Bedfordshire Hospitals
NHS Foundation Trust

QUALITY ACCOUNT

for the period April 2021
to March 2022

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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 2021/21 is included in this account alongside our priorities and goals for quality improvement in 2022/23 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 which sets out our corporate objectives for the coming year.
- Our performance in 2021/22 against the priorities that we set for patient safety, clinical effectiveness and patient experience.
- Our quality priorities and goals for 2022/23 for the same categories and 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 which includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.
- Our quality performance which 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 'super diverse' 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 per cent 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 are 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 while 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 new born 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 Heptology Neurology Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery - 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 - 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 2021/22 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 is in place to ensure that there is development and learning across service lines when required.

Statement on Quality from the Chief Executive

I am once again delighted to introduce the Quality Account for Bedfordshire Hospitals NHS Foundation Trust in what was a year of sustained challenge as we continued to deal with the challenges of the on-going global COVID-19 pandemic.

Throughout the year our staff have worked tirelessly to maintain a response to COVID-19 while still ensuring we can continue to provide high quality services. As we have entered 2022 we have been optimistic about the prospects for the slowing of the pandemic and it is admirable that our staff are still giving their all as we look ahead to the recovery phase.

Away from COVID-19, work has continued to integrate clinical services following our merger of the previous year and this is helping to drive up quality and efficiency and support our recovery efforts.

You will find within this document information regarding the exciting initiatives we have for the redevelopment of both hospital sites and these will play an integral role in improving the quality of services to our patients as well as improving the experience of both our patients and staff.

Whilst I am always incredibly proud of our staff and their achievements we know there are always things we could do better. In 2020/21 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. We have continued to maintain a focus on the safety and effectiveness of our Maternity services in the last year and in response to national initiatives and the Ockenden findings have broadened the scope of improvement activity and this will continue in the coming year. We are already seeing the benefits of this work and I am confident that maternity services on the Bedford site are well on the road to recovery.

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

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

David Carter
Chief Executive Officer

Corporate Objectives 2022/23

The Trust's Strategic and Operational Plans are underpinned by seven 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 an infection safe environment
5. Build on the integration work achieved during the first years of merger and finalise the clinical strategy
6. Development of the Master plan for both Trust sites
7. Becoming a sustainability exemplar organisation in the NHS
8. Develop the Bedfordshire Care Alliance to increase the integration of services between acute, community, primary care and social services with formal delegation of budgets from April 2023.

Achievements in Quality Improvement Priorities 2021/22

Quality priorities for 2021/22 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 hospitals. Despite our best intentions to proceed on our improvement journey, there was significant interruption to the work as we continued to face the challenges of the COVID-19 global pandemic, including high levels of staff absence with a 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.

Priority 1: Deliver Excellent Clinical Outcomes

1.1 Cirrhosis and Fibrosis Testing for alcohol dependant 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.

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 Fibro scan. 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 on availability of key clinical staff due to the pandemic.

How did we perform?

We have made some progress as described above although further development was hampered by the third and fourth wave of the COVID-19 pandemic. Cirrhosis and fibrosis testing for alcohol dependent patients is one of the national CQUIN schemes for 2022 – 2023, which will further support the ongoing work.

1.2 Rapid Rule out Protocol for suspected acute MI (excluding STEMI)

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 on the availability of key members of the clinical team.

How did we perform?

The development of a standardised guideline for patients presenting with chest pain had commenced but progress was regrettably hampered due to the pandemic.

However during the year a cross-site multidisciplinary clinical team was re-established and work started to agree pathways in line with best practice guidance.

Of particular importance has been the agreement related to patients receiving two high sensitivity troponin tests, however due to the complexity of the testing process required to within the laboratory the timing is still to be confirmed.

The clinical team are now working to ensure a robust pathway is established. Once complete an audit standards, will be put in place in order that performance across

biochemistry, cardiology and emergency department teams can be reviewed and improved.

1.3 COVID-19 recovery

Why was this a priority?

This was chosen as a priority to ensure clinical outcomes for patients are enhanced by improving the position for 52 week and 18 week targets.

In addition associated work such as restoration of clinical governance functions, for example to ensure the timeliness of investigations into serious incidents was deemed crucial to ensure clinical safety and learning to avoid recurrence of any errors.

What did we do?

- 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 planned 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.

How did we perform?

Covid Recovery Accelerator programme

The COVID-19 pandemic and national suspension of elective care created large elective care wait lists and long treatment waits across the health system. The Accelerator Programme arose because of high-level national NHS, political and public focus on recovering elective services given the increasing and unprecedented rise in size and length of elective RTT waits. In April, BLMK successfully applied to be one of 13 Accelerator sites across England with the aim to:

- Drive increased headline performance: Accelerator Systems aimed to meet 120% activity (of 2019/20 baseline) by the end of July 2021
- Create and share learning across the Bedfordshire, Luton and Milton Keynes Integrated Care system.
- Deliver critical interventions.

In overseeing the project an Elective Recovery Board was established, with senior membership from BLMK leadership, drive change.

The project saw positive signs of system working with the 9 sub-collaborative groups developing short, medium and long-term transformation plans, essential for a sustained recovery programme.
Within the Trust participation required the delivery of:

- 85% of the 2019/20 levels of planned care (inpatient, daycase and outpatient activity) by July 2021,
- improving on diagnostic activity levels,
- Having a single system PTL (patient tracking list) in place and ensuring that 25% of all outpatient activity was being delivered non-face-to-face.

By July 2021 the Trust's daycase and inpatient activity levels were achieving this 85% regularly and consistently on a weekly basis (shown below with some example specialties):

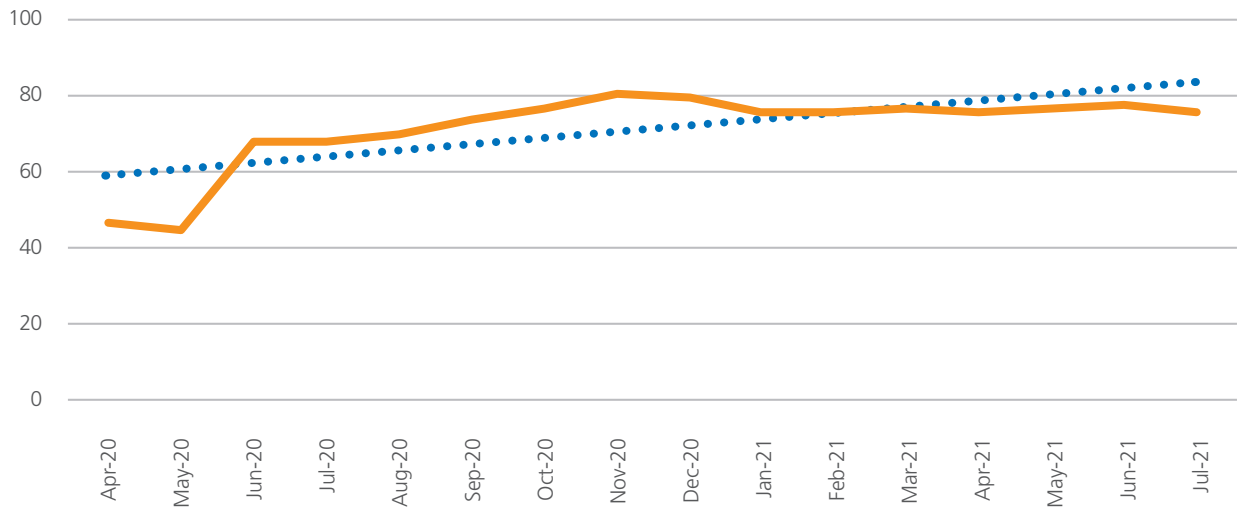
Spec	Cat	27 Jun	04 Jul	11 Jul	18 Jul	25 Jul	5 week Total
All Specialties	2021/22	1,234	1,323	1,289	1,246	1,369	6,461
	2019/20	1,382	1,279	1,428	1,318	1,395	6,802
	%	89%	103%	90%	95%	98%	95%
Gastroenterology	2021/22	352	370	356	372	316	1,766
	2019/20	339	326	375	363	344	1,747
	%	104%	113%	95%	102%	92%	101%
Trauma & Orthopaedic Surgery	2021/22	59	69	76	45	52	260
	2019/20	59	69	76	45	52	***301***
	%	71%	77%	74%	120%	106%	86%
Urology	2021/22	77	112	94	79	91	453
	2019/20	126	81	91	84	99	481
	%	61%	138%	103%	94%	92%	94%

