Dunstable, Bedford, Milton Keynes Hospitals) were involved, so aware of findings.
LDH	Maternity	External cephalic version (ECV)	<p>The evaluation demonstrated the majority of standards met to be satisfactorily met, with 52% success rate, above the RCOG’s guideline success rate of 50%.</p> <p>11 patients had a successful ECV with 7 patients going onto have a SVD. Only one standard not met in that I multip had ECV at 36 weeks and 76% of patients received tocolysis. Intended actions include improving the ECV documentation, have all ECVs recorded on the Day Assessment Unit ECV data sheet (including ones done outside of DAU) and Multip ECVs should be done over 37 weeks and if ECV fails - offer repeat ECV with use of tocolysis.</p>
LDH	Maternity	Pre-eclampsia and eclampsia	The audit highlighted MgSO4 has been correctly used in the case of severe pre-eclampsia cases and the outcomes have been generally good for both the mother and child. Improvements to be carried forward include finding a better means for identifying patient cases for future audits and determine incidence and raising awareness of unnecessary coagulation screens.
LDH	Neonates	Audit of babies undergoing therapeutic hypothermia	<p>The audit highlighted standards were being met in most domains with the exception of the completion of the Neuroprotection Care pathway, especially the last part where full neurological examination is not carried out before discharge. Also the target temperature is being achieved within the national 6h target in all eligible babies born locally, but could be improved for babies born elsewhere.</p> <p>Plan is to include neurological examination as a part of induction and in departmental teaching</p> <p>Target temperature achieved in 6 hours’ time in all eligible babies born locally but the ones born elsewhere could be improved.</p>

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	OMFS	Audit to determine whether pus MC&S was requested after drainage of dental abscess cases and assess whether it impacted patient management and REAUDIT	<ol style="list-style-type: none"> 1. Educational presentation to OMFS team to encourage team to collect pus MC&S samples and ensure that the results are acted on appropriately i.e. empirical antibiotics are changed if necessary. 2. Educational presentation at Clinical Governance. 3. Send both audits and collected MC&S data to Microbiology to assess whether developing local Trust specific guidelines would be more beneficial to adhere to for the population served than national guidelines. 4. Liaising with lead consultant of Microbiology and lead antimicrobial pharmacist to create local Trust antibiotic guidelines, which should be available on the Trust intranet and Micro guide app in the near future to assist on-call doctors
LDH	Ophthalmology	Eye care for ventilated patients in intensive care unit	<ol style="list-style-type: none"> 1. Displayed the simplified version of best practice guidance of eye care for ventilated in critical care setting. 2. Eye lubrication & taping was confirmed by pre-proning check list. 3. Educated critical care staff. 4. Arranged regular ophthalmic reviews by consultant eye physician during the first peek of pandemic. 5. Ophthalmology referral was done for red alerts
LDH	Radiology	Prognostic factors in COVID-19: initial chest x-ray, biomarkers and premorbid condition	This prospective service evaluation reviewed the chest x-rays of post COVID inpatients to determine whether they had residual changes. Surprisingly, we found that those of BAME ethnicity were less likely to demonstrate residual changes. As a consequence of this project the respiratory team followed up COVID-19 patients.
LDH	Sexual Health	PreventX Quality Improvement Project: Anglia Audit Group	Up take of online sexually transmitted infection home test kits (Preventx) in Luton Sexual Health were less than other clinics (60-80%) in East Anglia. Luton Sexual Health was only giving verbal instruction to patients to order home tests. Other clinics were sending Text link to all the clients who required home tests. Therefore we explored the ways to improve the uptake locally and agreed to send Text Link from the clinic as soon as possible & to re- audit after 3 to 6 months.
LDH	Stroke	Carotid endarterectomy (CEA) Prospective Re-Audit	Though we are below national average, there is considerable improvement in reviewing referrals and early surgery (within 2 weeks). There is no risk to patient safety. There was considerable increase in reviewing patients within one week and surgery within one week. Action plan is in progress including improvement actions such as new pathway for outpatient Carotid endarterectomy referral, improving communication between stroke and vascular colleagues, joint stroke -vascular Multidisciplinary Team meeting, continuous education to General Practitioners and public, same day Computed Tomography angiogram / Magnetic Resonance angiogram for eligible patients.

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	Therapies	To review therapy input prior to and post the implementation of the Malignant Spinal Cord (MSCC) Compression therapy pathway with all confirmed MSCC inpatients	Using a QI approach the Therapies team over the course of a year sought to address a number of care pathway and experience deficiencies for MSCC patients. The team's actions include further recruitment into the MSCC team to have more accessible contacts and improve the compliance of the pathway and increase the departmental training provided. The implementation of a developed MSCC neurological assessment proforma, to increase the number of neurological assessments completed and facilitates the monitoring of changes. Further MSCC training and feedback to the department about the outcome of the audit, to be specifically aimed at Band 5's and new members of staff to maintain awareness levels of the department.
LDH	Trauma & Orthopaedics	Operative management of closed ankle fracture against the BOAST guidelines	<ol style="list-style-type: none"> 1. Consideration of Computed Tomography (scan) in posterior malleolus fractures. 2. Improvement in initial document of neuro-vascular status in patients presenting with ankle fracture.
BH	Accident and Emergency/ Emergency Department	Caution- Cauda Equina Syndrome	<p>The following improvements were identified:</p> <ul style="list-style-type: none"> • New proforma to be shared on intranet • Re audit to measure adherence • Await Radiology approval for new Magnetic Resonance Imaging (MRI) recommendations. • Re-audit is required in 2021 but date TBC.
BH	Acute Medicine	Re-Audit - Night time Sleep Disruptions on a busy ward (AAU)	The actions resulting from this project were to offer ear plugs & eye masks to patients in wards to improve sleep quality. Also to put up signs to remind night staffs to keep volume down. Compliant no further actions required. Project closed.
BH	Cardiology	In-patient coronary angiogram waiting times audit for Acute Coronary Syndrome (ACS) patients	The action resulting from this project is to circulate the guidelines to the Cardiology Clinics, Coronary Care Unit (CCU) and Catheterisation Laboratory. Re-audit is required in 2021 but date TBC.
BH	Colorectal	Elective colorectal operating due to COVID- 19	The action resulting from this project is to re-audit the required of outcomes after the super green pathway implemented. Re-audit is required in 2020 but date TBC
BH	Gastroenterology	Assessment of the Knowledge and Usage of Gastromiro; X-ray contrast medium (Gastromiro)	<p>The following improvements were identified:</p> <ul style="list-style-type: none"> • Teaching sessions should be arranged for the further education about Gastromiro; X-ray contrast medium (Gastromiro) • Protocols should be disseminated within surgical areas and the department <p>Re-audit is required in 2021 date to be confirmed</p>

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
BH	General Surgery	Had Appendicitis and Resolved/Recurred Emergency Morbidity/Mortality (HAREM) Study	The action resulting from this project is to determine the long term consequence of treating appendicitis conservatively with antibiotics. A review of the outcomes in 1 year to see whether we can recommend conservative mx of appendicitis in certain situations. Re-audit is required in 2021 but date TBC.
BH	General Surgery	Testicular examination in paediatric males referred to surgeons for abdominal pain	The action resulting from this project is for all male paediatric patients presenting with abdominal pain should have a scrotal examination documented. Re-audit is required in 2021 date to be confirmed
BH	Gynaecology	Sacrospinous Fixation	<p>The following improvements were identified:</p> <ul style="list-style-type: none"> • Better documentation at presentation - standard proforma to be introduced • Better documentation of treatment options - proforma required • Clinical coding to be reviewed as not all cases captured and some captured wrongly • Standard information leaflets to be issued (nurses to be aware of correct leaflets) • British Society of Urogynaecology database to be utilised more <p>Re-audit is required in 2022 but date TBC.</p>
BH	Oral/maxilla Facial (OMFS)	Communication of risks during the written consent process of third molar extractions	<p>The following improvements were identified</p> <ul style="list-style-type: none"> • Educate OMFS clinicians in a local a teaching presentation as well as in a clinical governance meeting. • Encourage nurses to photo copy the consent form and give this to patients along with the information leaflet. • Create and display a consent checklist to act as a reminder for which risks to discuss in the consent process for wisdom tooth extractions. • A pre-populated and consent form specifically for wisdom tooth extractions has been created with aim to implement it across the OMFS network. It has been approved by the all the OMFS consultants. <p>Re-audit is required in 2022 date to be confirmed</p>
BH	Paediatrics	Food Challenges Held In Hospital	<p>The following improvements were identified:</p> <ul style="list-style-type: none"> • Set up database of all food allergy patients • Make comprehensive list of patient awaiting Oral Food Challenge • Costing of Oral Food Challenge provision needs to be • Proposal for Oral Food Challenge service with guidelines focusing on: <ul style="list-style-type: none"> - Home vs hospital testing - Prioritisation of patients <p>Re-audit is required in 2021 but date TBC.</p>

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
BH	Plastics	Compliance for Completion of the TCI Forms Re-audit	<p>The following improvements were identified:</p> <ul style="list-style-type: none"> • 100% Pre-filled Transient Cerebral Ischemia (TCI) Form stapled on every TCI Booklet • Repeat presentation for increased awareness of compliance in filling form • Continuous Monitoring of Transient Cerebral Ischemia (TCI) Forms <p>Re-audit is required in 2021 but date TBC.</p>
BH	Radiology	CT Kidney Urethra Bladder Imaging Renal Colic ReAudit	<p>The action resulting from this project is to emphasise to all staff about the importance of \pm 10% excess scan length to ensure the lower the radiation dose. Re-audit is required in 2021 but date TBC.</p>
BH	Respiratory	Assessment of lung nodule management plan	<p>The following improvements were identified:</p> <ul style="list-style-type: none"> • Follow best practice in reporting lung nodules. • Make more use of the risk assessment tools. • Document justification of MDT decisions • <p>Re-audit is required but date TBC.</p>
BH	Trauma & Orthopaedics	Management of Proximal Humeral Fractures in Adults	<p>The following improvements were identified:</p> <p>Initial documentation which should include the patient's dominant hand, Neurovascular (NV) status - focusing on axillary</p> <p>If patient is seen by the orthopaedic team as an inpatient or follow-up patient, then documentation concerning the duration of the wearing of the collar/sling should be made</p> <p>Documentation regarding the physio referral should be made during the follow up appointment.</p> <p>The patient's baseline status and co-morbidities should also feature within the documentation.</p> <p>Re-audit is required in 2021 date to be confirmed.</p>
BH	Urology	Venous Thromboembolism (VTE) post Holmium Laser Enucleation of the Prostate /Transurethral Resection of the Prostate (HOLEP/TURP)	<p>The action resulting from this project is to continue to review of post-operative complications Holmium Laser Enucleation of the Prostate /Transurethral Resection of the Prostate (HOLEP/ TURP). Re-audit is required in 2021 but date TBC.</p>

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 2020/21 and who were recruited during that period to participate in research approved by a Research Ethics Committee was 5004.

The Trust was involved in conducting 202 clinical research studies in 2020/2021 including the following areas: oncology; stroke; cardiology; neurology; dermatology; ophthalmology; surgery; midwifery; paediatrics; gastroenterology; rheumatology; Infection; orthopaedics; anaesthetics and respiratory medicine. This research can be broken down into 176 Portfolio studies, 17 Non-Portfolio and 9 COVID-19 studies.

The Trust's contribution to the COVID-19 pandemic Urgent Public Health (UPH) Trials, to which we recruited 4445 patients, was due to the remarkable contribution of every person involved in looking after patients admitted with COVID-19. The Recovery Trial which is the best known UPH study was run across both sites and the trust was the greatest contributor to the trial in the Eastern Clinical Research Network.

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

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 2020/21 were suspended by NHS England following the escalation of the COVID-19 pandemic in order to release staff to provide frontline clinical support.

The national CQuINs were however included in our Quality Priorities and some progress was made in implementing some of the schemes, as clinical pressures and availability of staff allowed.

NHS England has not published any CQuIN schemes for 2021/22, with payments being included in block payments to the Trust.

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.

Bedfordshire Hospitals NHS Foundation Trust is fully registered with the CQC and is rated as GOOD overall. However its current registration is **Registration with Conditions** which relate to Midwifery and Maternity services at its Bedford Hospital site.

Following an unannounced inspection by the CQC of maternity and midwifery services at the Bedford Hospital site in November 2020, the Trust was notified of the CQC decision that under Section 31 of the Health and Social Care Act 2008, conditions were imposed on our registration as a service provider in respect of these services.

The conditions required the Trust to make improvements related to the maintenance of safe staffing levels and the systems and processes that ensure that staffing levels are assessed and monitored.

The Trust also received an improvement notice under section 29A of the Health and Social Care Act 2008 for Maternity and Midwifery services at the Bedford site.

Whilst this is clearly a concerning and disappointing outcome for the Trust, we have implemented a comprehensive improvement plan to address those areas identified as requiring improvement. This improvement plan is overseen through the operational clinical quality boards of the Trust and, in addition, an assurance report is provided to the Trust Board's Quality subcommittee monthly.

The Trust also has a monthly engagement meeting with the CQC where progress is overseen.

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

3.5a Ockenden Review of Maternity Services (published December 2020)

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11 December 2020, a letter was sent to the Trust setting out the immediate response required.

The report described seven Immediate and Essential Actions (IEAs), some of which require direct investment to enable delivery. To reduce variation in experience and outcomes for women and their families across England, NHS England and Improvement is investing an additional £95.9m in 2021/22 to support the system to address all 7 IEAs consistently and to bring sustained improvements to maternity services.

Following the initial release of the report, the Trust achieved the requirement to provide an immediate response, demonstrating our level of compliance against the seven IEAs. Submission of a self-assessment was achieved as required in February 2021 using a national tool - The Ockenden Assessment and Assurance Tool. Feedback from the Chief Midwife from the East of England regarding an analysis of the Trust's self-assessment was received demonstrating that the Trust's self-assessment closely aligned with the assessment completed by the Regional Team.

The maternity teams on both sites have been collating evidence to support the Trust's position, including the service developments that are needed for the Trust to be able to demonstrate full achievement of all seven IEAs.

The Trust is working with partners from the Local Maternity and Neonatal System, and also progressing the application process to secure a share of the available funding to support the work.

The Seven Immediate and Essential Actions are:

- 1) Enhanced safety
- 2) Listening to women and their families
- 3) Staff training and working together
- 4) Managing complex pregnancy
- 5) Risk assessment throughout pregnancy
- 6) Monitoring fetal wellbeing
- 7) Informed Consent

For further information, please refer to <https://www.england.nhs.uk/publication/ockenden-review-of-maternity-services/>

3.6 Data Quality

The Trust recognises the importance of high quality, reliable information especially for the delivery of patient care. All decisions, whether clinical, managerial or financial need to be based on information which is of the highest quality. The Trust's patient activity information is derived from individual data items, collected from a number of sources whether they are on paper, or increasingly with, electronic patient 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, ultimate responsibility rests with the Chief Executive. 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.

2020/21 Data Quality Improvement

Internal monitoring reports continue to be produced (automated/manual/via the Trust Data warehouse) on a daily/weekly/monthly/quarterly/adhoc basis to all areas of the Trust. 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
- Appropriate use of referral sources
- Timeliness of admission/discharge (by Ward)
- Correct use of Consultant codes/Use of pseudo Consultant codes
- Duplicate Registrations
- A&E Clinical information completeness
- Inconsistency reports - ensuring clinical systems match and data is correct
- Reports identifying patient episodes with no consultant
- Reports identifying errors in RTT data

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

- Data Quality dashboards and reports from SUS
- HES Data Quality Indicators, Check-in and Auto-clean reports
- Data Quality Summary CHKS
- Challenges from Commissioners
- Case note audit
- Data Security and Protection Toolkit
- Audit commission audits

During 20/21 the Trust was transitioning and adapting to the merge. The Team continued to monitor the key data requirements across the two sites (as above) to ensure accuracy but in addition:

- a. Restructure of the clinical information and data quality team - new staff working together to combine experience and knowledge of key differences between sites to enable us to identify areas for improvement or areas of good practice
- b. Implementation of the Joint Data Quality Policy
- c. Reviewing cross site working practices and reporting needs to provide better quality and consistent approach to the collation and presentation of the trust data.
- d. Reviewing of The Trust Data warehouse and reference data within clinical systems to provide assurance that data across both sites is being capture and recorded consistently.
- e. Merging of National Commissioning data submissions to the secondary user services to ensure consistent quality checks and reporting
- f. Continued to work with service users to improve and promote Data quality across site
- g. Increased Batch tracing to enable better quality patient demographics

Action Plan for 2021/22 Data Quality Improvement

1) Reporting

- To work on a trust wide electronic data quality dashboard that will provide a clear and transparent overview of all key data items to enable Trust wide assurance of data quality.
- To build new data quality error reports to send to key departments so errors are highlighted and can be updated more frequently
- To work with the Technical Analytics team to build new data reconciliation reports for CDS submissions, thus providing further assurance that all data is being submitted to the secondary user service and to our

commissioners for payment.