Outpatient performance was however more challenging with multi-factorial reasons including the essential infection prevention controls which significantly reduced available clinic capacity in some areas. However, with increased reliance on non-face-to-face (either virtual or telephone) attendances the Trust continued to deliver well against the national expectations (shown below with some example specialties):

Spec	Cat	27.Jun	04.Jul	11.Jul	18.Jul	25.Jul	5 week Total
All Specialties	2021/22	13,784	13,009	13,658	12,668	11,581	64,700
	2019/20	14,018	14,261	14.063	13.797	13.430	69,569
	%	98%	91%	97%	92%	86%	93%
Cardiology	2021/22	605	513	632	572	514	2,836
	2019/20	673	712	686	642	651	3,364
	%	90%	72%	92%	89%	79%	84%
Clinical Haematology	2019/20	440	375	411	420	*321*	1,967
	2021/22	397	402	400	361	392	1,952
	%	111%	93%	103%	116%	82%	101%
Gastroenterology	2021/22	857	871	833	779	751	4,091
	2019/20	407	385	394	311	307	1,804
	%	211%	226%	211%	250%	245%	227%
Gynaecology	2021/22	711	605	668	647	582	3,213
	2019/20	699	717	640	671	736	3,463
	%	102%	84%	104%	96%	79%	93%
Medical Oncology	2021/22	503	549	586	597	492	2,727
	2019/20	521	500	495	647	500	2,663
	%	97%	110%	118%	92%	98%	102%
Oral & Maxillofacial Surgery	2021/22	315	278	344	321	355	1,613
	2019/20	359	252	361	314	393	1,679
	%	88%	110%	95%	102%	90%	96%
Paediatric Medicine	2021/22	386	443	370	316	275	1,790
	2019/20	439	399	413	339	379	1,969
	%	88%	111%	90%	93%	73%	91%
Respiratory Medicine	2021/22	380	365	407	372	380	1,904
	2019/20	461	388	363	413	421	2,046
	%	82%	94%	112%	90%	90%	93%
Rheumatology	2021/22	490	429	493	516	421	2,349
	2019/20	351	346	413	400	287	1,797
	%	140%	124%	119%	129%	147%	131%
Trauma & Orthopaedic Surgery	2021/22	927	968	966	912	846	4,619
	2019/20	808	987	824	817	906	4,342
	%	115%	98%	117%	112%	93%	106%

Diagnostic waiting times were also a challenge, with echocardiography being particularly constrained by a lack of available capacity. That said, the initial improvement aggregated across all modalities has been sustained as shown in the graph below:

Diagnostic Waiting Times - Maximum 6 week wait for diagnostic procedures



A decision regarding the single system Patient Timeline (PTL) was taken early on in the elective recovery planning process, which utilised the RAID report; this is created for the whole system at a national level. It can be viewed at patient level across the two provider Trusts within BLMK.

In October 2021 the Trust achieved the target expectation of delivering 25% of outpatient activity non-face-to-face. Inevitably some specialties lend themselves more to this type of clinical interaction:

Last 5 Weeks

	Firsts		Follow-Up		Total	
Spec	F2F	INon-F2F	F2F	INon-F2F	F2F	INon-F2F
Cardiolology	74.2%	25.8%	40.4%	59.6%	53.7%	46.3%
Clinical Haematology	43.0%	57.0%	35.1%	64.9%	36.3%	63.8%
Colorectal surgery	70.6%	29.4%	78.3%	21.7%	74.0%	26.0%
Dermatology	99.9%	0.1%	84.9%	15.1%	89.5%	10.5%
Diabetlc medicine	87.4%	12.6%	24.9%	75.1%	40.6%	59.4%
Elderly Medicine	46.5%	53.5%	32.1%	67.9%	40.0%	60.0%
ENT	89.6%	10.4%	84.6%	15.4%	86.9%	13.1%
Gastroenterology	6.4%	93.6%	52.1%	47.9%	45.1%	54.9%
General Surgery	92.8%	7.2%	87.2%	12.8%	88.3%	11.7%
Hepatology	15.8%	84.2%	45.3%	54.7%	39.9%	60.1%
Medical Oncology	92.9%	7.1%	76.4%	23.6%	77.7%	22.3%
Neonatal Intensive Care	100.0%	0.0%	95.3%	4.7%	97.7%	2.3%
Nephrology	47.2%	52.8%	39.2%	60.8%	40.2%	59.8%
Neurology	73.5%	26.5%	55.1%	44.9%	61.3%	38.7%
Neurophysiology	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
Ophthalmology	99.6%	0.4%	94.7%	5.3%	96.1%	3.9%

Last 5 Weeks

	Firsts		Follow-Up		Total	
Spec	F2F	INon-F2F	F2F	INon-F2F	F2F	INon-F2F
Oral & Maxillofaclal Surgery	99.1%	0.9%	75.7%	24.3%	85.5%	14.5%
Orthotics	96.1%	3.9%	75.9%	24.1%	80.6%	19.4%
Paediatric Medicine	97.1%	2.9%	64.4%	35.6%	80.8%	19.2%
Respiratory Medicine	82.8%	17.2%	68.1%	31.9%	73.4%	26.6%
Respiratory Physiology	100.0%	0.0%	75.1%	24.9%	77.1%	22.9%
Restorative Dentistry	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
Rheumatology	93.0%	7.0%	42.2%	57.8%	48.8%	51.2%
Speech and Language Therapy	13.3%	86.7%	41.4%	58.6%	35.6%	64.4%
Stroke Medicine	42.9%	57.1%	7.7%	92.3%	20.0%	80.0%
Transient Ischaemic Attack	94.2%	5.8%	57.4%	42.6%	81.2%	18.8%
Trauma & Orthopaedic Surgery	42.6%	57.4%	97.6%	2.4%	76.2%	23.8%
Urology	26.6%	73.4%	57.5%	42.5%	49.7%	50.3%
Vascular surgery	64.5%	35.5%	78.2%	21.8%	73.5%	26.5%
Grand Total	**78.6%**	**21.4%**	**72.1%**	**27.9%**	**74.0%**	**26.0%**

Despite significant efforts, the Accelerator Programme has not delivered all of its aims and several factors hindered recovery efforts. Covid rates increased across BLMK creating non-elective pressures, workforce constraints reduced opportunities to increase capacity, and finally the public's continued reluctance to engage with health care services combined with pressures from increased numbers of patients isolating due to rising community COVID-19 prevalence resulted in unused theatre and outpatient capacity that could not be recycled due to Covid restrictions.

In the coming year however the Trust will be seeking to implement the requirements of the Elective Care recovery programme which is a Quality Priority for 2022/23.

Learning from Serious Incidents

During the pandemic the work related to completing serious incident investigations was subject to a "Stop the Clock". This meant that whereby activity was paused to allow staff both at frontline and those working in back office functions with a clinical background to concentrate their efforts on the needs that surfaced due to the COVID-19 pandemic. At this time whilst we saw a slowing of activity for serious incident investigation, we did not pause all activity.

All necessary incidents continued to be reviewed to determine the level of investigation and also to ensure any immediate learning and improvement was actioned to avoid recurrence. Therefore whilst a backlog did occur in relation to the written final reports, the Trust was confident that key patient safety needs were met.

The backlog created by the pandemic has been subject to prioritisation throughout the year to ensure families now receive final written reports in as timely a way as possible given that the impact of COVID-19 is still being felt within the Trust.

Priority 2: Improve Patient Safety

2.1 Recording of NEWS2 score, escalation time and escalation of deteriorating patients.

Why was this a priority?

In 2020/21, there was a CQUIN around NEWS. The purpose of the National Early Warning Score (NEWS2) is to identify acutely ill patients, including those with sepsis and during the early stages of implementation it became apparent that there were differences in escalation protocols on the Luton and Dunstable hospital site when compared with the Royal College of Physicians and the protocol in use at the Bedford hospital site. This created a requirement to review escalation protocols and ensure the IT system, NerveCentre, was updated, with associated training for all clinical staff. The NerveCentre roll out at Bedford would enable the electronic recording and escalation in accordance with best practice following this alignment.

What did we do?

- 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 on effective observation frequency and escalation and direct QI work

How did we perform?

Within the Trust we now have implemented an agreed standard, Trust wide escalation protocol for adults aged above 16 years in line with the Royal College of Physicians guidance.

The protocol includes the minimum recommended frequency of observations whilst highlighting the need to perform observations that are more frequent if there is a concern about a patient's condition. This protocol supports timely escalation, consistency in the recording of observations and the response to deterioration.

The protocol was then shared with our Trust Global Digital Exemplar (IT) team who worked with the information to coordinate the embedding of alerts and escalation flags into the electronic observation monitoring system, Nerve-centre, used at Luton and Dunstable Hospital site.

Whilst at the Bedford Hospital site paper observation charts have been in use and these were altered to adopt the same standard protocol initially. The use of Nerve-centre will be rolled out in 2022/23 to make the same IT alert system available.

During the coming year ongoing audit will be undertaken to review the impact on recommended observation frequency and appropriate escalation. The national CQUIN scheme continues to include improvements related to NEWS 2 and these remain in our quality priorities for the coming year.

2.2 Modified Obstetric Early Warning Score (MOEWS) for pregnant women presenting in non-maternity parts of the Trust

Why was this a priority?

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.

What did we do?

- 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

How did we perform?

A project group was established to oversee the implementation of MOEWS across the Trust. This was a multidisciplinary group and included members of the clinical safety improvement team together with obstetric, respiratory, midwifery, education and nursing teams.

The group reviewed the MOEWS charts and agreed a standardised chart for use at both hospital sites.

In addition activity numbers of pregnant women who had been admitted across the Trust with non-maternity related conditions in the previous 2 years was used to prioritise the most frequent conditions patients presented with and the wards to which they are admitted. This data allowed for prioritisation and focus of the work to best deliver the safer care to women which implementation of MOEWS would facilitate.

The work of the project team included the establishment of a designated pathway for pregnant women needing admission for non-maternity reasons to a nominated medical, surgical and paediatric ward (as appropriate).

At the Bedford Hospital site, Pilgrim Ward was identified to adopt the use of a MOEWS. Ward 10 was the nominated medical ward at Luton and Dunstable University Hospital.

On the L&D site implementation of MOEWS was made more challenging by its use of the electronic observation system, NerveCentre, due to the IT requirement of adding MEOWS as an additional alert. Therefore, currently a paper MOEWS chart is in use across both sites.

The work on implementation will be continuing in 2022/23 to ensure it is integrated into electronic systems as well as to ensure its roll out is maintained in all areas.

2.3 Patient Safety Strategy implementation

Why was this a priority?

The Trust has 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 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.

How did we perform?

Throughout the year we have continued to implement and plan for the requirements of the Patient Safety Strategy however the ongoing impact of the COVID–19 pandemic has continued to curtail some activity.

Patient Safety Syllabus

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

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

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

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

This comprises of two sessions. The first introduces systems thinking (how the way we work can be used to reduce error and improve safety) and risk expertise (how we can identify and manage risk to keep patients safe).

The second session looks at human factors (the science of work and of working together in safely designed systems) and safety culture (the significance of a true learning culture, free of inappropriate blame).

There has been a good response to this training from staff and we continue to promote the training with the aspiration of reaching our 2023 target.

Patient Safety Partners

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

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

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

It is anticipated that recruitment for PSPs will be undertaken throughout May and June 2022.

Patient Safety Incident Response Framework (PSIRF)

The current system for investigating incidents is deemed to be a reactive and bureaucratic process, where opportunities to reduce recurrence of harm are often missed. The new approach in the PSIRF is intended to address these shortcomings by refocusing systems, processes and, crucially, behaviours to improve the quality of investigations and deliver a sustained reduction in risk.

The PSIRF therefore sets out significant changes in approach to be taken within the Trust in response to patient safety incidents. In a marked change to the current system the PSIRF sets out a broader, more proactive and risk-based approach.

There will be no distinction between incidents and 'serious incidents'. Instead, the PSIRF provides guidance on how to respond to patient safety incidents, defined as "unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare".

Some incidents will qualify for a Patient Safety Incident Investigation (PSII) but it is recognised that there may be other alternative proportionate responses (e.g. case note review; time mapping; 'being open' conversations; after action review; audit) as well as some incidents where 'do not investigate' or 'no response required' will be appropriate.

Under the new framework, the Trust will be required to develop a patient safety incident response plan (PSIRP) (reviewed every two years) setting out how incidents will be identified and investigated.

Timescales for application of the PSIRF have slipped nationally, however it is anticipated that information on the final requirements will be available to Trusts in summer 2022 at which point the PSIRF will be implemented.

Priority 3: Improving Patient Experience

3.1 Safe and Effective discharge arrangements

Why was this a priority?

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.

What did we do?

- 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 daily
- 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

How did we perform?

During the last year the Trust has been working hard to make improvements around its discharge processes, particularly in the context of the COVID-19 pandemic which put pressure on bed availability.

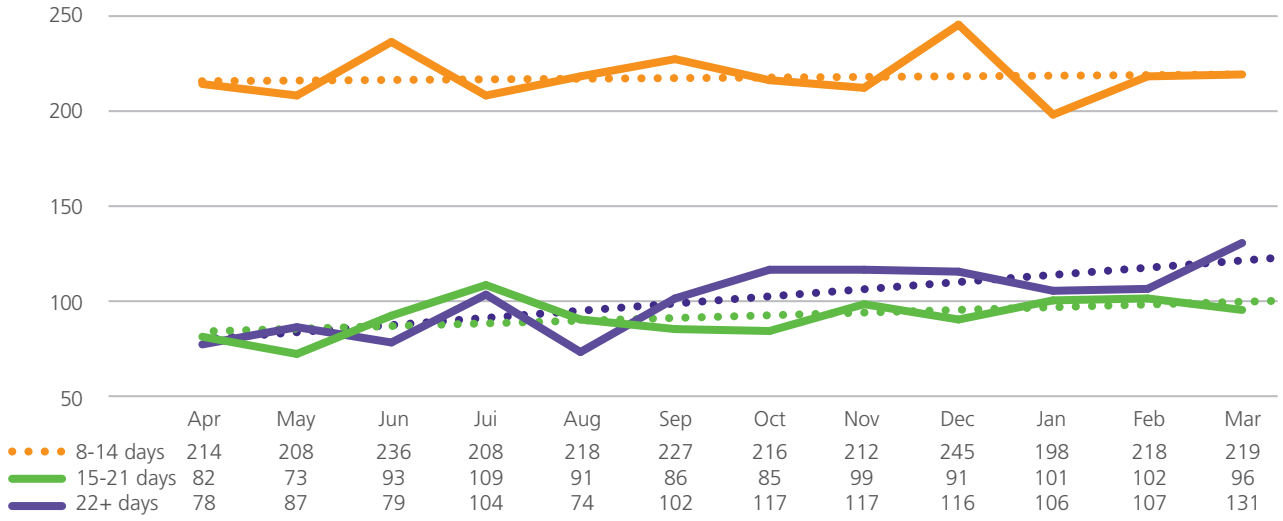
At our Bedford Hospital site particularly the Trust continued its work with the Emergency Care Improvement Support Team (ECIST). This is an external resource which supports systems, teams and individuals achieve enhanced patient outcomes across the urgent and emergency care pathway.