- To create new Data Quality Improvement plans (DQIPS) based on key data items, performance metrics and improvements tailored for the individual services. E.g. Ethnicity, NHS numbers, GP practices, RTT outcomes and validation.
- To work with the CCG to monitor and review data capture relating to patient pathways, to ensure data is captured in line with agreed pathways.
- To work with General Managers to establish specific data quality reporting needs that will benefit the services.
- To monitor new services providing expert knowledge in data capture so that the service can be reviewed and performance evaluated correctly
- To work with the ward accreditation programme to include data quality and completeness into the programme which will provide extra reassurance to the Trust.

2) Education and implementation

- To work with clinical systems training 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 build a data quality eLearning module for new staff, to be linked to clinical systems training modules
- To build a new Summary care eLearning module to improve the capture of patient demographics
- To continue to work with internal departments to offer advice and support on improving their Data quality and capture
- To review validation processes across site for 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 so that we have clear and consistent data that can be reported directly from source systems allowing more frequent and reliable reporting locally and nationally.
- To implement new cross site Data quality meetings, grouped by specialties so that the meetings can be aligned to the target audience and have a more meaningful approach. These meeting will be quarterly to allow teams to implement and address concerns. Monthly DQIP reports will still be sent and daily online reports will be available to show declines or improvements.
- To work with IT to investigate the possibility of a spine compatible patient administration system or implementation of a mini spine service. This will ensure patient demographics are updated on presentation which not only removes the need for

staff to look up each patient manually but will make sure that all patient correspondence will go to the correct GP practice or home address. This process would also stop any inaccurate data being passed through linked systems with community providers such as Systm1.

- To work with acute medicine to improve the data capture and compliance for the Emergency Care Data Set and the assault data submission to the local authorities to enable them to help improve community safety.

To review the function of the ward clerk service at BHT to ensure a constant approach to coverage. To look at data capture outside of the standard clerking hours of 8am - 4pm Monday to Friday so data is more timely and accurate.

3) Audits and system data quality

- 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
- To work with Technical Analytics and external providers to merge trust data warehouses - this will involve further data cleansing to ensure data can be reported consistently.

3.7 NHS Number and General Medical Practice Code Validity

Bedfordshire Hospitals NHS Foundation Trust submitted records during the reporting period 2020/21 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:

- Which included the patient's valid NHS number was:
 - 99.7% for admitted patient care
 - 99.9% 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
 - 99.9% for outpatient care
 - 99.7% for accident and emergency care

3.8 Clinical Coding Error rate

Bedfordshire Hospitals NHS Trust was not subject to a Payment by Results clinical coding audit during the reporting period April 2020 - March 2021 and the accuracy rates reported in the latest published audit for that period for diagnosis and treatment coding were 94.7% and 92.5%.

3.9 Data Security and Protection Toolkit (DSPT) Attainment levels

Bedfordshire Hospitals NHS Foundation Trust will be publishing an assessment on the 30th June 2021.

To achieve '*Standards Met*' compliance the Trust must meet the requirements of all assertions.

The Trust's current position is: '*Standards not met*'

- 85 of 110 mandatory evidence items provided
- 25 of 42 assertions confirmed

The figures above will rise slightly before the June 30th deadline, but this will not change the Trust's position to '*Standards Met*'.

We will be submitting a comprehensive action plan to NHS Digital and, if it is accepted, the position will change to '*Standards Not Fully Met - Plan Agreed*'.

The Trust was selected to take part in a fully funded DSPT audit. We feel that this is a really positive step towards The Trust achieving '*Standards Met*' compliance and it will also ensure that our interpretation of vague assertions are correct and assure the Board that we are on the right path to achieving '*Standards Met*'.

We have received the first draft of the audit which is being reviewed and will be discussed at the Information Governance steering group on the 9th June 2021.

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 six reported incidents (using this tool) for the last year. One of the incidents required further input from the ICO which has been completed and no further action was taken.

3.10 Learning from Deaths 2020/21

During 2020/21, 2823 of Bedfordshire Hospitals NHS Foundation Trust patients died. There were 1206 deaths in Bedford Hospital and 1617 deaths at Luton and Dunstable University Hospital.

Bedford Hospital

Quarter	Deaths	Primary review	*SJR requested
1	339	85	**
2	169	125	5
3	250	149	13
4	448	153	11
Total	1206	512	29

Luton and Dunstable University Hospital

Quarter	Deaths	Primary review	SJR requested
1	487	175	12
2	231	228	19
3	374	359	31
4	525	514	47
Total	1617	1276	109

* Structured Judgement Review

** The process of undertaking SJRs did not formally start at Bedford until July 2020

On 1 April 2020 Bedford Hospital NHS Trust and Luton and Dunstable Hospital NHS Foundation Trust merged. Prior to the merger, both trusts, in line with national guidance, had introduced a Medical Examiner (ME) service starting on 1 January 2020. The ME service, which is currently on a non-statutory basis, is part of DHSC's Death Certification Reform Programme for England and Wales. It also forms part of the NHS Patient Safety Strategy and the NHS Long Term Plan in England. MEs carry out a proportionate review of patient records and discuss causes of death with the doctor completing the Medical Certificate of Cause of Death (MCCD). They ensure concerns about patient care are identified promptly and referred for further investigation to improve services and care for all patients

Currently there are seven MEs working at Luton and four at Bedford. In addition, a Medical Examiner Officer (MEO) has been recruited at Luton and will provide the continuity and oversight of the ME service.

All deaths are under the scope of the review, excluding:

- Still births
- Deaths that occur in maternity which are investigated by a separate process
- Child deaths - investigated via CDOP (Child Death Overview Process).

It is expected that most deaths in hospital will be unavoidable with good care given to the patient. However following scrutiny of the notes by an ME, the patient record can be put forward for a more in-depth review by one of a dedicated group of reviewers, this is known as a Structured Judgement Review (SJR). Cases that may require an SJR include:

- Family concerns
- Staff/ME concerns
- Learning disability or mental illness
- Trust mortality alert
- Unexpected death
- Special circumstances (sepsis. Acute kidney injury)
- Fractured neck of femur
- Possible hospital-acquired Covid

SJRs are carried out using an electronic mortality review module, Datix Cloud IQ that has been customised in-house so that it reflects the need of the Trust. Should there be particular concerns regarding a death this may be discussed by a panel of reviewers for consideration as to whether a more detailed a Serious Incident Investigation is required.

The appointment of MEs has led to an increase in the number of deaths reviewed and this review is carried out within a short timeframe of the death occurring. The system allows for more accurate recording of the cause of death. Additionally a good working relationship has been developed with the coroner enabling more appropriate referrals and discussions regarding the circumstances leading to death.

During the Covid-19 pandemic, the number of deaths that could be scrutinised, particularly at the Bedford Hospital site, was reduced and so priority was given during these times to patients who may have acquired Covid in hospital or any other death of potential concern. A number of the MEs used their enhanced training in death certification processes to become full-time certifiers. This released frontline doctors from an administrative task so that they could prioritise frontline caring duties. Both hospital sites had a significant impact from Covid in terms of patient admissions during both first and second waves.

In February 2021 the publication of a white paper **Integration and innovation: working together to improve health and social care for all** provides confirmation of the government's intention to put medical examiners on a statutory footing in England and Wales.

The Joint Medical Director (previous Medical Director for Bedford Hospital NHS Trust) is the executive lead for Learning from Deaths and chairs the monthly meetings that report to the Clinical Quality Operational Board and Quality Committee. The other Joint Medical Director (previous Chief Medical Adviser for Luton and Dunstable Hospital NHS Foundation Trust) at Luton is the executive lead for the Medical Examiner service.

The Trust seeks to learn from all deaths. Themes that rose from case reviews where care could have been improved include:

- The timely and appropriate completion of DNAR (do not attempt resuscitation) and TEP (treatment escalation plan) forms
- The recognition of the dying patient

Assessment of the impact of the actions

The Trust's Learning from Deaths Board reviews statistical information relating to mortality and any learning from those deaths classed as avoidable. Reviews at speciality level are commissioned as required.

At Bedford 13 deaths following elective surgery during the 2020/21 period were reviewed including a thematic review of five deaths following elective vascular surgery. A number of themes that were common to the vascular deaths were identified and these were shared with the relevant specialities. The other eight deaths were felt to be unavoidable.

Covid-19

Across both sites, deaths from Covid-19 peaked in April 2020 during the first wave and January 2021 during the second wave. Altogether, there were 1323 coronavirus deaths in the whole Trust. For the year ending March 2021, there were 343 more deaths at Bedford Hospital than for the year ending March 2020 and 393 more deaths at the Luton and Dunstable Hospital for the same period. This excess number of deaths, many of which were a result of infection with Covid, often involved frail elderly patients with other significant comorbidities. Review of the notes showed that in the second wave in particular, many of these patients received input from the palliative care team.

In the absence of national guidance, the Trust is undertaking a thematic review of hospital-acquired Covid-19 deaths (Hospital-onset Probable Healthcare-Associated infection - positive specimen date 8-14 days after hospital admission; Hospital-onset Definite Healthcare-Associated Infection - positive specimen date 15 or more days after hospital admission). This includes 56 patients on the Bedford Hospital site and 87 patients on the Luton and Dunstable Hospital site.

3.11 Seven Day Services Board Assurance Framework

NHS England committed in 2015 to providing a 7 day service across the NHS by 2020. The declared intention is that all in-patients admitted through Emergency and Urgent Care routes will have access to consistent and equal clinical services on each of the 7 days of the week, at the time of admission and throughout the stay in an acute hospital bed.

Ten standards have been set. Four of these are priority standards and are those most closely linked to the improvement in safety and efficiency and it is these four standards that the NHS expects to be in place for all Acute Trusts by 2020. These standards have been endorsed by the Academy of Royal Colleges.

In response to the COVID-19 pandemic, the 7-day services Board Assurance Framework self-certification was suspended by NHS England.

3.12 Freedom to Speak Up (FTSU) and Guardian

The Trust Board is committed to ensuring that all staff have a voice in relation to patient and staff safety and welfare. The Trust Board wants to continue to establish an environment where all staff are committed to supporting a transparent and open culture, where all staff including agency and temporary workers, students, volunteers, governors and other stakeholders are encouraged and feel safe to Speak Up.

The Freedom to Speak Up roles aim to:

- Improve patient safety
- Improve service quality
- Improve staff health and well-being leading to lower levels of turnover and sickness absence
- Improve staff engagement and retention

Both hospital sites have well-established FTSU Guardian and Champion roles. The Communications Team has worked with the Guardians and Champions to ensure maximum publicity was arranged during FTSU month in October 2020 with displays and articles in the weekly cross-site communication 'The Week'.

We know that staff are often the first to identify problems within the hospitals and we want to encourage them to come forward and raise their concerns in confidence, safe in the knowledge that they will suffer no detriment as a result. The FTSU ethos is about helping the Trust to create a culture where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. It is important that it is an open and transparent place to work and includes matters relating to patient safety, the quality of care and attitudes and behaviours. To support an open culture, managers need to feel comfortable having their decisions and authority challenged; Speaking up, and the matters that this may highlight, are welcomed and seen as opportunities to learn and lead to improvements which embrace the new Trust THRIVE values

**Teamwork,
Honesty and Openness,
Respect,
Inclusivity,
Valuing People,
Excellence**

The Guardians provide quarterly reports to the Trust Board summarising the themes and areas of concern. Over the past year, there has been a rise in concerns raised about attitudes and behaviour which have been dealt with via appropriate processes. One of the ways the success of the function is measured is by the National

Staff Survey which has specific questions relating FTSU. This has shown that the newly combined Trust results are within the 'average' range for all Trusts.

The conversations our Freedom to Speak up Guardians and Champions have had throughout the pandemic have been an important barometer for the 'temperature' of the hospitals. We continue to look at ways to ensure all staff are aware of the support available to them by working with our Wellbeing and organisational development (OD) colleagues to promote the information and training available on an on-going basis and also at induction, as part of the online mandatory training programme and in the curricula of our development programmes.

We plan to increase the number of Champions now the worst of the COVID-19 pandemic has passed and national training will be available.

There is an established Peer to Peer listening service on the Bedford site but this has been used rather less due to the pandemic. Working with our Clinical Psychologist, we are undertaking a review of this role before making any adjustments and introducing it to the Luton site. To better reflect the diversity of our people, the Guardians are also working alongside the Black and Minority Ethnic (BAME) Staff network in the recruitment of FTSU Champions and Peer to Peer listeners. We are also supporting the establishment of further staff affinity networks.

Other means of staff support are available through our Chaplaincy team, Occupational Health, the Employee Assistance Programme - CiC service - which offers 24 hour access to confidential information and support, legal and financial advice in addition to counselling and emotional support. Additional support is provided through the staff side organisations (Unions) and the BLMK Health and Wellbeing Hub.

The Trust's current FTSU policy is to be updated in line with the new national policy which will be launched later in 2021.

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 would contain 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:

- d. differences in the total hours of work (including opportunities for rest breaks)
- e. differences in the pattern of hours worked
- f. differences in the educational opportunities and support available to the doctor, and/or
- g. 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

Due to the impact of COVID-19 pandemic upon workforce and operational demands, the Guardian Reports have not been available.

Review of Quality Performance

3.14 Review of clinical indicators of quality - progress 2020/21

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. We have continued to follow the selected data sets and any amendments

have been described below the table as they are still considered relevant and are reviewed annually by the Council of Governors through their External Audit review indicator section. Data for 2020 or 2020/21 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	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	1	1	2	2	N/A	The Trust has a zero tolerance for MRSA.
Hospital Standardised Mortality Ratio* (n)	Patient Safety CHKS*	105.1*	102.3	97.94	111.18	100	The annual rolling HSMR has deteriorated but there has been recent improvement.
Number of hospital acquired C.difficile cases (n)	Patient Safety Trust Board Reports	9	5	42^	51^	N/A	National reporting changed in 2019/20
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	12	14	5	33 (of which 1 was G4)	N/A	Covid had a detrimental impact to numbers of pts with pressure damage.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	5	5	1	2 L&D	N/A	Maintaining a good performance
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.08	0.72	0.94	1.08	unavailable	Slight increase in rate
Average Length of Stay (LOS) (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.2 days	3.0 days	3.1 days	3.3 days	N/A	Length of stay has slightly increased
Rate of falls per 1000 bed days for all patients	Clinical Effectiveness Trust Board Report	3.97	4.08	4.0	5.04		Performance is slightly better than the national average.
Rate of falls per 1000 bed days for 16+ no maternity***		4.73***	4.89***	4.78	6.32	6.63	

Performance Indicator	Type of Indicator and Source of data	2017* or 2017/18	2018* 2018/19	2019* 2019/20	2020* 2020/21	National Average	What does this mean?
% of stroke patients spending 90% of their inpatient stay on the stroke unit	Clinical Effectiveness SSNAP data	85.3%	79.9%	87.6%	80.5% for Dec 2020 (SSNAP data not available)	Target of 80%	The Trust is marginally above the national target for December.
% of fractured neck of femur to theatre in 36hrs [to end Feb '21]	Clinical Effectiveness CHKS****	76%	71.3%	79.8%	80% LDH 40% BH	69%	LDH significantly better than national, BH significantly low compliance
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness CHKS****	50.8*	63.16*	67.82	94.71	100	This is demonstrating the Trust as a positive outlier.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness CHKS****	100.3*	76.5*	74.91	69.91	100	This is demonstrating the Trust as a positive outlier.
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness CHKS****	7.00%*	5.8%	6.6%	6.3%	unavailable	This shows a slight improvement
% Caesarean Section rates	Patient Experience Obstetric dashboard	31.2%	31.3%%	33.09%	35.4%	25%	The Trust shows a higher rate than average and continues to monitor rates.
Patients who felt that they were treated with respect and dignity**	Patient Experience CQC National inpatient survey	9.0	8.9	8.9	2020 inpt survey not yet published	(2019) Range 8.4 - 9.2	Stayed the same and within expected range
Complaints rate per 1000 discharges	Patient Experience Complaints data and coded discharges	5.50	4.70	4.31	5.1	N/A	The Trust continues to encourage patients to complain to enable learning but has seen a reduction in formal complaints.
Patients disturbed at night by staff (n)	Patient Experience CQC National Inpatient Survey	8.1	8.2	7.6	2020 inpt survey not yet published	(2019) Range 7.3 - 9.2	Slight decrease but within expected range

Performance Indicator	Type of Indicator and Source of data	2017* or 2017/18	2018* 2018/19	2019* 2019/20	2020* 2020/21	National Average	What does this mean?
Venous thromboembolism risk assessment	Patient Safety Audit reported on Board Quality Report	Achieved >95%	Achieved >95%	>95%	96.5%^^^	National target >95%	First whole Trust performance just below 95% - due to 3 months of low perf at BH

(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 Quality Improvement

Learning from Excellence

Traditionally health care safety has focused on avoiding harm by learning from error, however often our concern with avoiding error and harm in healthcare has always been wrapped around rules which can, without balance, cultivate a culture of fear and may stifle innovation. There is no doubt that a harm review approach is important, however we may miss the huge number of opportunities to learn from excellent practice and behaviour, which is in fact highly prevalent in healthcare.