The improvements have included a twice weekly, system wide, length of stay meeting which spans all wards and has now become part of normal practice. These meetings are undertaken virtually to avoid staff leaving the ward area as much as possible and at the meeting staff discuss plans for the 10 patients with the longest stays on each ward.

This provides a platform for discussion and constructive challenge to clinicians, therapy, and discharge planning teams alongside system partners to expedite any issues that are contributing to a patient's stay in hospital with the view of timely safe discharge for patients back to their normal place of residence.

Over the last year reducing the length of stay has been a challenge (see chart below), this has largely, but not entirely, due to lack of capacity in provision of package of care for patients and bed capacity in the community. Other factors have included challenges around discharge arrangements with patients who become COVID-19 positive and availability of staff due to sickness with COVID-19.

Diagnostic Waiting Times - Maximum 6 week wait for diagnostic procedures



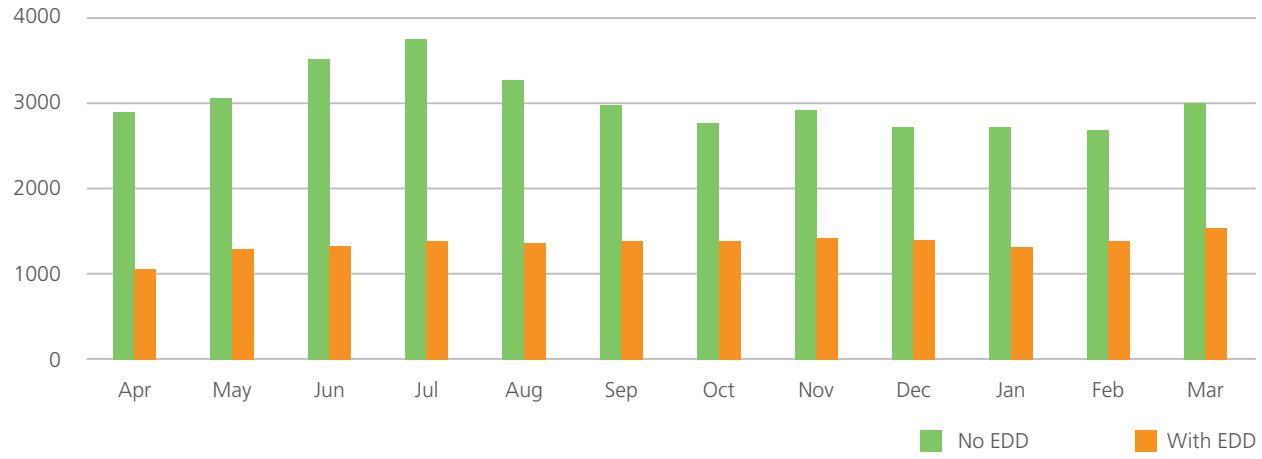
	Apr	May	Jun	Jui	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
8-14 days	214	208	236	208	218	227	216	212	245	198	218	219
15-21 days	82	73	93	109	91	86	85	99	91	101	102	96
22+ days	78	87	79	104	74	102	117	117	116	106	107	131

System wide operational calls take place across the whole week and at these there is a review of medically fit patients to look at any blocks across the discharge pathway. In addition at the Bedford hospital site the teams use an IT messaging platform to improve communication in real time to ensure improved responsiveness in managing operational challenges.

A once weekly call with system partners involving senior leaders is also in place and these meetings focus on those patients who are medically fit but have a length of stay over 21 days with the aim to resolve more complex discharge issues

During the coming year work will continue and particularly an initiative to improve the allocation of Expected Dates of Discharge (EDD), as during the previous year performance has remained static (see table below).

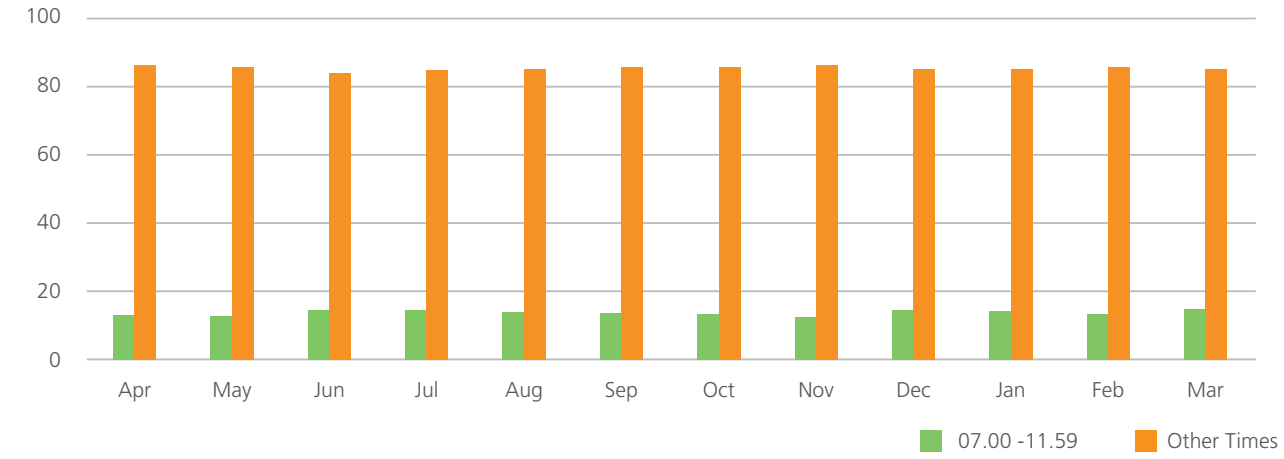
Bedford Hospital Number of Patients with an Expected Date of Discharge Set 2021-22



Additionally work focussed on the discharge of patients before noon will also remain a key improvement activity in the coming year, as during this year we have found that activity remained static (see table below).

At our Bedford site, the "Golden Patient" initiative (discharge before 10:00) will also be invigorated as a key part of a comprehensive programme of ongoing work around safe and timely discharge.

Bedford Hospital Percentage of Patients Discharged Before 12:00 2021-22



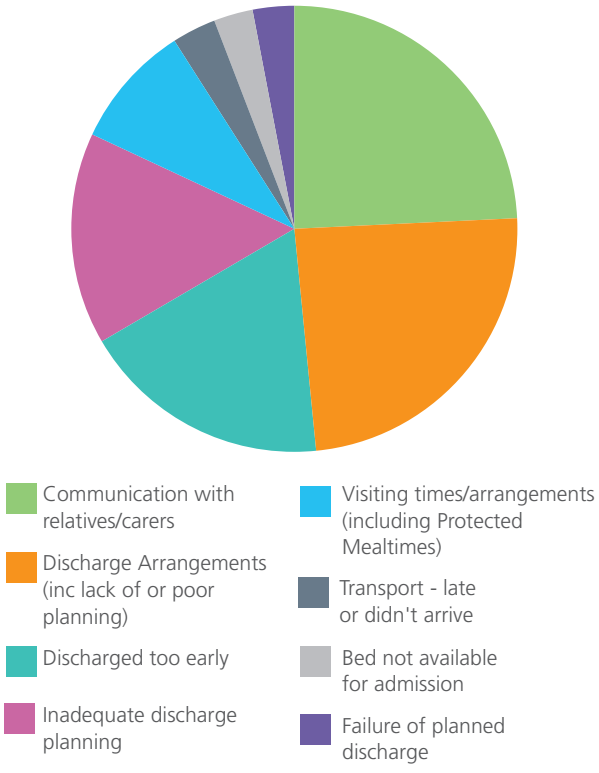
Performance improvement activity has also been complemented by initiatives to ensure an improved experience for patients and their families in respect of the discharge process. This has included collaborative working with voluntary sector partners and Healthwatch.

Support at the Bedford Hospital site has been provided by Healthwatch, who have undertaken local patient surveys. These have provided timely feedback on patient quality and experience thus allowing more timely improvements to be initiated where needed.

Analysis of information related to complaints and PALS contacts over the last year indicates that the main theme relates to challenges in communicating discharge plans with relatives and/or carers. Other key themes are confusion and problems with understanding discharge arrangements as well as a significant number of complaints that patients have been discharged too soon.

A revised discharge policy for the Trust was put in place to account for changes related to impact of the COVID-19 pandemic, in line with a national Discharge Policy. This included a "Criteria to Reside" matrix which removed a significant aspect of patient choice from the discharge process in order to manage operational pressures and it likely this will have contributed to the rise in complaints around the discharge process.

Formal complaints by Sub-subject



For the coming year improvement work will be an important cross site activity for the Trust.

A system wide strategic steering group has been put in place and their improvement activity includes:

- Continued work around early discharge planning
- Timely notification of discharge for patients on specific pathways (1-3)
- Management of community capacity
- Quality of discharges including communication with patients, carers and families
- Improving relationships with Care Home providers

A Quality Improvement event is being planned for May 2022 to consider patient and family feedback with specific examples by way of actual patient stories. There will be a focus on:

- Identification of barriers and gaps impacting patients
- Understanding what does good look like for families and patients

3.2 End of life care

Why was this a priority?

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.

What did we do?

- 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

How did we perform?

The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland.

The third round of the audit included the following components:

- **An Organisational Level Audit**, WHICH focused on the Trust's policies and processes, activity, the specialist palliative care workforce, staff training and anticipatory prescribing.
- **A Case Note Review,** which reviewed 20 consecutive deaths between 12th April –25th April and 20 consecutive deaths between 1st May –14th May 2021 for acute Trust providers. The content of the Case Note Review focused on the themes of recognition of imminent death, communication, involvement in decision making and individualised plan of care. 80 case note reviews were submitted by the Trust across Bedford and Luton sites.
- **A Quality Survey – designed to gain feedback from relatives**, carers and those close to the person who died on their experiences of the care and support received at the end of life
- **A Staff Reported Measure,** which was new for 2021 and completed by staff online. The Staff Reported Measure was designed with the NACEL Steering Group and focused on themes of staff experience, confidence, support and culture. Participants were able to send the Staff Reported Measure to any inpatient staff within the hospital/site, who were likely to come into contact with dying patients and/or those important to them. 204 surveys were completed by staff across Bedford and Luton sites.

The findings are shown in the table below which compares the Trust results to all acute and community hospitals in England and Wales taking part in the third round of NACEL.

The information is presented thematically in seven sections, covering the five priorities for care and other key issues. The themes are:

1. Communication with the dying person
2. Communication with families and others
3. Involvement in decision making
4. Individualised plan of care
5. Needs of families and others
6. Families' and others' experience of care
7. Governance
8. Workforce/specialist palliative care
9. Staff confidence
10. Staff support
11. Staff care and culture

Summary Themes	National Score	Bedford Site Score	Luton Site Score
Communication with the dying person	7.9	9.4	8.1
Communication with families and others	7	9	7.5
Involvement in decision making	9.5	10	8.9
Individualised plan of care	7.7	9	7.6
Needs of families and others* *data not submitted	5.6	-------	-------
Families and others experience of care*	6.5	-------	-------
Governance	9.7	10	10
Workforce/Specialist Palliative care	8.1	10	9.4
Staff Confidence	7.5	7.2	7.2
Staff Support	6.4	5.8	5.8
Care and Culture	7.3	6.9	6.9

The report shows the trust submitted a full set of data which was reported in 9 out of the 11 sections.

Areas above national average:

Bedford & Luton sites - **Communication with the dying person** – documented evidence of communication in the following areas;

- Possibility that the patient might die
- Patient was involved (if able) in discussing individualised care of the dying plan of care

Bedford & Luton sites - **Communication with families and others** – documented evidence of communication in the following areas;

- Possibility that the patient might die
- Families and others involved in discussing individualised care of the dying plan of care

Bedford site - **Involvement in decision making** – documented evidence of communication in the following areas;

- DNAR and TEP decisions undertaken by a senior clinician
- Capacity assessments included
- Bedford site - Individualised plan of care- documented evidence of;
- Holistic assessment was evident apart from spiritual, social and practical needs
- Anticipatory prescribing and administration

Bedford & Luton sites - **Governance** – including evidence of;
- A member of the trust board with a responsibility for end of life care
- Processes to learn from deaths
- Care plan to support the Five Priorities for Care of the Dying Person

Bedford & Luton sites - **Workforce/Specialist Palliative care** – including evidence of;
- Access to a Specialist Palliative Care Service
- Face to face Specialist Palliative Care Service seven days a week

Areas below national average:

Bedford & Luton sites - **Staff Confidence** – evidence from the staff survey identifies;
- The majority of staff were confident in recognising imminently dying patients
- A number of staff were unsure how to respond to requests from families to die outside of hospital

Bedford & Luton sites - **Staff support** –evidence from the staff survey identifies;
- Fewer staff in the trust felt supported to deliver end of life care during the COVID-19 pandemic, compared to the national average
- Fewer staff in the trust received appropriate and responsive training to deliver end of life care during the COVID-19 pandemic, compared to the national average

Bedford & Luton sites - **Care and culture** – evidence from the staff survey identifies;
- End of life care should be prioritised in relation to respect, dignity and provision of an appropriate peaceful environment that maximises privacy for dying people and their families. This relates to use of side rooms and Blossom rooms at Bedford.

Luton site - **Individual Plan of Care** – The 5 priorities of Care make it clear there must be a plan of care in place.
- Documented evidence of assessments was very high apart from spiritual, social and practical needs
- Anticipatory medicine – good documented evidence of discussions and prescribing

Conclusion and Ongoing work

The findings of the audit and report indicate ongoing improvement and areas of good practice across the Trust and reflect both the Trust wide and specialist team commitment to ensure End of Life Care is a priority across the Trust.

However it is recognised that there is a need for continuous improvement to build on progress and further ensure the best possible quality of care and support for our patients and families. This work includes the following four key areas of improvement which address key findings of the report:

- **Work stream 1** – Patients who are approaching EOLC are identified early, a plan of care is agreed and communicated appropriately and effectively with the patient and those closest to them. Developing individual goals of care around end of life care conversations.
- **Work stream 2** – Staff feel competent and confident to communicate with patients and families in a way that ensures that the patient and their families are clear about their plan of care in order to make informed decisions and ensure conversations are reflective of this.
- **Work stream 3** – To establish a set of key performance indicators that are easily measured and enable teams to plan and implement improvement work effectively.
- **Work stream 4** – Improve the patients and carer experience at end of life.

The key issues which underpin the work for each of the four work streams are:
- Documentation of patients' preference place of death (work stream 1)
- All medical and nursing staff with responsibility for the care of dying people should attend communication skills training specifically on care in the last days/hours of life, and this should be recorded in their training records (work stream 2).
- Discussions undertaken about the dying patient's spiritual/cultural/religious/practical needs (work stream 4)

This work plan continues through 2022/23 led by the End of Life Care Strategy Group and monitored through the Trust's Clinical Operational Quality Board.

3.3 Staff wellbeing and organisational development

Why was this a priority?

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.

What did we do?