Formal systems to capture excellence are less common and we tend to regard excellence as something to gratefully accept, rather than something to study and understand.

Here at Bedfordshire Hospitals NHS Foundation Trust we feel it is time to redress the balance. We believe that through reviewing examples of excellence in healthcare we can create new opportunities for learning, improving resilience and impacting staff morale in a positive way

Prior to the merger of the two hospitals, Bedford hospital site had launched a tool by which to learn from excellence called GREATiX and it is this concept which Bedfordshire hospitals intends to build upon. Throughout the coming year we will develop a revised version of the GREATiX system, moving away from its current link to the Datix incident reporting system, to an online form and hard copy format which are easily accessible for all staff.

The form will allow for a short descriptor of the excellence incident being reported in order that the learning opportunity can be understood. In addition, it will provide an opportunity to commend either the individual or team who have been witnessed in providing excellence in patient care and/or safety in the workplace. All staff and/or teams nominated will receive recognition by way of a certificate and the Quality and Safety Governance team will review the reports to pull out learning and feedback to the clinical service lines.

After Action Reviews (AARs)

AARs for Bedfordshire Hospitals NHS Trust

Prior to merger both hospital Trusts had well understood incident reporting and escalation processes and, over the last year, our serious incident processes have come together to provide an integrated approach.

In doing so we recognised there was room to improve systems for those incidents that did not meet the serious incident investigation threshold to ensure more effective and consistent learning. In addition, in line with our drive to learn from excellence, we felt there was no process to review the drivers of excellence when events have gone well.

To bridge that gap the Trust is implementing the use of After Action Reviews as a single, consistent approach to review and learning.

What is it?

The after action review process is a structured approach for reflecting on the work of a group and identifying strengths, weaknesses and areas for improvement. An after action review method of evaluation usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved and it captures learning, which can then be shared more widely.

When to use it

AARs can be used after any activity or event that has been particularly successful or unsuccessful. It is particularly helpful in learning widely so that good practice can be shared and others can learn from mistakes.

How to use it

AARs aim to include as many of the multi-disciplinary team involved in the activity or event so that a wide range of viewpoints can be explored. A prerequisite of an AAR is that everyone feels able to contribute without fear of blame or retribution. AARs are about learning, not holding people to account.

This approach will allow a commonality of methodology and foster an improved learning and sharing environment through the use of AARs. It will not only provide support for debrief and learning from incidents but will provide the organisation with a clear debriefing process for supporting staff and learning following any significant event.

AARs involve a trained facilitator (conductor) who can guide the group through the discussion and help create a safe and open atmosphere.

Discussions tend to last a maximum of one hour and the conductor will guide the group through a series of questions:

- What happened that we want to learn from?

Creating a common understanding of the experience under review:

- What did we set out to do?
- What actually happened?
- Why were there differences?
- What went well? Why?

Reflecting on the successes and failures:

- • What could have gone better? Why?
- Identifying specific recommendations:
- What would you do differently next time? What next?

Finally, the implementation of the AAR programme supports the revised Patient Safety Strategy, particularly the requirements of the Patient Safety Incident Response Framework (PSIRF). AAR is strongly advocated within the PSIRF as a tool to improve understanding of safety by drawing greater insight from all patient safety incidents and enhance learning opportunities.

Integration & Transformation

Background

The Integration & Transformation Team (ITT) formed on 1 April 2020 post the merger between L&D and BHT. The Team's portfolio of work covers four main areas: Clinical Integration, Corporate Integration and Large-scale Transformation and the Merger Benefits Realisation Programme.

Corporate Integration

ITT support the corporate areas with their post transaction implementation plans to form the key enablers that supports the clinical teams. This is critical to successful clinical integration within the hospital, and ranges from consultations to the merging of policies/procedures to digital systems merging.

Transformation

The ITT work on cross cutting transformational programmes which cover multiple clinical service lines (CSLs). The two main areas of focus are Theatres Re-design, predominantly on the Bedford Site and Outpatients Re-design cross-site.

Theatres Re-design consists of three workstreams; Elective Bookings, Pre-operative assessment and Theatre Productivity. All of which aim to improve the patient pathway to make it more efficient and responsive to patient needs.

The Outpatients Re-design is focusing on virtual appointments and patient initiated follow-ups across CSLs, which should prevent patients having to travel to the sites unnecessarily.

Clinical Integration

The bulk of the team's resource is dedicated to supporting the CSLs through their integration journey. In order to ensure the correct level of support to whose CSLs will the largest and/or most integration agendas, the CSLs have been categorised into the following:

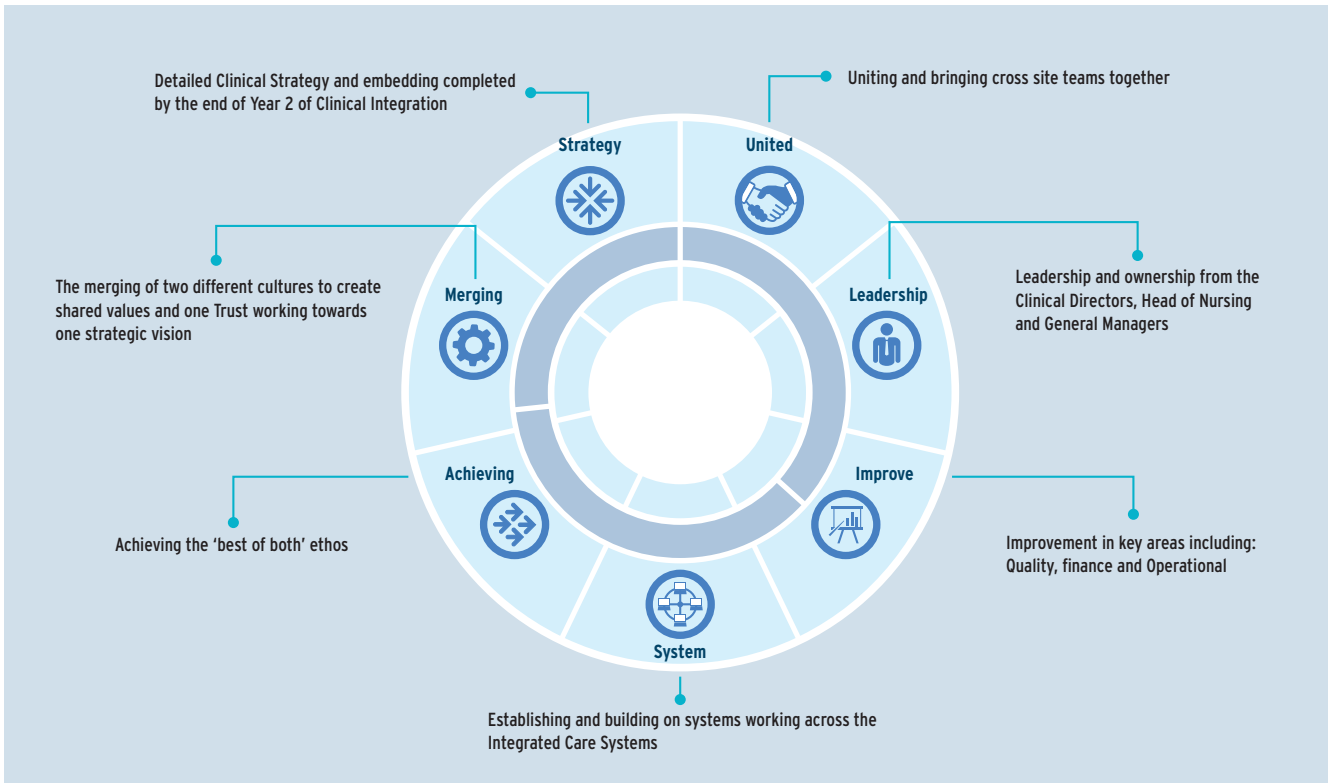
Category 1	Category 2	Category 3
Vascular Trauma & Orthopaedics Gastro / Endoscopy Cardiology General Surgery Imaging / Breast Screening Womens - Maternity & Gynaecology	Plastic Surgery Pharmacy Therapies / Limbs Orthotics Urology Clinical Haematology Neurology Respiratory Stroke DME / Frailty Breast	OMFS ENT Pathology Ophthalmology Dermatology End of Life Rheumatology Diabetes / Endocrine Paediatrics inc. NICU Renal Critical Care Anaethetcis Cancer Acute Medicine ED Ambulatory Care

In order to formulate the clinical strategies the CSLs utilise the clinical integration model, which consists of 3 phases; the discovery phase, outputs and implementation.

All clinical strategies are submitted to the Clinical Validation Committee in the first instance, which consists of a group of senior clinicians chaired by the Medical Directors where strategies are scrutinised and considered as part of the Trust's wider strategy including interdependent services. These, in turn, are ratified by the Integration Board, chaired by the Trust CEO.

To ensure patient care is at the centre of decision making a Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) is completed with every strategy to ensure any negative impacts are considered and discussed. If the Board deem a change to be unsatisfactory it will not go ahead to Integration Board and will need to be revised by the CSL. Once in implementation the CSLs must produce QIAs for any service changes outside of business as usual which will need to go to the CVC for approval before proceeding.

Ultimately, the aim for clinical service lines is to have the following outputs:



Integration: Progress to date

The merged organisation has an ethos of clinically led and managerially enabled. One of the key tasks for completion in the integration journey was the appointment of cross-site Clinical Directors for CSLs to lead change. In the first year, Clinical Directors have been appointed to the majority of CSLs with the exception of those where it is clinically appropriate to have site based leads.

To date, four clinical integration strategies have been presented and approved at Clinical Validation Committee and Integration Board; Vascular, Plastic Surgery, General Surgery and Imaging & Breast Screening. The focus of all the strategies is to improve the quality of care provided to patients through pathway reviews and re-design. Any major changes to services will be submitted to the Regional Clinical Senate for review; Vascular is currently in the pipeline to attend this meeting due to proposing a change of site for services.

Corporate integration is progressing with the majority of areas finalised consultations within their teams and supporting the CSLs with the enabling components for integration. The Digital Strategy remains an important focus.

Project management software, PM3, has been implemented within the Trust. At present, all corporate project plans are uploaded to the system with highlight reports generated monthly for Integration Board. Once

clinical strategies are approved the implementation plans will be monitored through the system.

In further collaboration with the ICS, conversations have begun to roll PM3 out across the ICS for discreet programmes of work.

Non-financial and financial merger benefits are also being captured throughout the integration journey.

Future Plans

- The Trust are on track to produce an overarching and detailed Clinical Strategy by September 2022
- A Surgical Strategy will be in place by Summer 2021 working in parallel with COVID Recovery Programme and BLMK Accelerator Programme
- Cardiology, DME/Frailty and Pharmacy Clinical Strategies planned for June with Trauma & Orthopaedics for July
- A focus on the importance of culture/OD in conjunction with integration going forward
- Those strategies that have been approved moving into implementation with regular progress reporting to CVC and Integration Board
- Progression of working with the BLMK ICS on patient pathway re-design aligned to clinical integration working to improve patient outcomes for the local population
- Focus on movement into a quality improvement approach and culture of continuous improvement throughout the Trust through the re-launch of QSIR

teaching programme

- Ensuring the ongoing capturing of benefits associated with the merger both financial and non-financial
- Development of a strategy for patient participation in the formation of clinical strategies and implementation plans to ensure service users views are considered

Site Redevelopment

Luton & Dunstable Hospital NHS Foundation & Bedford Hospital NHS Trust merged on the 1st April 2020 forming Bedfordshire Hospitals NHS Foundation Trust.

The joint Medical Directors and the Chief Nurse have overall accountability for Quality and Safety delivery and the Director of Quality and Safety Governance has accountability for the systems and processes that underpin that delivery together with responsibility for regulatory and compliance improvements to deliver an optimal CQC rating for the organisation.

Quality Management Structure

There is a single oversight sub-committee of the Trust Board, the Quality Committee, chaired by a Non-Executive Director. A Clinical Quality Operational Board (CQuOB), chaired by a Medical Director/Chief Nurse which provides an assurance and risk report to the Quality Committee.

To support the CQuOB there is a further operational sub-Board, The Specialist Committee Oversight Board (SCOB). This committee will be responsible for oversight of those groups which have a topic specific mandatory or statutory responsibility e.g. resuscitation committee, thrombosis committee etc. and is chaired by Medical Director to foster clinical engagement, a written upward summary highlight report of activity, describing any issues of risks and gaps in assurance directly to CQuOB and onto the Quality Committee.

The Trusts vision is;

“To attract the best people, value and develop them so that the teams they work in deliver outstanding care to our patients”

This vision places significant emphasis on employing the very best staff and ensuring they are equipped and inspired to work to the highest standards. Furthermore, the organisation has a commitment to providing exemplar clinical services informed by consideration of the “best from both”

The Trust has a culture of learning and continuous quality improvement, which it hopes it is more likely

to achieve a rating of Outstanding in CQC ratings.

Therefore, in fostering this approach, the corporate quality and safety governance functions are aligned to support not only the transactional elements of the quality governance agenda but will support learning and transformation ensuring that, where suboptimal clinical performance is identified, improvement action is prioritised and supported.

Quality Priorities

Priority 1 - Improve Patient experience

Improving our patients' experience is very important to us. We know that to improve our patients' experience we need to consider 'what matters most to our patients?'

Priority 2 - Improve Patient Safety

People assume, quite rightly, that hospitals are safe places. It is everyone's responsibility to take all possible steps to avoid harm to our patients.

Priority 3 - Delivering Excellent Clinical Outcomes

As a Trust, we strive to provide the most effective, evidence-based care for our patients in order to ensure the best possible clinical outcomes.

Priority 4 - Prevention of Ill Health

The Trust is committed to working with our staff and partner organisations to deliver improvements in the health and wellbeing of our community (patients and our staff), by engaging in a range of health prevention initiatives and strategies.

We are committed to developing, coordinating and expanding our capacity and capability to continually improve. In order to support the delivery of our quality priorities and ensure an excellent experience for our patients, carers and staff, we recognise the need to continue with and further develop the resources and support mechanisms.

The Trust outlined in the OBC the clinical objectives of redeveloping the L&D site. Each of these objectives supports the organisations Quality Priorities and will result in a range of clinical quality benefits.

Objectives

- The resolution of maintenance backlog issues relating to the Delivery Suite, Maternity Wards and Triage, the Neonatal, Critical Care, modular theatres (Theatres A-D) and Trust headquarters, significantly reducing the risk associated with service delivery and service maintenance.
- The co-location of 14 operating theatres, introducing a “pod” system which is designed to support patient outcomes and flow.
- The flexibility of the design addresses current workforce challenges experienced across theatres and critical care through service co-location.
- Increased capacity within maternity, neonatal care, surgery and critical care to support demand.
- Sustainability and efficiency of services will be improved

Benefits

The development of new buildings will assist in the achievement of the quality and safety standards and improvement in patient experience outcomes linked to the organisations quality priorities.