- 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 FT SU Champions
- THRIVE values embedded in recruitment and appraisal processes
- Improvements monitored through national staff survey

How did we perform?

In 2021 we continued delivery of our Culture and OD Strategy with an emphasis on the following areas of priority:

Freedom to Speak Up (FTSU) and Peer Listeners

We completed a review of the Bedford Peer to Peer Listening Service and progressed implementation on the Luton site recruiting new listeners and renaming to Peer Listeners. All Peer Listeners now have Mental Health First Aid training and the network is supported by our newly appointed Clinical Psychologists.

The Freedom to Speak up Strategy and Policy were approved in February 2022, priority actions have been identified for the year ahead and will be monitored through the Workforce Committee. Much work has been undertaken to raise awareness and a video introducing the FTSU Guardians and Champions is now available for our staff on the on the intranet and is included in our induction package for all new starters to the organisation.

Wellbeing

The Trust set up a Clinical Psychologist service in April 2021. This was initially on a temporary basis to establish what would best meet the needs of our staff, particularly during and post pandemic.

It has proven to be a very helpful and timely intervention which staff value and as such funding has been secured to continue the service on a permanent basis.

Supported by charitable funds, both of our hospital sites now also have dedicated permanent Health and Wellbeing rooms. They are equipped with reclining chairs and provide a restful space for staff to take time out.

To ensure we continued to meet staff needs we carried out an audit on all of our all staff rest areas and identified that improvements to basic facilities were required. Again thanks to our charitable funding we were able to replace old and unsuitable furniture with new chairs and tables. Finally we set up a Staff Involvement and Wellbeing Group which meets monthly and they play an important role in progressing the wellbeing projects within the Trust and support our twice yearly staff engagement events.

Staff survey

The 2020 staff survey was analysed and the data distributed to department and clinical managers for the development of improvement plans. The findings were shared at our Workforce Committee who receive regular updates on progress.

The 2021 staff survey ran from September to December 2021 with the results published on the 30th March 2022. In response to the survey, results have been again been shared with staff and distributed to department and clinical managers. Our OD team provide facilitated support for teams in developing improvement plans.

Work is also underway to also develop our trust-wide response and this will form a significant component of the Culture and OD programme for this year.

Embedding our values

At the end of 2021 we launched our new Trust branding and this allowed us to amplify the profile of our values. We have partnered with A Kind Life to embed our THRIVE (Teamwork – Honesty – Respect – Inclusivity – (and) Valuing People – (which leads to) Excellence) values into our recruitment, appraisal and resolution approach.

Co-creation workshops with subject matter experts took place in March 2022 and will be followed by 'leading with values' master classes and 'kindness in action' training for all our staff. This will be supported with access to other materials such as e-learning and train the trainer sessions.

Leadership Development and Talent Management

We continue to run a range of development 'Bursts' and leadership development programmes both generic and bespoke for groups and individuals. Our Talent Management strategy was developed and approved in late 2021 and we commenced a talent management and succession planning exercise, starting with our senior leadership team. The new Scope for Growth model, developed by the Leadership Academy, will be utilised going forward as we extend our succession planning reach.

Schwartz rounds

March 2022 saw the re launch of Schwartz rounds across both Trust sites. Schwartz rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare. The first session was very well attended, with positive feedback and there is a programme of events planned for the year ahead.

Quality Improvement Priorities 2022/23

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

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

- to 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 2022/3, as we write this account the future still remains uncertain in respect to the global pandemic so we may seek to review and reprioritise as the year progresses.

Quality Priorities For 2022-2023

Corporate Objectives	Deliver Excellent Clinical Outcomes
Quality Priorities	1. Cirrhosis and Fibrosis Testing for alcohol dependant patients 2. Treatment of community acquired pneumonia in line with the British Thoracic Society (BTS) care bundle 3. Elective care recovery
Rationale	1. NICE Guidance recommends that people who are alcohol dependent should receive a test for fibrosis and cirrhosis. This priority aims to support the consistent delivery of that care pathway. This priority, based on a national CQUIN, will increase the number of early liver disease diagnoses, which will change patient behaviour, allow for more effective treatment and better prospects of recovery. 2. The BTS care bundle sets out discrete steps that need to be followed to improve care for patients with community acquired pneumonia (CAP). Adherence to the care bundle can reduce 30 day mortality, length of stay in hospital and improve patient experience. 3. Following the impact of the COVID-19 pandemic on elective care a national three year work plan is proposed to ensure clinical outcomes for patients are enhanced by improving the position for patients with long waits for elective care.
Measures of Success	1. CQUIN target: Achieving 35% of all individual inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis. 2. CQUIN target: Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle. 3. Achievement of success will be measured against programme targets which include: a To eliminate waits of over one year by March 2025, and waits of over two years by July 2022. b Reduce diagnostic waiting times, with the aim of least 95% of patients receiving tests within 6 weeks by March 2025. c Deliver the cancer faster diagnosis standard, with at least 75% of urgent cancer referrals receiving a diagnosis within 28 days by March 2024, and return the 62 day backlog to pre-pandemic levels by March 2023
Monitoring Committee	Clinical Quality Operational Board and the Trust Board Quality Sub- Committee

Corporate Objectives	Improve Patient Safety
Quality Priorities	4. Recording of NEWS2 score, escalation time and response time for critical care admissions 5. Implementation of Patient Safety Strategy 6. Staff flu vaccination programme
Rationale	4. The NEWS2 protocol is the Royal College of Physicians and NHS-endorsed best practice for spotting the signs of deterioration, the importance of which has been emphasised during the pandemic. This quality priority will support adherence to evidence-based steps in the identification and recording of deterioration, enabling swifter response. Nationally, as many as 20,000 deaths in hospitals each year could be preventable and deterioration is linked to 90% of NHS bed days. Reducing the need for higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts. 5. The National Patient Safety Strategy continues to be rolled out across England. There are a number of elements which need to be put in place over the next year, including : - Implementation of the Patient Safety Incident Response Framework. - Ensuring an organisational risk management / incident reporting system compliant with the national Learning from Patient Safety Events (LFPSE) database. - Introduction of Patient Safety Partners 6. Staff flu vaccinations are critical in reducing the spread of flu during winter months, therefore protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID-19 at the same time which is associated with worse outcomes., and reducing staff absence and the risk for the overall running of safe services
Measures of Success	4. CQUIN target: Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded 5. Produce Trust wide Patient Safety Incident Response Framework within the year Introduce and implement a risk management and incident reporting system which is integrated across site and also meets the requirements of LFPSE compliance Develop job descriptions and recruitment strategy for the implementation of Patient Safety Partners within the Trust to commence in line with national strategy targets 6. CQUIN target: Achieving 90% uptake of flu vaccinations by frontline staff with patient contact. (This includes a broadened definition of front line staff to include all staff groups that may have contact with patients)
Monitoring Committee	Clinical Quality Operational Board and the Quality Committee

Corporate Objectives	Improve Patient experience
Quality Priorities	7. Appropriate antibiotic prescribing for UTI in adults aged 16+ 8. Anaemia screening and treatment for all patients undergoing major elective surgery 9. Implementation of the Trust's People Plan
Rationale	7. NICE guidance sets out steps to follow around the correct prescribing of antibiotics for urinary tract infections. These steps require no complex changes or additional investment, and improve diagnosis and management, reduce treatment failure, and reduce the risk of bacteraemia and associated length of stay. In 2019, there were over 175,000 admissions nationally where a UTI was the primary diagnosis at a cost to the system of over £450m. A third of all UTI admissions have a length of stay > 7 days. UTI is a leading cause of healthcare associated gram-negative bloodstream infections. Improving the management of acute UTI in adults will reduce deterioration and associated length of stay, releasing bed capacity to support NHS recovery activity. 8. NICE guidance details the requirements to offer iron before surgery to patients with iron –deficiency anaemia and draws attention to the importance of screening and treatment to drive more consistent delivery of standard clinical practice. This improved compliance would reduce blood transfusion rate for major blood loss surgeries, reducing the occurrence of patient safety risks associated with blood transfusion including fluid overload, infection and incorrect blood transfusions being given. Overall, this screening would save on use of blood with lower transfusion rates, reduce in critical care periods, avoid stays in hospital and also reduce the readmission rates, thus enhancing patient experience. 9. There is a well-established link between staff wellbeing, team working and patient experience.
Measures of Success	7. CQUIN target: Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment. 8. CQUIN target: Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24. 9. The Trust will be working as part of the integrated care system to deliver a range of work streams around the following elements of the People Plan • Looking after our People • Growing for the future • Belonging in the NHS • New ways of working
Monitoring Committee	Clinical Quality Operational Board and the Quality Committee

Statements of Assurance from the Board

3.1 Review of services

During 2021/22 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 2021/22 represents 100% of the total income generated from the provision of relevant health services by Bedfordshire Hospitals NHS Foundation Trust.

3.2 Participation in Clinical Audits and National Confidential Enquiries

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

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 2021/22, we took part in 45 (100% of those applicable) national clinical audits at Luton and Dunstable Hospital and 46 (100% of those applicable) at Bedford Hospital; 2 national confidential enquiries at LDH and 2 at BH (100%).

The information provided includes the latest published case ascertainment for relevant national audits and/or the number of cases submitted for the current audit cycle as required by the terms of that audit or enquiry for previous data submissions. 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, which are identified as continuous data collection.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2021/22 are shown in the tables below.

No. and work streams		Audit Title	Participated at LDH	Stage/ number or % of Cases submitted LDH	Participated at BH	Stage/ number or %of Cases submitted BH
1.	1	Case Mix Programme	Yes	827 cases submitted	Yes	412 cases submitted
2.	2	Child Health Clinical Outcome Review Programme [1]	Postponed due to COVID – Questionnaire completed January 2022. Clinical Questionnaires due to be submitted by 29th April 2022			
3.	3	Chronic Kidney Disease registry	Non participation on either site managed by Lister hospital			
4.	4	Cleft Registry and Audit Network Database	Not applicable registration via Addenbrookes hub			
5.	5	Elective Surgery: National PROMs Programme	Yes	526 cases submitted along with National Joint Registry	Yes	Continuous data collection
6.		Emergency Medicine Quality Improvement Projects :				
	6	*a. Pain in children*	Yes	210 cases submitted	Yes	274 cases submitted
	7	*b. Fractured Neck of Femur*	Yes	101 cases submitted	Yes	73 cases submitted
	8	*c. Infection Control*	Yes	126 cases submitted	Yes	141 cases submitted
7.	9	Falls and Fragility Fracture Audit Programme [1] :				
	10	*a. Fracture Liaison Service Database*	No service on this site		Yes	534 cases (56% case ascertainment)
	11	*b. National Audit of Inpatient Falls*	Yes	Continuous data collection	Yes	Continuous data collection

No. and work streams		Audit Title	Participated at LDH	Stage/ number or % of Cases submitted LDH	Participated at BH	Stage/ number or %of Cases submitted BH
	12	c. National Hip Fracture Database	Yes	311 cases submitted (113%) case ascertainment	Yes	87% case ascertainment
8.	13	Inflammatory Bowel Disease Audit	Yes	Continuous data collection	Yes	1892 cases submitted
9.	14	LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	Yes	Case by case base submission	Yes	Case by case base submission
10.	15	Maternal and Newborn Infant Clinical Outcome Review Programme [1]	Yes	Continuous data collection	Yes	Continuous data collection
11.	16	Medical and Surgical Clinical Outcome Review Programme [1]				
12.	17	Mental Health Clinical Outcome Review Programme [1]	Not applicable to this organization.			
13.	18	National Adult Diabetes Audit [1] :				
1.	19	*a. National Diabetes Core Audit:*	N/A as submission not open yet for 2021-22, NHS Digital usually opens platform for submission May			
	20	*b. National Diabetes in Pregnancy Audit*	Yes	Rolling submission Total 98 submissions (75 deliveries and 23 miscarriages) from 1.1.21 to 31.12.21.	Yes	40 cases submitted
	21	*c. National Diabetes Foot Care Audit*	Yes, managed by ELFT	30 submissions from LDH from Aug21- Feb 22	Yes, managed by ELFT	Yes, managed by ELFT
	22	*d. National Diabetes Inpatient Safety Audit*	N/A- NDISA has not started yet	NaDIA HARMS submission cases = 21 from April /2021 to March 2022	N/A- NDISA has not started yet	Continuous data collection
14.	23	National Asthma and Chronic Obstructive Pulmonary Disease Audit [1] :				
	24	*a. Paediatric Asthma Secondary Care*	Yes	62 (01/04/21 to 30/09/21) Yet to submit data 01/10 to 31/3/22 as deadline May 22	Yes	Deadline for data submission May 2022
	25	*b. Adult Asthma Secondary Care*	Yes	171 cases submitted	Yes	Continuous data collection
	26	*c. Chronic Obstructive Pulmonary Disease Secondary Care*	Yes	543 cases submitted	Yes	107 cases submitted
	27	*d. Pulmonary Rehabilitation – Organisational and Clinical Audit*	Yes	132 cases submitted	Yes	Continuous data collection
15.	28	National Audit of Breast Cancer in Older Patients [1]	Yes 334 cases cross site			
16.	29	National Audit of Cardiac Rehabilitation	Yes	1221 cases submitted	Yes	288 cases submitted

No. and work streams		Audit Title	Participated at LDH	Stage/ number or % of Cases submitted LDH	Participated at BH	Stage/ number or %of Cases submitted BH
17.	30	National Audit of Cardiovascular Disease Prevention (Primary Care) [1]	N/A		N/A	
18.	31	National Audit of Care at the End-of-Life [1]	Yes	33 cases submitted	Yes	32 cases submitted
19.	32	National Audit of Dementia [1]	Yes	Continuous data collection	Yes	Continuous data collection
20.	33	National Audit of Pulmonary Hypertension	Not applicable toorganisation			
21.	34	National Clinical Audit of Seizures and Epilepsies for Children and Young People Epilepsy 12 [1]	Yes	86 cases submitted	Yes	Continuous data collection
22.	35	National Cardiac Arrest Audit	Yes	81 cases submitted	Yes	52 cases submitted
23.	36	National Cardiac Audit Programme:				
	37	*a. National Audit of Cardiac Rhythm Management*	Yes	Continuous data collection	Yes	263 cases submitted
	38	*b. Myocardial Ischaemia National Audit Project*	Yes	75 cases 2022 (98% case ascertainment)	Yes	301 cases 2022 (91% case ascertainment)
	39	c. National Adult Cardiac Surgery Audit	Not applicable to either site.			
	40	d. National Audit of Percutaneous Coronary Interventions	Yes	408 cases submitted	Yes	310 cases submitted
	41	*e. National Heart Failure Audit*	Yes	63% case ascertainment	Yes	23% case ascertainment
	42	*f. National Congenital Heart Disease*	Service not set up			
24.	43	National Child Mortality Database [1]	Part of the (Child Death Overview Panel) CDOP process and managed in the community.			
25.	44	National Clinical Audit of Psychosis [1]	Not applicable to either site.			
26.	45	National Comparative Audit of Blood Transfusion [3] :				
	46	*a. 2021 Audit of Patient Blood Management & NICE Guidelines*	Yes	100 cases submitted	Yes	32 cases submitted
	47	*b. 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery*	Organisation was not invited to participate			
27.	48	National Early Inflammatory Arthritis Audit [1]	Yes	8cases, still collecting	Yes	0 cases
28.	49	National Emergency Laparotomy Audit[1]	Yes	168 (Annual data 1st Jan 21 – 1st Jan 22)99% case ascertainment	Yes	97 (93%) case ascertainment
29.	50	National Gastro-intestinal Cancer Programme [1, 2, 3, 4]				
	51	*a. National Oesophago-gastric Cancer*	Yes	(85-100%) case ascertainment	Yes	45 cases submitted (85-100%) case ascertainment
	52	*b. National Bowel Cancer Audit*	Yes	90% case ascertainment	Yes	190(78.60%) case ascertainment