Priority 1 - Improve Patient experience - Improved Clinical Quality

- Critical care same sex accommodation we will be providing separate male and female accommodation
- Provide private and dignified bathroom facilities for patients in both maternity & critical care with en-suite facilities in the delivery suite and bathroom facilities for (L2) patients in critical care
- Provide access for patients, staff and visitors with disabilities (DDA compliant accommodation) giving accessibility to all
- Maintain business continuity by providing service resilience with compliant accommodation
- Improve friends and family feedback across maternity, neonates, critical care and theatres with complaint accommodation
- Reduce staff time responding to complaints from patients and families due to the environment by delivering better accommodation
- Paediatrics undergoing elective surgery will stay in hospital through an improved surgical pathway, having accommodation for the arrival and recovery will provide shorter pathways and decrease overall LOS for children freeing up paediatric nursing time
- Reduced agency staff by providing a high performing and happy workforce and retain skills within the organisation improving patient outcomes

Priority 2 - Improve Patient Safety

- Clinical segregation in theatres for Paediatric patients including surgical arrivals and recovery by providing separate adult and child accommodation
- Reduce clinical incidents by providing ventilated clinical accommodation in line with HBN requirements offering appropriate air changes in clinical accommodation
- Reduce backlog requirement per annum to eliminate completely
- All new accommodation provided will be Health & Safety compliant
- Providing PLACE compliant accommodation

Priority 3 - Delivering Excellent Clinical Outcomes - Maximising space efficiencies

- Reduction in waiting times for surgery by creating capacity to manage demand
- Birthing mums requiring level 3 neonatal beds will stay local using increased delivery suite capacity preventing in utero transfers out due to lack of capacity
- Level 3 babies will stay local using increased neonatal capacity preventing ex utero transfers
- Critical Care level 2 & 3 patients receive the right level of care in the right environment with rapid access by creating capacity to manage demand and reduce transfer times ensuring no patient is waiting for a L2 or L3 bed

Priority 4 - Prevention of Ill Health

- By coordinating and expanding our capacity and capability relieves pressure on our system partners preventing further deterioration of conditions, supporting the well-being of our patients.

Bedford Hospital A&E expansion

The Trust received an allocation of £3.75m towards the end of 2020 to support the Covid response. The allocation had to be used to expand ED capacity, increase socially distant waiting space, ensuring no patient waiting outside to be seen, and to ensure segregated flows. The project at Bedford has 3 distinct phases; phase 1 increased the SDEC capacity on Victoria ward. Phase 2 provided a modular extension to support segregated and enlarged waiting and triage spaces. Phase 3 provided an increase to cubicle capacity and the segregation of adults and children. The scheme supports the Covid response, and importantly, it supports improved access and patient

outcomes, through increased capacity and earlier decision making. Furthermore, the investment aligns with the Children and Young People Strategy, supporting children centred care.

A subsequent project targeting rapid access to diagnostics for patients on an emergency pathway, will see CT provision in the A&E department. This scheme will complete in 2022.

Primary care hub, Bedford

The Trust continues to work closely with their colleagues across the ICS, to support primary care at scale and is aligned to the population health benefits that this brings. Plans are underway to design a primary care hub in Bedford, bringing together a number of GPs with community health teams and mental health. The national hub programme aims to deliver primary care services at scale supporting population health through improved health outcomes, a reduction in health inequalities, improved access and admission avoidance to secondary care, amongst other things.

Car Parking

The Trust invested £6m in 2020/21 to provide car parking for patients, staff and visitors on both hospital sites. The car parking investment aligns with the trust's redevelopment plans and transport and access strategy. Whilst the Trust adopts and supports a number of sustainability measures, including greener travel options to both hospital sites, car parking is a necessity and improving access for patients, aims to support them at the start of the journey on to the hospital site.

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. Furthermore, the Trust will seek to integrate the teams and the quality improvement endeavours across both sites of the newly merged organisation.

Our staff and the feedback from the people using our services were central to the development of our Quality Strategy launched in 2017/18 and the Trust is committed to continued delivery of that strategy, thus ensuring a quality improvement methodology is applied both locally and corporately in addressing issues and risks identified.

To support that delivery the Trust appointed an executive Director of Quality and Safety Governance to provide leadership to our quality improvement plans, with specific objectives around maintaining the Trust's Care Quality Commission's (CQC) rating of good together with developing a programme of work to support the organisation on its journey to outstanding. Over the past year, the work of the Quality and Safety Division has continued to evolve to bring sharper focus to learning and improving in a triangulated way. This work will continue to develop as we consult on the structures needed to deliver new ways of working in the newly merged organisation.

A delivery plan has been developed to provide a focus for the quality improvement agenda and a broad outline of key elements for that plan are summarised in the diagram below.





Local Accreditation and Shared Decision Making

Local accreditation programmes have been implemented in numerous locations across the UK and when used effectively have been shown to drive improved patient outcomes, increase staff engagement, satisfaction and retention and their experience at ward and unit level. Accreditation can be used to generate a collective shared goal, helping communication, encouraging ownership and providing robust measurements of care delivery and improvement.

Monitoring a detailed set of standards allows for sensitive measurement of an areas performance and progress, allowing both internal and external benchmarking and providing accessible, detailed measures of quality and safety performance on an individual area level. This in turn generates a robust framework for re-evaluating progress using documented development plans. Implementing and embedding an accreditation framework enables us to identify and celebrate excellence in practice, generate a culture of continuous improvement and tailor ongoing support to an area's specific needs.

This approach will enable collective leadership to underline all nursing and midwifery practice at Bedfordshire Hospitals NHS Foundation Trust, and will be instrumental in the Nursing Strategy and our progress towards achieving Pathway to Excellence® Accreditation as one of the 14 Trusts selected nationally to form the first NHS cohort.

Benefits of local accreditation:

For patients:

- Demonstrates a commitment to quality of care and patient experience
- Reduces avoidable patient harm
- Standardises best practice, reducing unwarranted variation in outcomes
- Promotes the professional image of the nursing and midwifery workforce
- Provides an accessible measure of a ward or departments performance and care delivery

For staff:

- Sets clear expectations of standards of care and provides a measure of how well their ward / department is performing against these
- Identifies and celebrates excellence in nursing and midwifery care, allowing staff recognition and the sharing of best practice
- Increases staff engagement and reduces turnover, sickness and reliance on temporary staff
- Ensures effective leadership at all levels and provides focus for teams

- Creates a platform for continuous improvement, allowing opportunities for all staff to contribute and engage in local quality improvement projects.

For the Organisation:

- Ward - to - board assurance on quality of care and compliance with fundamental standards
- Reduces unwarranted variation by utilising an evidence-based, standardised approach which supports the delivery of care and provides a focus for quality improvement.
- Improves accountability at all levels and encourages shared governance by identifying both excellent practice and key risks.
- Provides a platform for shared learning, enabling all wards and areas to learn and share excellent practice.
- Creates a strong culture of pride and accomplishment, supporting collective leadership and professional development.

Accreditation Process

190 elements are assessed within the 14 Accreditation standards during a detailed, unannounced visit by a team of senior nurses. This is supported by data gathered from other sources, such as rosters, training records, incidents and complaints. The assessment team spend a day in the Care Unit, observing the environment, clinical practice and nursing documentation, as well as speaking to staff and patients. A 'Time to Shine' interview is conducted with the Unit Manager at the end of the visit, enabling them to share their successes and achievements, as well as highlighting any challenges or key risks.

Fig 1: Accreditation Standards

1. Organisation and Management of the Clinical Area
2. Environmental Safety
3. Safeguarding Patients
4. Patient Safety
5. Person Centred Care
6. Nutrition and Hydration
7. Pressure Ulcers
8. Falls Prevention
9. Elimination
10. Pain Management
11. Medicines Management
12. End of Life Care
13. Communication
14. Infection Prevention and Control

A detailed report is compiled, with key successes and examples of excellence in practice highlighted, alongside suggested areas for improvement. If the threshold for accreditation is reached, the team are awarded an accreditation rating (Bronze, Silver or Gold) according to their performance against the standards. A personalised development plan is devised, and support is implemented as detailed in Fig. 2. The Accreditation team offers support to the unit managers and their teams to implement their planned improvements, in collaboration with Nursing and Midwifery leaders.

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Fig. 2: Accreditation thresholds and support for development

Standard	Total Red standards	Actions
Gold	1-2	Plan drawn up to sustain current standards. Regular 1:1s between matron and unit manager to review and refine a development plan. Allocated as a buddy to a bronze ward / area to share best practice. Presented with certificate / plaque to display in entrance to ward
Silver	3-4	Local development plan which covers sustaining success in green elements and identifies improvements in amber / reds Regular 1:1s between matron and unit manager to review and refine development plan. Consider support from specialist teams in specific areas - eg. IPC, meds management etc Support with QI projects to address risks. Presented with certificate / plaque to display in entrance to ward
Bronze	5 - 11	Local development plan which covers sustaining success in green elements and identifies and prioritises risk in amber / reds enabling quality improvement efforts to be best directed. Support implemented from relevant specialist teams eg. IPC, meds management etc. Regular 1:1s between Matron and Ward manager. Regular 1:1s between Matron and relevant HON to show improvements against red rated standards. Support given with QI projects to address key risks and improve red standards. Presented with certificate / plaque to display in entrance to ward Requests for additional resource support through matron / assessment team.
White	12-13	Not Accredited. Immediate collaborative review of results to identify and resolve any safety concerns. Intensive support to ward implemented, including 1:1 support to ward manager / leadership team. Development plan supported by corporate nursing team in addition to above plan.

When a Unit successfully achieves accreditation, this is celebrated at a presentation with representation from their leadership team. A certificate is presented by the Chief Nurse to be displayed within their unit and key positive observations are publicly shared. The timescale for reassessment is dependent on the level of accreditation achieved and will be conducted using the same process (Fig. 3).

Fig 3: Reassessment Timescales

White	Immediate support measures, reassess after approx. 1 month
Bronze	Reassess in approx. 2 months
Silver	Reassess in approx.. 4 months
Gold	Reassess in approx. 6 months

Progress

The first phase of the Accreditation process began in August 2020; since then 20 assessments have been completed, with all Units successfully achieving Accreditation. To date 1 gold, 6 silver and 13 bronze Accreditations have been awarded. As a new method of assessment, with intentionally high thresholds it was expected that most, if not all Care Units would achieve bronze accreditation at first assessment.

Findings so far

The thresholds within the tool are set deliberately high to encourage progression through the accreditation levels, and demonstrate our commitment to providing the highest standards of safety and quality for all of our patients. This aspirational approach ensures longevity of the programme, and supports our teams to achieve excellence in practice. It is therefore to be expected that many standards will be returned as red during the first round of assessments; particularly as within some standards it only requires 1 element to be unmet in order to score red. Although the elements within the tool will be familiar to the Care Unit teams, they have not been

assessed in this comprehensive format before, which provides an opportunity to focus their priorities and support them to progress.

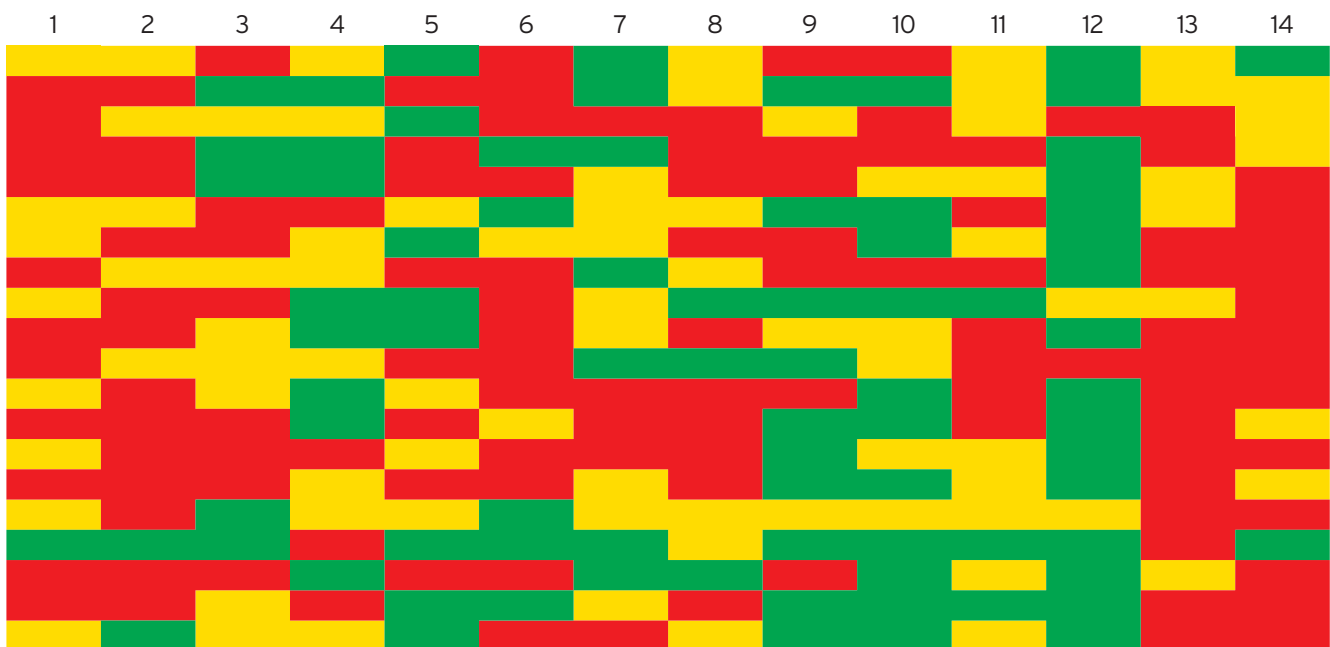
Due to the weighting within the assessment, the overall scoring and analysis is based on the number of 'red' results, as amber demonstrates > 80% compliance and green >90%.

From this analysis (fig. 4) it is clear to see that there are some areas which are performing consistently well against assessment, in particular End of Life Care, with Pressure Ulcer Prevention and Patient Safety also achieving good results in most areas.

There are also clear areas for focused improvement, such as Falls Prevention, Communication and Medicines Management.

Further breakdown of these standards allows detailed analysis to inform training, quality improvement initiatives and collaborative working with specialist teams.

Fig 4. Results Heatmap



- 1. Organisation and Management of the Clinical Area
- 2. Environmental Safety
- 3. Safeguarding Patients
- 4. Patient Safety
- 5. Person Centred Care
- 6. Nutrition and Hydration
- 7. Pressure Ulcers
- 8. Falls Prevention
- 9. Elimination
- 10. Pain Management
- 11. Medicines Management
- 12. End of Life Care
- 13. Communication
- 14. Infection Prevention and Control

Sharing Best Practice

Care Unit managers that have demonstrated excellent results in a particular area can provide peer support and guidance to areas who have not scored so highly. An example of this would be in relation to documentation standards where the manager of the well performing area was identified as a 'buddy' for a Care unit manager who had not achieved consistently good results. They were able to advise on strategies for sustained improvement, which has been well received.

The engagement seen from the Care Unit Managers and their teams has been inspiring; a desire to improve and obtain the highest standards of care delivery is underpinning numerous improvement initiatives across the organisation. The accreditation team will support the dissemination and sharing of successes and learning in order to ensure that all areas are able to benefit from it.

Supporting Organisational Improvement

The results from the Accreditation programme so far have already begun to inform and provide evidence for improvement at an organisational level. An example of this is discussed in detail below.

Standard 8. Falls Prevention

The detailed results for standard 8 demonstrate generally good compliance with risk assessment, reassessment and completion of the post fall protocol when indicated. The results highlight issues with the recording of lying and standing blood pressure, vision assessments and medication review.

On reviewing the results, a limitation of the current methodology has been identified, as the current elements only focus on documentation review. When the tool is revised following the first complete cycle of assessments this will be expanded to include observation of practice and the assessment of staff knowledge.

This data has been reported to the Bedfordshire Hospitals Falls Steering Group to inform discussion and planning of Improvement initiatives. A pilot project is underway to trial a new model for 'Falls Champions' with representation from each Care Unit and the Therapies Team. The proposed model of combining education and skills sessions with a dedicated Shared Decision Making Forum aims to support a cohort of empowered Falls Champions across the organisation who can affect positive changes in practice within their clinical areas. The efficacy of the pilot will be reviewed after 6 months and learning shared. The multi-professional nature of the steering group facilitates collaborative working between all stakeholders, which will be instrumental in improving compliance with elements such as the medication review.

Supporting Local Improvement and Shared Decision Making

The Care Unit Managers and their teams are encouraged to take ownership of their Accreditation results, which has resulted in initiatives such as forming local working groups to focus on meeting the Accreditation standards, with involvement from team members at all levels. An example of this is on Ward 3, where the Unit Manager produced an accreditation guide for all team members, sharing their results in detail and including photos of examples of improvements identified. This documents their starting point and allows them to see visible progress with improvements.

Consistent messaging is given that progress along the accreditation journey, towards 'Gold' accreditation and beyond is unique to that area and team, engaging with the process and availing themselves of the support offered will enable them to achieve their desired results.

The formation of a Care Unit Shared Decision Making Forum is encouraged as this enables all staff to contribute to local improvement, sharing their ideas and accessing peer support to put them into practice; as well as discussing challenges and working through them collaboratively. It also enables access to the Leadership Forum, consisting of representatives from all active forums across the organisation and chaired by Liz Lees. This provides a platform for sharing successes, learning and excellent practice alongside escalating challenges or risks identified.

Support is offered by the Accreditation team with improvement initiatives identified locally in response to the Accreditation feedback. Some examples of this include:

- A project underway on Shand Ward to trial new information boards above the patient's bed to ensure all relevant safety and clinical care information is clearly displayed.
- Redesigned display boards displayed on Ward 23 to ensure all staff are able to access relevant information for safe and effective practice.
- A night shift checklist implemented on Ward 11 for the Nurse in Charge to ensure that all relevant documentation has been commenced / completed and relevant safety checks have been conducted overnight.
- A new local induction process, designed by the Care Unit team to support new starters and ensure they have access to all necessary information on AAU.

Accreditation results and feedback will be reviewed within Quality Performance Meetings, held with the Chief Nurse and Nursing, Midwifery and Therapies Leaders alongside other Quality and Performance Metrics. This enables organisational oversight of local achievements and the identification of any additional support requirements.

Next Steps

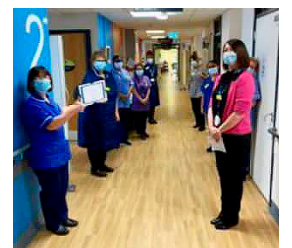
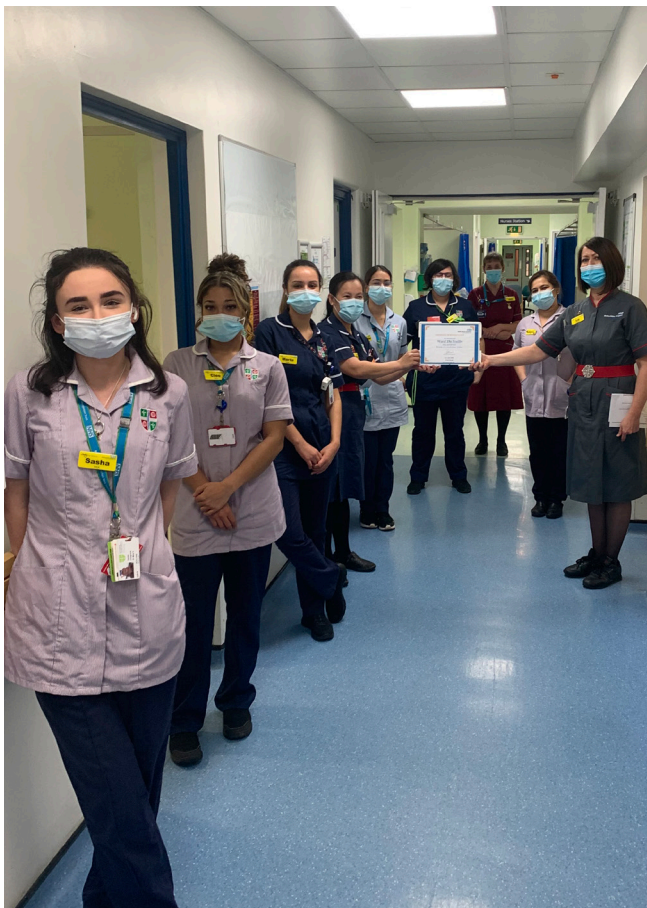
Due to the unavoidable delays to the programme during the pandemic response, it has not been possible to conduct revisits in accordance with the original timescale planned. As the programme recommences this month, a balance will be sought between accomplishing all initial assessments in adult inpatient areas and revisiting units to allow them to evidence and celebrate their progress against the standards. It is projected that all adult inpatient areas will have had their initial assessments completed by the end of October 2021.

As expected the majority of Care Units have begun their journey with bronze accreditation, and are being supported to work towards achieving gold. Once an area has sustained gold for a minimum of three assessments, they will be eligible to apply to become an exemplar ward. We anticipate reaching this point in approximately 2 years and rigorous process will be developed to ensure that an area merits this prestigious award. Modified tools are being developed for other areas keen to commence Local Accreditation, including Maternity, Paediatrics, Theatres and Outpatients, informed by learning from the rollout across the adult inpatient areas, and tools in use in other organisations nationally.

Conclusion

The engagement and enthusiasm demonstrated by Care Unit managers and their teams for the accreditation process is highly commended, particularly in light of the past challenging year. This is key to ensuring that the accreditation programme achieves its aim of supporting all areas to achieve and sustain the highest levels of safety and quality in care delivery.

All Care Units assessed through this process so far have successfully achieved accreditation, and many examples of excellent practice have been identified. There are also a number of areas for improvement highlighted, both on an organisational and local level. Multiple improvement initiatives are underway with many more in the planning phase. The aspirational approach taken when designing the tool ensures longevity of the programme and allows our teams to use this process to be confident they are providing the highest standards of care at all times. Local accreditation facilitates both internal and external benchmarking as well as providing robust assurance of the quality and safety standards being achieved within all Care Units. It enables Care Unit managers and their teams to take ownership of their areas and their commitment to demonstrating improvement and achieving the desired results is evident.

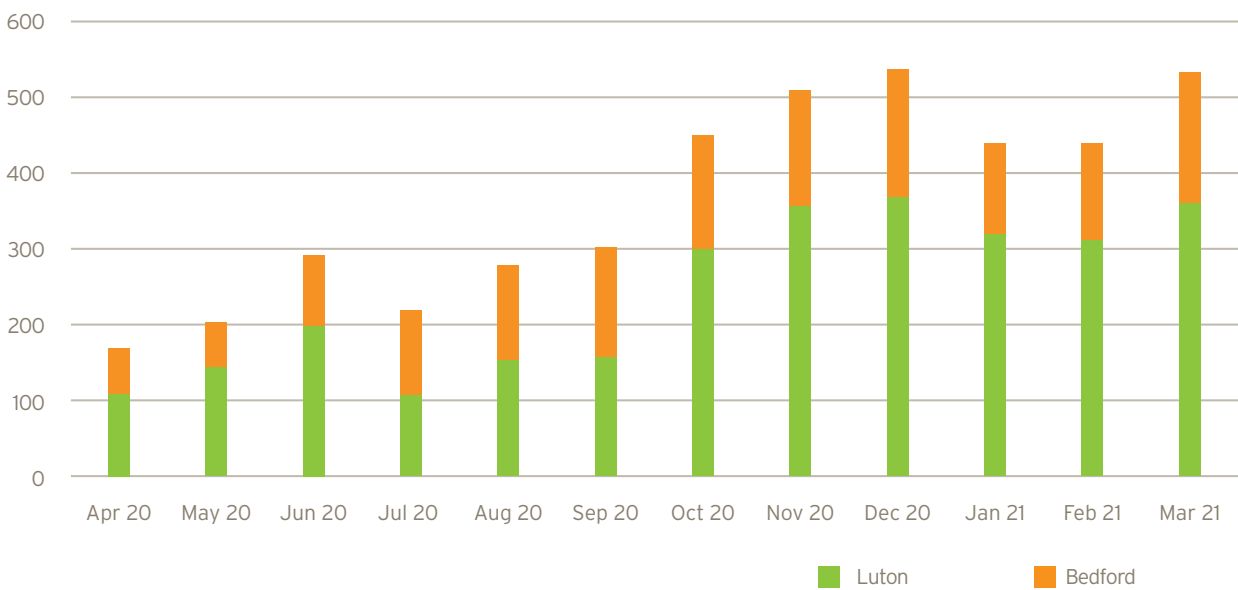


3.16 Complaints

The Trust has continued to work towards streamlining processes and achieving goals set in 2019/20. Not only is it important that we listen to people who give us feedback, whether they are patients, loved ones, carers or visitors, but that we also respond to them in a timely and robust way that addresses the issues they raise. We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations.

The Patient Advice and Liaison Team (PALS) have maintained a presence in the last year, in order to resolve issues raised with them and prevent escalation to formal complaints. This has been largely via email and telephone, owing to the impact of Covid restrictions and the reduced visiting for patients on site. Some face-to-face meetings have taken place and a few virtual meetings to support those with concerns about care. During 2020/2021, we received 4388 PALS concerns.

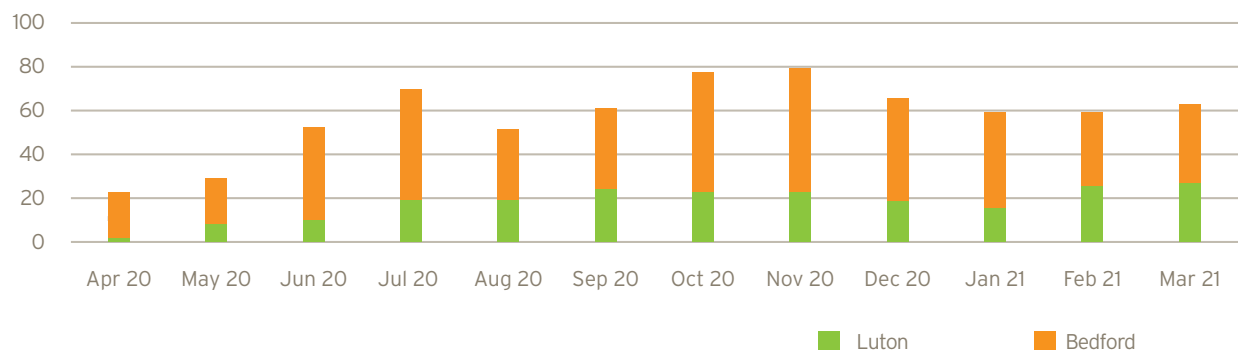
PALS Concerns 2020/21



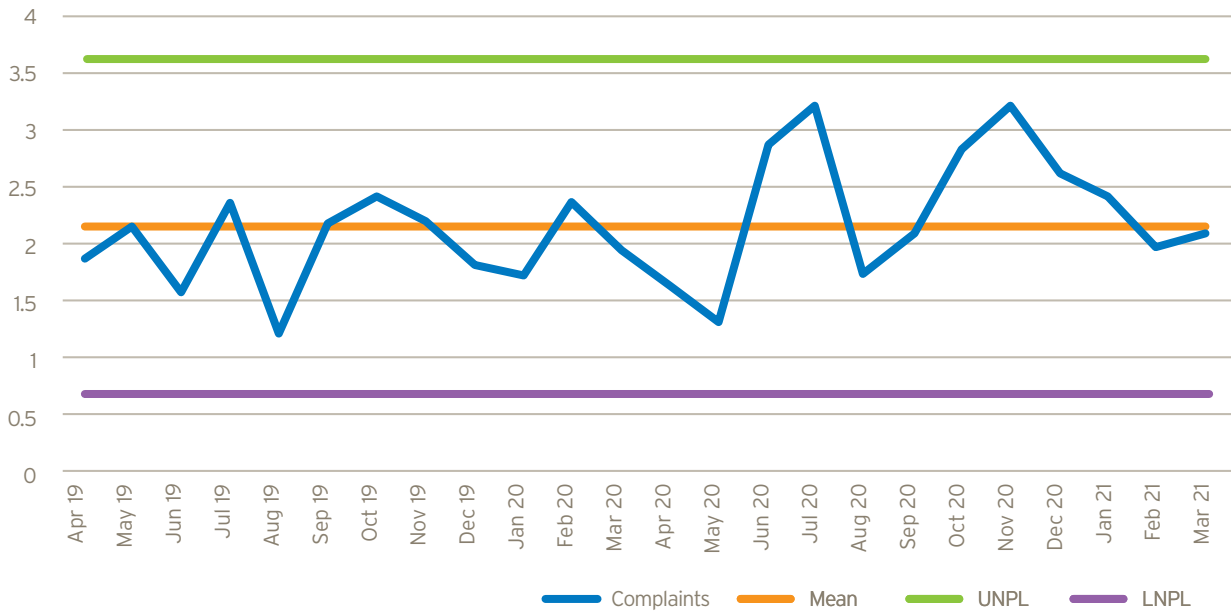
During 2020/2021, we received 698 formal complaints. There has been a decrease in formal complaints due to early intervention by the PALS Team, resolving issues before they get to the formal stage, as well as work by Clinical, Service and General Managers to deal with them

early. This is a reflection on the hard work and proactive efforts by all members of staff and positive outcomes compared to increased number of patients coming into the hospital.

Complaints by month 2020/21



Number of Complaints per 1000 bed days, both sites combined



We endeavour to acknowledge all complaints within 3 working days and have achieved an average of 99.6 %.

During this year, the target for responding to complaints has been standardised for both sites to 35 working days. Each site has some differences in how the complaints are managed and responses achieved. The patient experience team have commenced review of the complaint processes to achieve consistency at both sites within the new clinical service structures

The goal remains to respond to complaints within 35 working days, and whilst all teams strive to achieve this target, in some cases it is not always attainable. Some delays may be beyond the control of team but careful monitoring of progress by the central team, under the lead of the Chief Nurse, has seen an improvement during the year. At the Luton site, weekly tracker is sent to all service line Complaints Leads, which is RAG rated identifying where on the timeline each of the complaints in their service line is placed. Those RAG rated as overdue are prioritised and reasons for the delay are fed back to the central team, where further assistance is given. This reporting system has been implemented at the Bedford site.

During the year, the Datix system has been modified to reflect the new merged Trust clinical service line structure. The patient experience teams are providing reports for these new teams that relate to their performance for quality reviews and boards. Further integration of the Datix system and patient experience modules is planned to enable cross-site reporting and consistently applied categorisation.

Whilst some Covid measures have been in place, the Parliamentary and Health Service Ombudsman (PHSO) suspended the investigations of complaints in response to the Covid pandemic from 26/03/2020 to 01/07/2020. At Bedfordshire Hospitals Trust, the complaints were still internally investigated and this process was not significantly delayed.

Learning from Complaints

In 2020/21 we continue to share learning from complaints at service level through the governance process. Below are examples of some of the improvements made during 2019/20: Examples include:-

May 2020 - Management of eye injuries in the Urgent Treatment Centre - A meeting was held with streaming nurses and other clinicians regarding the referral pathway for eye injuries. All clinicians invited to a case discussion on acute eye injuries resulting in a training programme on slit lamp examination/PH testing to avoid any future mismanagement of such cases.

July 2020 - Thyroid Function tests performed in A&E - Complainant had to return to hospital at a later date after long wait in A&E for thyroid function testing. - Learning shared with all clinicians the department to reiterate that TFT testing can be done by telephoning the laboratory first; improving patient experience and avoiding return trips to hospital.

September 2020 - as a result of a complaint regarding poor communication with a family member relating to a patient's deterioration, all staff were asked to reflect on

their communication and the patient and complainant's story was included in the ward monthly newsletter.

ED senior nurses (HoN, DHoN and Matron) have now arranged with the PALS staff for them to ring their mobile rather than sending emails if they have an issue to be resolved. This has enabled issues to be resolved quickly rather than being missed as clinical staff may not see the emails in a timely way.

Listening to Patient Concerns

The top five themes of complaints related to Clinical Treatment, Communication, Appointment Delays and Cancellations, Values and Behaviours (attitude of staff) and Admissions and Discharges.

The majority of complaints were resolved at the local resolution level. Unfortunately, in the last year, six complainants asked the PHSO to review their complaints. During this year the PHSO has not upheld one case, partially upheld one case and four are still under investigation. One case has also been through the mediation process.

During this year, complaints and PALs teams at both sites have amalgamated into one team and have begun the review of the complaints process. The Covid pressures however have resulted in this detailed review being delayed until Q1 in 2021/22 and is underway at time of this report (May 2021).

Compliments

We also keep a log of all compliments and if received centrally the relevant staff or the service is given the feedback. Below are examples of some of the compliments we received:

General

'Extremely high praise for all involved in the Patient's care when he was admitted with COVID. The whole team at L&D were amazing not just the nurses and doctors who were fighting for my life but everyone from the paramedics, A&E, Radiologists, Porters, cleaners, the meal man as I called him. Everyone was outstanding and so kind and caring.'

Maternity

'I am writing to inform you of my positive experience. Fourth delivery and finally I had a midwife who listened. She was everything I needed and I truly felt blessed to have been gifted such a beautiful soul to assist in the delivery of my fourth child. I would like to thank her for being herself, lovely, empathetic, maternal and the dept. That trained her for my positive birthing experience.'

Surgical ward

The son stated that the care his mother received was exemplary and the staff on the ward did a fantastic job at caring for their mother. Not only was the care given to their mother outstanding but also the support the son and his brother received was brilliant. In particular surgical clinical practitioner who had to call them with the difficult news, everything was explained to them. They were able to come in and spend time with her and be with her when she took her last breath and her death was as peaceful as it could have been. He also mentioned three nurses by name.

AAU

'I just wanted to say thank you to the nurses on AAU after my nan's recent stay there, she came in very unwell and did decline at one point, but with their close monitoring and care my nan quickly improved and is now thankfully at home recovering, she mentioned that a nurse in particular was very kind and helped her with her medication and explained what the doctors had said so she could get a better understanding as to what was going on and to inform family, and on one of her worst days she said she had a lovely CSW help her get up out of bed and assist with showering and sitting up in her chair which made her feel much better. My nan lastly mentioned a nurse who had made her laugh and a Dr for overseeing her care. I am extremely grateful for the care my nan received, the quick treatment and monitoring as things could have been very different. She will now be followed up as an outpatient to continue to be monitored. Thank you again, you all do not receive enough credit especially when there can be shortages, but you all still delivered a high level of care.'

A&E

'My 19 year old son attended A&E on Thursday morning feeling suicidal, anxious and quite depressed. From the moment of arriving at reception until his discharge later that day, his care was excellent and I am sending my heartfelt thanks and gratitude to all the members of staff he came into contact with.'

3.17 Friends and Family Test

The Friends and Family Test (FFT) continues to be a mandated programme to gather patient feedback. The organisation submits monthly data to NHS England.

Since the merger of the Trust, there have been two systems in operation to gather FFT data. At Bedford hospital the healthcare communications system Envoy has been used, and largely relies on text messages to patients after their care episode. At the Luton site the IQVIA system has been used and patient feedback is provided by patients using iPad. The impact of Covid

was significant, as reporting ceased nationally in April 2020 and recommenced in January 2021. During this time, FFT data was gathered for the Bedford site, with the use of Text messages and as such did not pose a Covid transmission risk. Data collection continued. At the Luton site data collection was suspended, as use of the iPads would have posed an infection control transmission risk. Nationally, patient feedback was collected from December 2020.

At the end of March 2021, the contract with Healthcare communication was terminated at the Bedford site, who will adopt the IQVIA system for FFT data going forward.

Following the national review of the FFT process by NHS England the Trust has implemented the change to the questions asked. Patients will be asked about their experience rather than recommending a service, which is far more appropriate for people using hospital services. They are

- Thinking about your recent visit, overall, how was your experience of our service?

Respondents will be asked to rate the experience from 'very good' to 'very poor'.

- What was good about your visit?
- What could we improve?

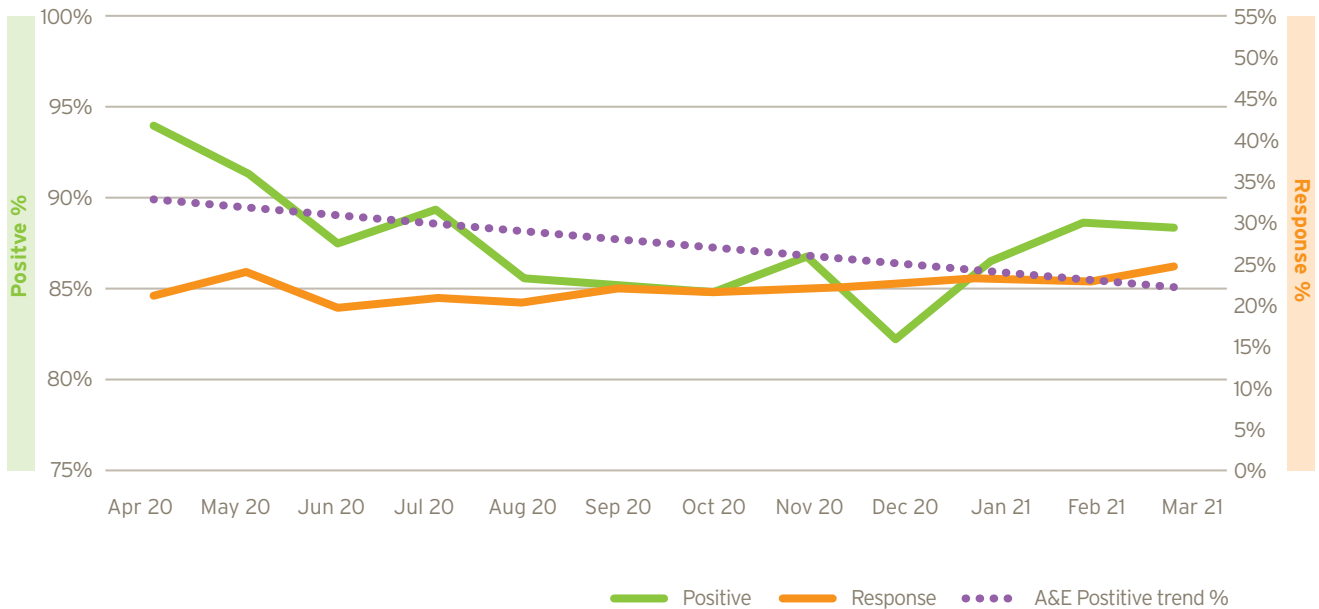
We continue to collect information from the following clinical areas:

- Inpatients and Day Case Patients
- Maternity Services
- Outpatient Service
- Emergency Department (ED)

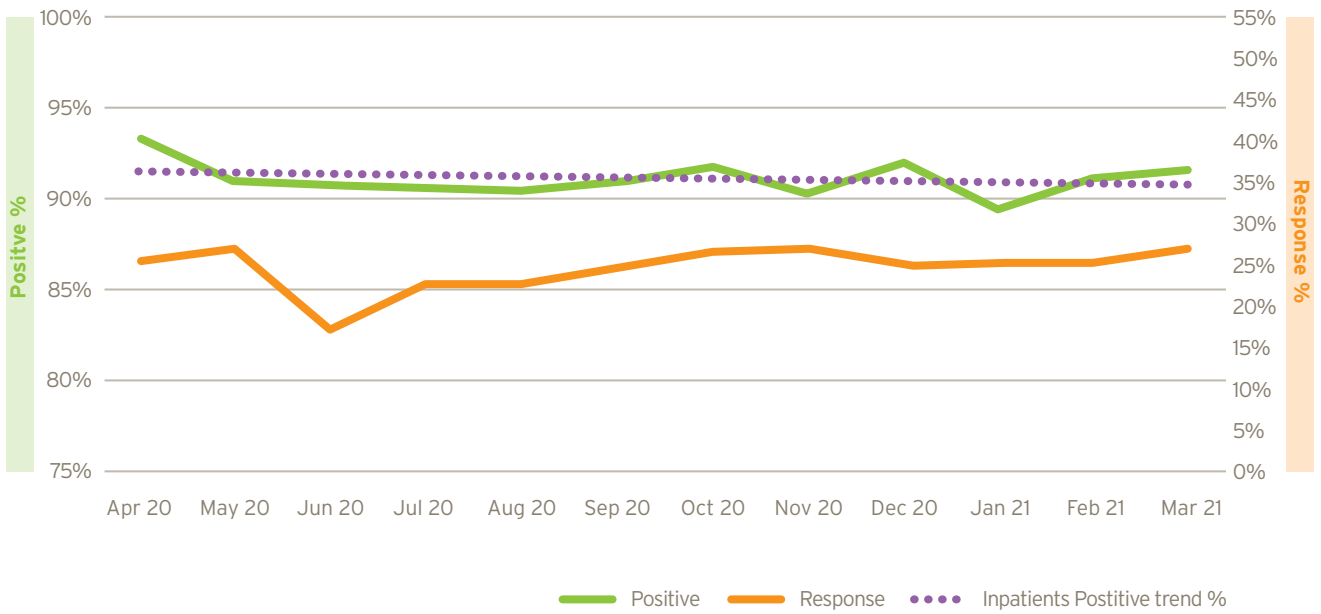
Monthly reports relating to patient experience feedback were reviewed at the Clinical Outcomes and Quality Committee, then to Quality Committee.

The plan for 2021/22 is to utilise the narrative feedback for each clinical area and demonstrate what improvements and changes have been made in response this feedback.

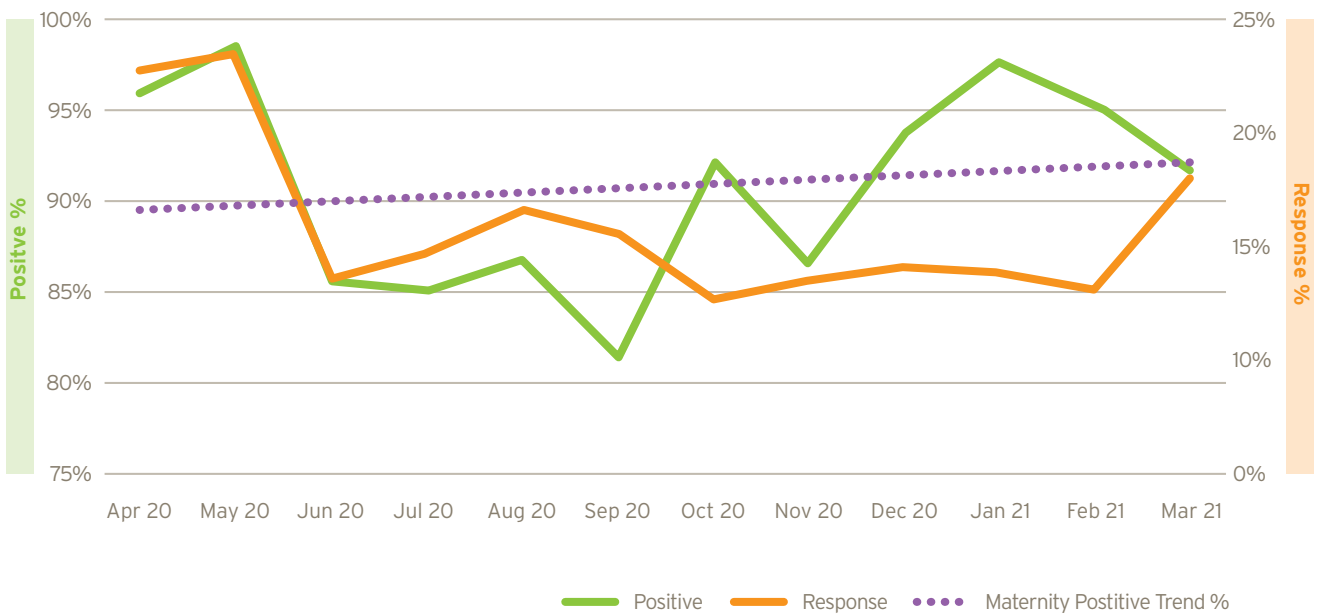
Bedford FFT Positive Scores & Response Rates - A&E 2020/21



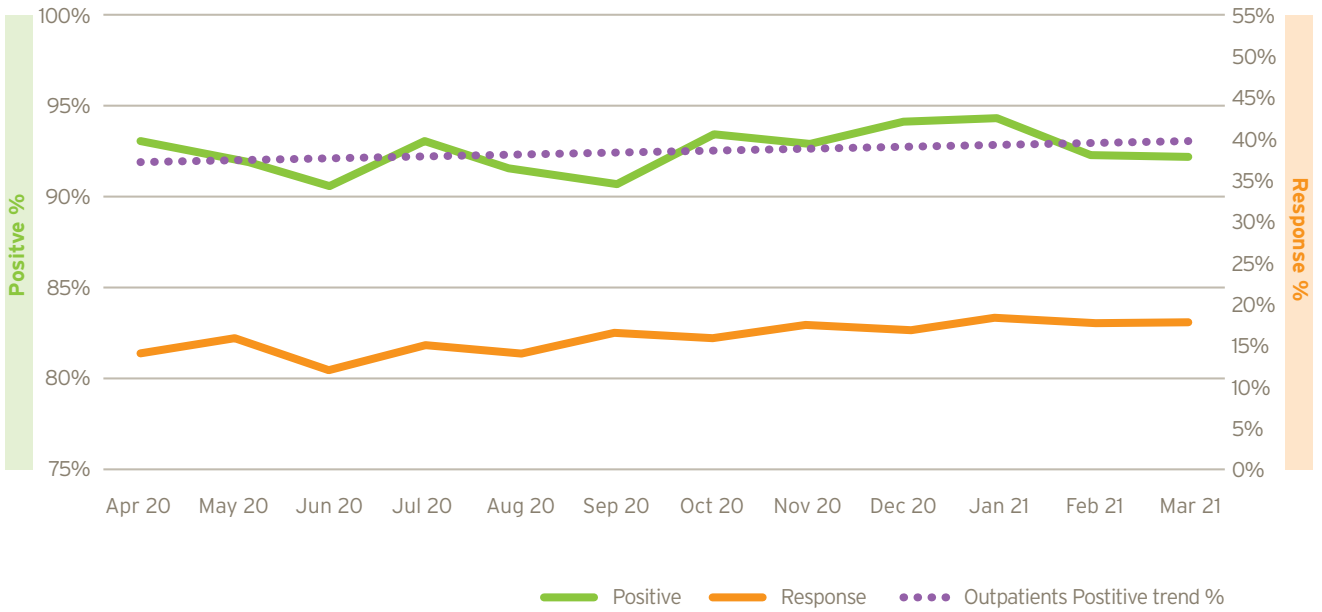
Bedford FFT Positive Scores & Response Rates - Inpatients 2020/21



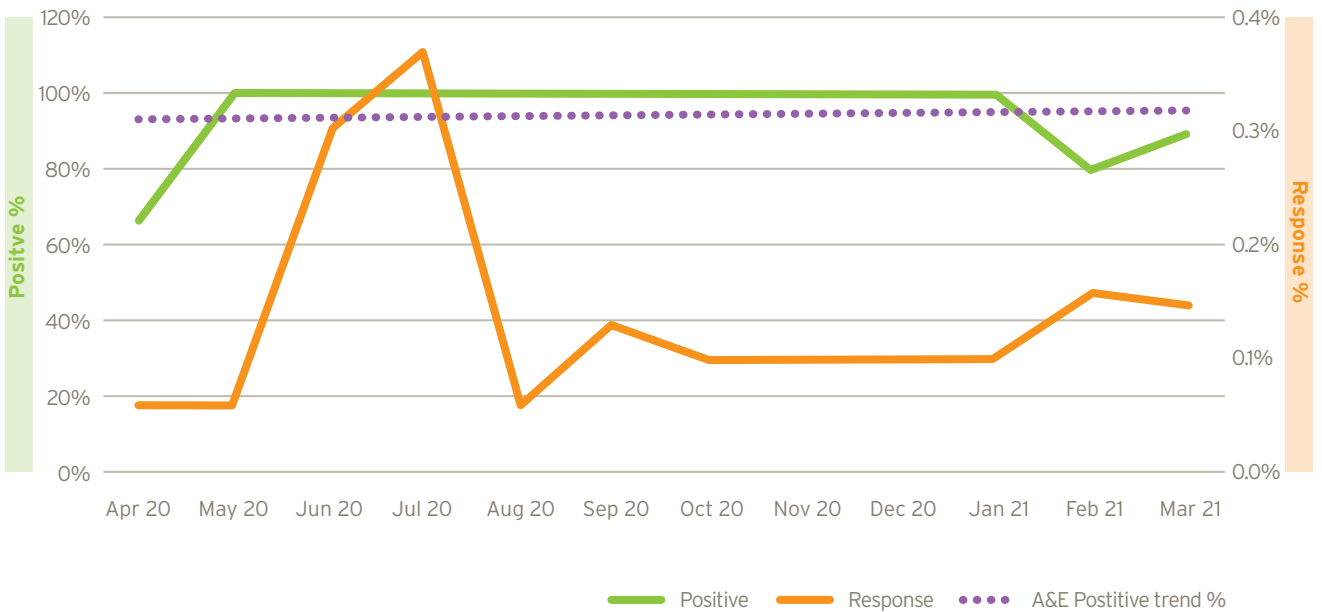
Bedford FFT Positive Scores & Response Rates - Maternity 2020/21



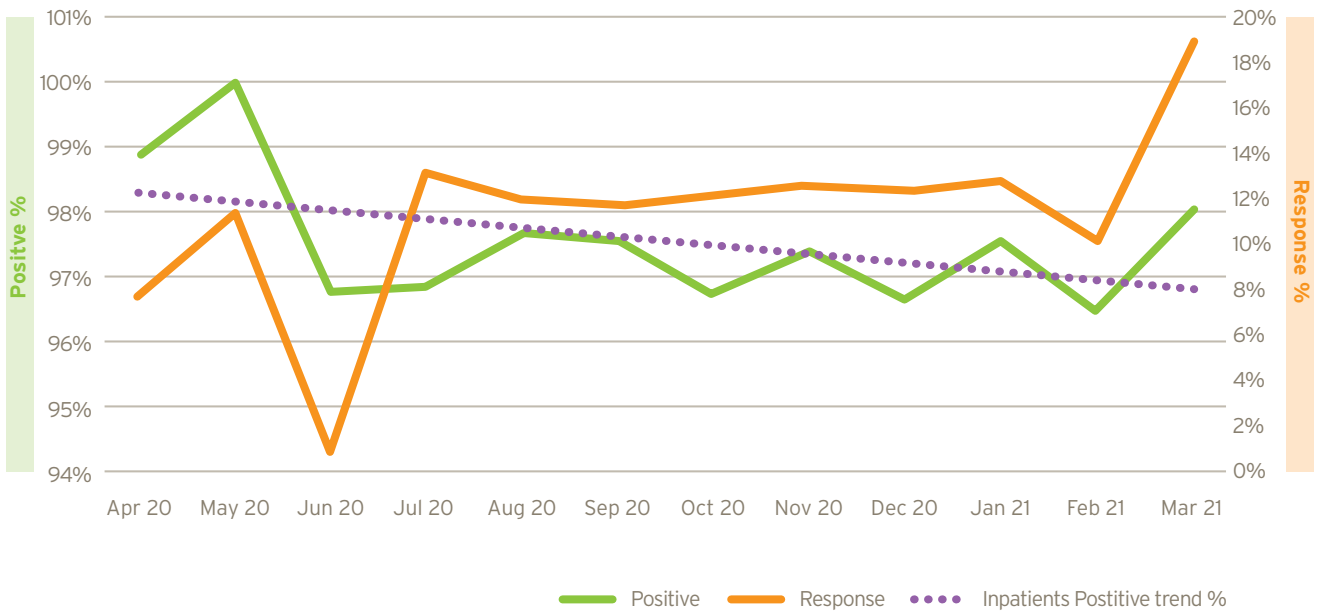
Bedford FFT Positive Scores & Response Rates - Outpatients 2020/21



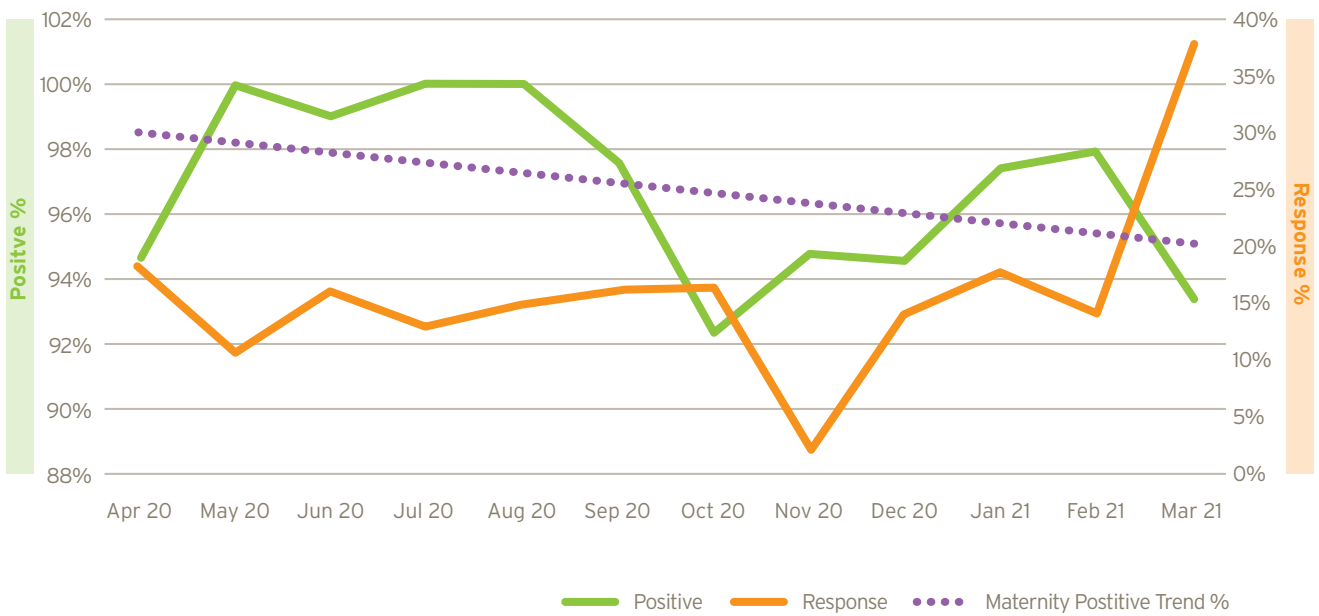
Luton FFT Positive Scores & Response Rates - A&E 2020/21



Luton FFT Positive Scores & Response Rates - Inpatients 2020/21



Luton FFT Positive Scores & Response Rates - Maternity 2020/21



3.18 National Surveys CQC

The impact of Covid has delayed the 2020 surveys for Urgent and Emergency care, Inpatients and Children and Young people. Patients have been surveyed in the Summer and Autumn of 2020 and publication of these surveys is expected in September and November 2021. The Maternity 2020 survey was postponed by a year.

In the summer of 2020 the Trust converted its survey contractor to Quality Health.

National Inpatient Survey 2019

The national inpatient survey reports were published by the CQC on 2nd July 2020. Detailed management reports are shared internally and a programme of work will be developed and monitored at Quality committee.

Service impact of COVID

Visiting restriction and Next of Kin (NOK) Helpline

Since March 2020, the Covid restrictions required visiting to be restricted for in-patients and partners of women in maternity services.

In the early phase of the Covid restrictions between March to June 2020, a Next of Kin (NoK) Liaison service was established at both sites to support the carers and NoK of patients in the absence of visiting. IT infrastructure systems meant at each site this service was operated differently. This continued until early June 2020. This service provided much relief for patient and their families. The service received patient property and conveyed emails and messages to patients. In some instances, a video service was enabled to use virtual meetings for patients and their NoK. Some exemptions were made for end of life patients, children and women in labour and visiting allowed in controlled circumstances. Clinical teams have resumed responsibility for liaising with relatives. In September, a pilot scheme for visiting was commenced however; this had to be discontinued as transmission rates of Covid-19 in the community increased. In late January 2021, as the pandemic was at a peak, the NOK service was reinstated, then closed in mid-March.

Improvements to PALs process

ED senior nurses (HoN, DHoN and Matron) now arrange with PALS staff for them to ring their mobile rather than sending emails if they have an issue to be resolved. This has enabled issues to be resolved quickly rather than being missed as clinical staff may not see the emails.

During the second wave of the pandemic, the Emergency Admission Units introduced a system whereby a member of staff was tasked each day with ringing relatives to update them about their loved ones and record any issues raised. This complimented the work of the NoK Helpline and resulted in very few calls made the helpline because relatives were being updated in a timely manner. This process was adopted by a number of wards and significantly reduced the number of calls made to the Helpline

The team also themed some of the issues normally reported under the generic term communication to generate some discussion and improvement work to address the most common concerns. This has led to a focussed piece of work with outpatients as a recurrent theme.

3.19 National Staff Survey 2020

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in eleven indicators. The indicator scores are based on a score out of 10 for certain questions with the score being the average of those.

The survey ran from the beginning of October to the end November 2020 and was published on the 11th March 2021.

The survey was a full on-line staff survey; with paper copies available for those with no digital access. 2,600 surveys were completed with an overall response rate of 35% compared to a national average response rate of 49%. Some technical issues affected the response rate on the Luton site which are being addressed ahead of the next survey.

As the first survey for Bedfordshire Hospitals NHS Foundation Trust, there is no direct comparable historical data, however a proxy, based on last year's predecessor organisation results, has identified areas of good performance and priorities for attention.

National Results

Scores for each indicator together with that of the survey benchmarking Group 'Acute Trusts' are presented below.

	2020/21		2019/20			2018/19		
	Trust	Benchmarking Group	L&D	Bedford	Benchmarking Group	L&D	Bedford	Benchmarking Group
Equality, diversity and inclusion	8.9	9.1	8.8	9.0	9.0	9.0	9.0	9.1
Health and Wellbeing	5.9	6.1	6.1	5.9	5.9	6.0	5.9	5.9
Immediate Managers	6.6	6.8	7.0	6.8	6.8	6.9	6.7	6.7
Morale	6.0	6.2	6.3	6.0	6.1	6.1	6.1	6.1
Quality of Appraisals	Not measured	Not measured	6.2	5.8	5.6	6.0	5.7	5.4
Quality of care	7.5	7.5	7.8	7.6	7.5	7.6	7.4	7.4
Safe environment - bullying and Harassment	8.0	8.1	7.9	8.0	7.9	7.9	8.0	7.9
Safe environment - violence	9.4	9.5	9.4	9.6	9.4	9.5	9.5	9.4
Safety culture	6.7	6.8	6.8	6.8	6.7	6.8	6.7	6.6
Staff engagement	7.0	7.0	7.3	7.0	7.0	7.2	7.1	7.0
Team working	6.4	6.5	6.8	6.5	6.6	Not measured	Not measured	Not measured

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 difference between the national average and the Trust overall average score was either 0.1 or 0.2.

Local Analysis

Based on the proxy historical comparison it is encouraging to see the most improved areas are:

- In last 3 months, have not come to work when not feeling well enough to perform duties (52%)
- Last experience of physical violence reported (74%)
- Don't work any additional paid hours per week for this organisation, over and above contracted hours (60%)
- Enough staff at organisation to do my job properly (38%)
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public (73%)

There are areas for improvement in particular support from immediate line managers, work related stress and staff considering leaving the organisation, are of concern. A combination of the pandemic coupled with the merger will have affected the feedback from staff. Analysis indicates five main themes for us to focus on in the coming year:

- Equality Diversity & Inclusion
- Health & Wellbeing
- Immediate Managers
- Morale
- Team working

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

Equality Diversity & Inclusion

There has been good progress with equality, diversity and inclusion, specifically with the launch of the Black, Asian and Minority Ethnic staff network in June 2020. However, there is still much to do and we plan to launch further staff affinity networks, improve our Equality, Diversity and Inclusion training, launch a Reciprocal Mentoring programme, improve the diversity of our FTSU Champions and further develop our Talent Management process and succession planning over the coming months.

Health & Wellbeing

During the height of the pandemic, we introduced wellbeing hubs and have since embarked upon a programme of enhancing our wellbeing and rest facilities across all sites. As we emerge from the pandemic and into a new phase, the health and wellbeing of our people has never been more important. We have employed an Occupational Psychologist to work alongside our Head of Wellbeing and Occupational Health teams and in addition to local and national offers we are introducing a variety of easy access and sustainable health & wellbeing initiatives and support for managers.

Immediate Managers

We recognise that the past 12 months have been especially challenging for our managers and team leaders and we are focusing on providing them with development and support including the resumption of a Managers toolkit, wellbeing conversation guide, leadership development, introduction of a talent management and succession planning, coaching and mentoring and community of practice action learning sets.

Morale

In addition to supporting line managers to support their teams, we have reintroduced monthly individual and team awards, redesigned our staff engagement events and improved internal communication channels.

Team working

Teamwork is at the heart of our new THRIVE values and also underpins our clinically lead and managerially enabled ethos. By supporting our managers, Health & wellbeing initiatives, the development of more staff affinity networks, staff engagement events, the initiation of a range of internal Leadership development programmes for Medical and non-medical staff, we will improve staff experience and strengthening our teams as they deliver safe, sustainable and high quality services to our local communities.

3.20 Health and Wellbeing / Occupational Health

Occupational Health/Health and wellbeing

We have an Occupational Health department on each of our two sites, offering a full range of Occupational Health and Wellbeing Services which contribute to increasing the effectiveness of the organisation, by enhancing staff performance and morale through reducing ill-health, absence and accidents. A merge of both Occupational Health Departments is likely in the future although not imminently. The Occupational Health team on the Luton and Dunstable Hospital site were successful in retaining their reaccreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the Faculty of Occupational Medicine. SEQOHS accreditation is the formal recognition that an Occupational Health Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

During 2020/2021, Covid-19 presented many challenges, in dealing with multiple complex issues, resulting in a majority of Occupational Health time being involved in risk assessments, supporting staff and signposting to specialist services with regards mental health challenges.

At the end of March 2020, it was recognised that spaces on both sites needed to be created in order that staff could have an area away from their work space in order to focus on their own wellbeing and refuel and recharge. These spaces were in place for approximately three months and were supported with many donations of food and drink from our local communities. The spaces included information on health and wellbeing, and advice on how to access additional support if required. What the Covid-19 experience has taught us, is that our staff need to have spaces that they can go to in order to have some quiet time and space, and this is something that is currently being examined further.

With staff continuing to face immeasurable distress, with the challenges that Covid-19 presented, it was increasingly important that we supported their mental, emotional and physical well-being through the continuing provision of an Employee Assistance Programme (EAP). Whilst this had been available to the LD staff for a number of years, the service was extended to include our Bedford site colleagues, and was supported by Charitable funds. Mental Health support was also provided by our colleagues from EPUT and ELFT who offered up some additional support

for Covid-19 related mental health first aid support, which was accessed through our Occupational Health teams.

The importance of enhanced psychological support for our staff has been recognised, and with this in mind we were successful in obtaining funding from NHS Charities together, for the provision of a full time clinical psychology post (fixed term one year contract), to work with the Occupational Health teams to ensure our staff are able to avail themselves of timely support and interventions where required.

Smoking cessation

In August 2020, the Luton and Dunstable Hospital became a smoke free site. Staff receive support through Total Wellbeing Luton and have access via the specially set up text service to free support.

Flu Vaccine

This year's flu vaccine uptake by frontline staff was 67.4%.

At Luton and Dunstable, uptake was 70% (compared to 81% last year) and at Bedford, uptake was 63.89% (compared to 74.5% last year). The uptake figures were disappointing and lower than many other acute NHS Trusts. It has been hard to establish reasons for the lower uptake, with a majority of those staff actively declining stating that they just didn't want it, and the second most popular reason was individuals being concerned about side effects.

Vaccination against Covid-19

From the beginning of January, the Trust established a vaccination hub to deliver the Covid-19 vaccination to staff working within healthcare settings, both from within the Trust and the local health system.

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 indicator 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 which occurred outside of hospital within 30 days (inclusive) of discharge.

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	Best performing Trust	Worst performing 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
% 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	1	59	N/A
	Published May 21 (Jan 20 - Dec 20)	35	37	8	61	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 intends to take the following actions to improve this score, and so the quality of its services, by:
- On-going Use of “Structured Judgement Reviews” led by our team of newly appointed Medical Examiners, as a methodology for mortality reviews. The learning from these feeds through to the regular morbidity and mortality learning meetings held within each of the clinical services
- We have appointed a Board-level Executive lead for the Mortality Review Process, and we have a non-Executive lead charged with oversight and challenge.
- The outcomes from Mortality Reviews are shared quarterly through a Board level quality report as from September 2017.
- Membership of our Learning from Deaths Board has been broadened to include representation from external stakeholders; including our lead Clinical Commissioning Group this allows oversight to ensure that any deaths that require a community review are subject to a consistent process.

Indicator: Readmission within 28 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	National Average	Best performing Trust	Worst performing Trust
Patients aged 0 - 15 years	2019/20	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2018/19	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2019/20	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2020/21	Not Avail*	Not Avail*	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 is being reduced by six months, however, at time of publication of the 2020/21 Quality Account, the 2020/21 data is only provisional.

	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	2017/18	0.43	0.46	0.55	0.36
	2018/19	0.45	0.46	0.52	0.41
	2019/20	0.37	0.46	0.54*	0.37*
	2020/21	Only provisional data available on NHS Digital			
Primary knee replacement	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	Only provisional data available on NHS Digital			

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 CCG 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	*	*	*	*
	2020/21	*	*	*	*

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. 2018/19 data relates to the survey of people who were inpatients in July 2018, who responded to a survey between August 2018-January 2019, which was published in August 2019.

*The data for this indicator for patients responding to the 2019 and the 2020 inpatient survey has not yet been published on NHS Digital (as at 28th May 2021). The 2020 survey would have provided the first available data for the new Bedfordshire Hospitals NHS Foundation Trust.

The Bedfordshire Hospitals NHS Foundation Trust intends to take the following actions to improve responsiveness to personal needs of patients, and so the quality of its services, by:

- Themes from complaints identified discharge from hospital as a concern. Therefore this was included as a Quality Account Priority for 2020/21 and will continue for 2021/22.

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%

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			

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 - although there was a national pause on VTE data collection requirements during 2020/21 due to the Covid pandemic.
- The Bedfordshire Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:
- Introduction of an electronic VTE risk assessment tool, this mandates risk assessments on admission and prompts our clinicians to consider prescribing thromboprophylaxis at the same time.

Indicator: Clostridium 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 <i>C. difficile</i> 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 HOHA	8.3	17.0	0	76.1
	COHA	7.1	7.7	0	33.3

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 *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
- *Data for the rolling 12 months to February 2021 includes L&D data prior to merger (PHE Fingertips)

The reporting criteria for diarrhoeal disease due to *Clostridium difficile* changed from the previous financial year 2019/20.

For 2019/20 and onwards, cases reported to the healthcare associated infection data capture system are assigned as follows:

1. *Hospital onset healthcare associated (HOHA)*: cases that are detected in the hospital two or more days after admission.
2. *Community onset healthcare associated (COHA)*: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
3. *Community onset indeterminate association*: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.

4. Community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

In 2019-20 the Health care associated or hospital acquired cases (HA) i.e. Trust apportioned cases included the first 2 categories (HOHA & COHA).

All cases of *Clostridium difficile* diarrhoea were 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. The Trust follows the agreed appeals process with the CCG in cases where it is established that there were “No lapses of care”. All C.difficile isolates are typed to enable early warning of clusters or point source outbreaks.

Indicator: Patient safety incident rate

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or 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)	April 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
	April 19 - Sept 19	n=5019 r=43.24	49.8	26.3	103.8
	Oct 19 - Mar 20	BH n= 3551 r=48.05 LDH n=5970 r=50.13	National comparative data unavailable at time of reporting		
Total number (n) and percentage (%) patient safety incidents resulting in severe harm or death	April 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
	April 19 - Sept 19	n=17 0.34 %	0.3	1.6	0
	Oct 19 - Mar 20	BH n=31 0.87% LDH n=22 0.37%	National comparative data unavailable at time of reporting		

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 safety incidents;
- Data is collated internally and then submitted to the National Reporting and Learning System
- Data is taken directly from NRLS reports

The number of patient safety incidents reported continues to reflect a positive culture for reporting all patient safety incidents and near misses. The number and percentage of incidents resulting in severe harm or death has reduced following the introduction of a more consistent approach to aligning the level of harm reported to NRLS with the outcomes of investigations. 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 over the next year or so. We work closely with commissioners and the National Reporting and Learning

System (NRLS) to ensure that any changes made to incident classifications following a root cause investigation are reported to NRLS and that data provided to NRLS 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 most recent organisational data was for the period Oct 2019-March 2020, published in October 2020. At the time, the two hospitals were still separate NHS providers so two sets of data are provided. The national comparative data has not been published for the most recent reporting period.

3.22 Performance Against National Priorities

		2017/18	2018/19	2019/20	2020/21	Target 20/21	
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	9	5	42	51	33	
MRSA	To achieve contracted level of 0 cases per annum	1	1	2	2	0	
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	100%	100%	100%	97.3%	96%	
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	89.2%	87.6%	88.7%	73.7%	85%	
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	96.3%	95.8%	93.9%	90.4%	93%	
Cancer	Maximum waiting time of 31 days for second or subsequent treatment						
		Surgery	100%	100%	100%	92.6%	94%
		Anti-cancer Drugs	100%	100%	100%	97.4%	98%
Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	91.9%	91.1%	89.8%	68.6%	92%	
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.4%	98.1%	**	**	95%	
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	3.4	0.8	1.04*** 0.6 (M1-11)	30.5% ***	<1	

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

** Data not provided as Trust part of pilot for new Emergency Access Monitoring data

*** March 2020 and 2020/21 yearly performance adversely impacted by the COVID-19 crisis resulting in cancellation of all but the most urgent diagnostic testing.

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
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
Contenance	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
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 communicate key issues and learning

Term	Description
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.
MRSA (Meticillin-Resistant Staphylococcus aureus)	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.

Term	Description
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
QSIR	Quality, Service Improvement and Redesign 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.
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.

Term	Description
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.
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 2020/21
- 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 2020 to May 2021;
 - papers relating to quality reported to the Board over the period April 2020 to May 2021;
 - feedback from commissioners dated June 2021;
 - feedback from governors dated (suspended requirement due to COVID pandemic);
 - feedback from local Health watch organisations dated June 2021;
 - feedback from Overview and Scrutiny Committee has not been provided this year;
 - [the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 - NHS England suspended data collection and reporting to create capacity for the COVID-19 response];
 - [the 2020 national patient survey is unavailable as delayed due to Covid];
 - the latest national staff survey dated March 2021;
 - the Head of Internal Audit's annual opinion of the trust's control environment (suspended requirement due to COVID pandemic);
 - CQC inspection report dated 7 December 2018 and November 2020.

- 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.

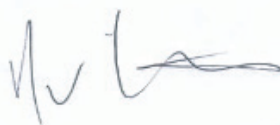
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. By order of the board

28th June 2021



Simon Linnett
Chairman

28th June 2021



David Carter
Chief Executive

Stakeholder Feedback



Statement from Bedfordshire, Luton & Milton Keynes Clinical Commissioning Collaborative (BLMK) to Bedfordshire Hospitals NHS Foundation Trust Quality Account 2020 - 2021

BLMK Commissioning group acknowledges receipt of the 2020/2021 Quality Account from Bedfordshire Hospitals NHS Foundation Trust (BHFT). The Quality Account was shared with BLMK's Non-Executive Director (lead for Patient Safety), Executive Directors, Performance and Quality Teams and systematically reviewed by key members of the CCG's Quality Committee & Performance as part of developing our assurance statement.

The report is a well-constructed document and is welcomed despite the short timeframe for development in an equally challenging time of significant pressure of pandemic. We would like to extend gratitude to all individuals involved in developing and produce this account. We recognize the significant volume of work that is now required in reset and restoration of service provision and would like to commend BHFT on their efforts to manage and support patients and staff through the unparalleled challenges faced through the COVID-19 Pandemic of 2020 and the current additional pressure to resume and catch up on service delivery.

We welcome the joint work across the ICS with other local providers to reduce system pressure and are appreciative of the continued efforts undertaken to prioritise areas of critical/clinical care and re-model wider services to meet patient demand endeavoring to provide a positive patient experience. BLMK CCG will continue to work collaboratively with the BHFT to support these endeavours.

In addition to the ongoing commitment of delivery of Acute care, BLMK CCG values the significant contribution of BHFT to the mass vaccination programme for Covid 19.

BLMK CCG understand that delivery against the 20/21 BHFT collective priorities have been impacted to some degree by the pandemic in delivering the desired outcomes and some of these priorities (NEWS, discharge, and cirrhosis) have been rolled into the 21/22 priorities. Good progress has been made in priority areas such as (iron deficiency for major blood loss in elective surgery, smoke free hospitals and commitment to continue to work in a "just culture" way.

As a system we are working collaboratively across the local maternity and neonatal systems (LMNS) and have worked specifically with Bedford hospital on its recent CQC Maternity inspection/action plan and ongoing Ockendon review action plans. It is welcome therefore, to see MEOWS (Modified early Obstetric warning Score) to enable early identification of deteriorating or seriously ill women, as a priority for 2021/22.

We recognise the significant work of the previous two Trusts in the merger to the one BHFT Trust and the need to realign and refresh an overarching Quality strategy to meet the needs of a new Trust. Acknowledgement of this significant work is important, but are however, mindful from our working with the Trust the level of evolution in areas such as clinical audit and quality improvement. We look forward to work with local teams in utilising these functions to demonstrate evidence in quality improvement work and impact on patient outcomes.

BLMK CCG understand the impact of workforce over the last 18 months and are pleased to see areas of improvement in the NHS Staff surveys and support the identified improvements and potential for aligning some of those quality improvement areas across our collective ICS Peoples Board.

BLMK welcomes the Trust's continued commitment to safe, effective and well-led health care and recognises the Trust's alignment of their quality improvement and quality strategies. The plan provides clarity on direction of strategy (a best of both culture) and associated partnership delivered clinical outcomes in patient experience, safety and prevention of ill health.

We recognise the challenging year we are in as a system and acknowledge the ongoing commitment from the Trust to keep our local population and health workforce safe in the coming year in areas such as focussed Infection Control and flu vaccinations for staff.

We look forward to working with the newly formed Bedfordshire Hospitals NHS Foundation Trust (Bedford Hospital & Luton & Dunstable University Hospital) across our Integrated Care system in 2021/22 and beyond.

Anne Murray
Chief Nurse/Executive Director Nursing & Quality
BLMK Commissioning Collaborative



Luton Council comment on the Bedfordshire Hospitals NHS Foundation Trust Quality Account 2020/21

The Quality Account was sent to Luton Council on 1st June 2021. No response or statement has been received.

Bedford Borough Council comment on the Bedfordshire Hospitals NHS Foundation Trust Quality Account 2020/21

“Thank you for providing the draft Quality Account. Unfortunately the Bedford Borough Council Health Overview and Scrutiny will not be able to provide a comment at this time due to the scheduling, as there is no meeting within the time frame that can agree a response.

We will circulate the draft to the Committee members for their information”

Senior Officer and Policy Adviser (Health)
Central Bedfordshire Council
10th June 2021



Feedback from Healthwatch Central Bedfordshire - Bedfordshire Hospitals NHS Foundation Trust's Quality Account 2020/21.

Healthwatch Central Bedfordshire Directors have had an opportunity to consider and comment on a draft of the Quality Account 2020/21 and can say that we recognise the purpose of the paper and how it allows for increased public accountability, helps drive quality improvement and identifies areas for improvement. We recognise that on the whole it looks at patient safety, the effectiveness of treatments and the patient experience and this leads to the setting of new corporate objectives (see P9).

In relation to those Objectives, we do ask why the recent BLMK ICS Strategic Priorities are not listed or linked to how the Trust will work strategically next year?

We recognise and applaud the extreme pressures that the Trust and its staff were working under this past year and clearly appreciate that the impact Covid-19 still has on hospital activity and thus performance. All are to be thanked for all that they did and continue to do. As ever, or even as usual, we would like to see some terms used explained in more detail in the text (other than in the Glossary) in order to help the general public better understand what is being written. For example, references early on to CQUIN, EBI, NEWS2 and LIFEQI (on P's10-14). These terms will be well known to many health professionals but not necessarily to others reading this Account.

We note and support the drive to eradicate smoking on the Trust sites but ask if the same might also be applied to healthy eating too, setting examples for the public at large, why are late night snacks (from dispensers) primarily sweet, sugary things?

We note the results and comparisons with Local and National Audits but note too, the on-going CQC ratings (P44) that we recognise as coming from 2018 findings but trust that much has been done in relation to those areas that back then 'Requires Improvement'. An example clearly being the work referenced in Bedford Hospital maternity (P45).

We note also (P48) concerns re data quality and do ask why this is still an issue, whilst noting the eight action points set out (P46/7).

In relation to Quality Improvement, we recognise the benefits that will come from the After-Action Reviews (P60/61).

Page 65 lays out the Quality Priorities for the coming year with detail provided and we look forward to those aims being reached and believe that that work links into the Local Accreditation chapter (P70-74) but it would assist comprehension if the Results Heatmap chart (fig4 on P73/74) was set out on a single page.

In relation to Complaints, we note the progress being made, the changes to the Friends & Family Test questions and the mainly positive responses received, though note the slightly downward trends for Luton Inpatients and Maternity Services, that no doubt the Trust will be working on.

We hope that something will be done in relation to staff's uptake of Flu vaccinations, to encourage more to take the vaccine, especially with the on-going pandemic issues.

And we note too the Trusts position in relation to the National Core Set of Quality Indicators and feel sure that Management and Governance arrangements are in place to monitor and action appropriate measures to maintain the highest level of care.

Finally - we say again that we fully appreciate the work done - not only in producing this Report but by all across the site during this the most challenging of times.

Diana Blackmun
Chief Executive Officer
Healthwatch Central Bedfordshire

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Re: Bedfordshire Hospitals NHS Foundation Trust Quality Accounts 2020/21

Healthwatch Luton: Board Director Response: Author - Lucy Nicholson, CEO and Board Director

The Bedfordshire Hospitals NHS Foundation Trust, and specifically the Luton and Dunstable site, has continued to provide an ongoing dialogue with Healthwatch Luton throughout the last year, ensuring patient views and experiences are of paramount importance. Our great relationship with the Patient and Liaison Service and Patient Experience Manager at the L&D allows patient concerns, feedback and queries to be acted upon swiftly and professionally, ensuring patient quality of care is upheld.

Healthwatch Luton provide Luton and Dunstable with Brief Summary Feedback reports of thematic feedback from Luton residents every quarter, as well as individual concerns raised when needed. We found over the last year this feedback from residents altered dependent on the pandemic and continuity of service delivery.

The overall collection of nearly 100 individuals who we spoke too highlighted a near split on positive and negative feedback. In more in-depth analysis of the year’s feedback, it is clear to note that the positive feedback was prior to the pandemic, and then toward the end of the year (with September 2020 showing highest rates of positive feedback on all services delivered in the hospital). In line with most NHS services, there was limited feedback from March - June 2020, and then as the lockdown eased we found more patients returning with experiences, with more of a negative overview. The specific overview of these feedbacks are highlighted to the hospital, and each and every individual query is dealt with personally, something that few other providers are able to do.

The Hospital continues to involve and ensure patient views are embedded in the delivery of their care. Healthwatch Luton meets with the Patient Experience Manager regularly to ensure we can support any programmes of care, and we currently sit on the newly formed Patient Experience Council. We also worked with L&D and Healthwatch England on the national report on Hospital Discharge during the pandemic which many Healthwatch across the network fed in to. (https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20201026%20Peoples%20experiences%20of%20leaving%20hospital%20during%20COVID-19_0.pdf)



Themes

The main feedback theme from people in Luton in 2020 for hospital care was mainly focused on treatment and care. On further analysis of this feedback, many people reported issues regarding ongoing care - or care supported by other organisations supporting hospital care (such as social care and community services). The access to services theme was weighted disproportionately during the pandemic, as many services focused on the pandemic effort and could

not provide ongoing care for ongoing conditions. The communications theme was also weighted through March - June around family communications for those staying on wards during the pandemic or communications out from the hospital to those with long term conditions and accessing services. The hospital swiftly reacted to the pandemic and patient concerns, and created a family line for family members to communicate with those patients staying at the hospital

Theme	Count	Positive	Negative	Neutral
Treatment and care	27	48%	52%	0%
Access to services	19	21%	74%	5%
Communication	17	12%	71%	18%
Unspecified	17	59%	24%	18%
Administration	12	0%	92%	8%
Continuity and integration of care	10	0%	90%	10%
Referrals	10	0%	90%	10%
Staff	10	60%	30%	10%
Diagnosis/assessment	7	0%	100%	0%

All of the above themes have been addressed in individual case management, and we continue to work closely with the hospital in the development of the NHS transformation in becoming an Integrated Care System, as well as engaging through the formed Bedfordshire Care Alliance. We work on preventative programmes of work with the hospital, upholding patient views to ensure their feedback and experiences shape delivery of care, such as with cancer care services, pain management services and acute hospital stays and experiences.

We are very aware of how hard the last year has been for the Hospitals Trust, on both sites, and welcome the merger as well as the transformations within the NHS which will affect the whole health and care system.

Healthwatch Luton commend the staff and workforce at the hospital who have provided many people with comfort and care through a global pandemic, as well as uphold patient experience in their system design and reacted to patient views.

“Today I had my appointment by telephone and got my blood test results, had a chat about my health. A reassuring consultation and over within 10 minutes too. A far more efficient use of time for a busy consultant and myself. This has got to be the way forward for the NHS. Thank you.”



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