No. and work streams		Audit Title	Participated at LDH	Stage/ number or % of Cases submitted LDH	Participated at BH	Stage/ number or %of Cases submitted BH
30.	53	National Joint Registry	Yes	526 cases submitted - Continuous data collection (93%) case ascertainment	Yes	93% case ascertainment
31.	54	National Lung Cancer Audit [1]	Yes	Bedfordshire Hospitals, Jan – Dec 2021: total of 262 records	Yes	239 cases
32.	55	National Maternity and Perinatal Audit[1]	Yes	5262 cases	Yes	Continuous data collection
33.	56	National Neonatal Audit Programme [1]	Yes	808 cases submitted, 100% cases ascertainment	Yes	100% case ascertainment
34.	57	National Paediatric Diabetes Audit [1]	Yes	178 cases submitted	Yes	149 cases submitted
35.	58	National Perinatal Mortality Review Tool [1]	Yes	37 cases submitted	Yes	14 cases submitted
36.	59	National Prostate Cancer Audit [1]	Yes	Continuous data collection	Yes	Continuous data collection
37.	60	National Vascular Registry [1]	No	N/A	Yes	Continuous data collection
38.	61	Neurosurgical National Audit Programme	N/A to this organization			
39.	62	Out-of-Hospital Cardiac Arrest Outcomes Registry	Organisational participation			
40.	63	Paediatric Intensive Care Audit [1]	N/A applicable to tertiary centres			
41.	64	Prescribing Observatory for Mental Health [3]:				
	65	*a. Prescribing for depression in adult mental health services*	N/A to this organization			
	66	*b. Prescribing for substance misuse: alcohol detoxification*	N/A to this organization			
42.	67	Respiratory Audits [3]:				
	68	*a. National Outpatient Management of Pulmonary Embolism*	Organisation did not participate			
	69	*b. National Smoking Cessation 2021 Audit*	Yes	93 cases submitted	Yes	100 cases submitted
43.	70	Sentinel Stroke National Audit Programme [1]	Yes	731 cases submitted	Yes	219 cases submitted
44.	71	Serious Hazards of Transfusion	Yes	20 cases submitted	Yes	6 cases submitted
45.	72	Society for Acute Medicine Benchmarking Audit	Yes	98 cases submitted	Yes	52 cases submitted
46.	73	Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Continuous data collection	No	Not applicable
47.	74	Trauma Audit and Research Network	Yes	189 cases submitted	Yes	75 cases submitted
48.	75	UK Cystic Fibrosis Registry	Not applicable to either site.			
49.	76	Urology Audits [2, 3]				

No. and work streams		Audit Title	Participated at LDH	Stage/ number or % of Cases submitted LDH	Participated at BH	Stage/ number or %of Cases submitted BH
	77	*a. Cytoreductive Radical Nephrectomy Audit*	To be confirmed			
	78	*b. Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)*	To be confirmed			
	79	National Diabetes Audit Integrated Specialist Survey	N/A as submission is not about case number. We've already submitted our return combined for both sites.			

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

Participation in Clinical Outcome Review Programmes 2021/22

Name of Enquiry	Did Luton and Dunstable Hospital participate?	Stage / % of cases submitted	Did Bedford hospital participate?	Stage / % of cases submitted
Maternal, New-born and Infant Clinical Outcome Review Programme – Perinatal mortality surveillance	Yes	37 cases submitted	Yes	14 cases submitted
Maternal, New-born and Infant Clinical Outcome Review Programme – Maternal mortality surveillance and confidential enquiry	Yes	100%	Yes	*100%
Maternal, New-born and Infant Clinical Outcome Review Programme – Perinatal confidential enquiries	Yes	100%	Yes	100%
Maternal, New-born and Infant Clinical Outcome Review Programme – **Physical Health in Mental Health Hospitals**	No – not applicable	N/A	No – not applicable	N/A
Medical and Surgical Clinical Outcome Review Programme - Epilepsy study (National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	4 cases submitted for LDH, 5 cases submitted for BH.			
Child Health Clinical Outcome Review Programme - **Transition from child to adult health service**s (National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Organisational questionnaire submitted in January 2022. Clinical questionnaires/case notes due to be submitted by 29th April 2022.			

National clinical audits

Site	Specialty	Project Title	Quality Improvements
LDH	Acute	Society for Acute Medicine Benchmarking Audit (SAMBA)	Compared to the national average our compliance levels are acceptable in Emergency Department (ED) and Ambulatory Emergency Care (AEC), but not in Acute Medical Unit (AMU). Although the number of patients seen in the medical take in AMU is small, there is room for improvement in compliance levels if a dedicated AMU (even with limited number of beds) with adequate staffing levels was available. **Key actions:** 1. Temporary creation of beds in Emergency Assessment Unit to streamline General Practitioner expected patients and some of the Emergency Department due for a staged implementation as part of forward plans 2. Consider a dedicated health care professional to do the Early Warning Score for the patients directly presenting to AMU 3. Consultant presence in AEC to improve compliance in standard 3
LDH	Breast Screening	ABS Audit. National audit of screen detected cancers	Discussion with Surgeons and at Programme Management Board. Challenges identifies as radiotherapists are not site based / local. Data coordinator at East and North Herts has supplied all data for next audit and further information is expected from data coordinators at West Herts and Bedford site.
LDH	Cardiology	National Audit of Cardiac Rehabilitation (NACR)	This is a cohesive multidisciplinary team that strive to ensure as many patients as possible are able to access their service. This approach is reflected in successful attainment of goals for both assessments 1 and 2. Patients have access to four key health professionals within the team, and there are good links with other services such as clinical psychology and diabetology. Out of 223 UK Cardiac Rehabilitation programmes that contribute to NACR 93 programs there is a requirement to meet all 7 Key Performance Indicators. In England 69 programmes are amber (meet 4 -6 of the standards) 51 are red (meet 1 – 3 standards) and 10 met none of the standards. The trust met 5 out of 7 and whilst not in the top 25% have managed to provide a safe, evidence-based service under the challenging conditions of the pandemic.
LDH	Cardiology	National Cardiac Audit Programme (NCAP) -National Heart Failure Audit	Improvements required include • Increase input and follow up from cardiology and heart failure specialist team. • Develop a NTproBNP based diagnostic pathway at both sites to improve diagnostic accuracy. • An increase in data entry above 90% requires more licenses for trained staff or dedicated coordinator. • Continue to improve definitive Heart Failure therapy performance at both sites • Increase involvement of heart failure team which will improve patient understanding and ability to manage and report symptoms preventing readmission.
LDH	Cardiology	National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI)	There has been an increase in complex PCI work. Good outcomes regarding radial work [> 90% since 2017 and improving], this is now above the national average [89.5%].

Site	Specialty	Project Title	Quality Improvements
LDH & BH	Colorectal surgery	National Bowel Cancer Audit Short Report: Hospital- and surgeon-level volumes for rectal cancer surgery	Improvement responses in progress
LDH	Diabetes	National Diabetes Audit	The L&D site performs within the England average for cholesterol control for Type 2 Diabetes Mellitus patients. Results for Type 1 Diabetes Mellitus care processes at L&D compare favourably compared to the England average.
LDH	Diabetes	National Diabetes Inpatient Audit (NaDIA) Harms, 2020, Annual Report	The service is fully compliant with safety and quality of inpatient diabetes services since the start of NaDIA HARMS audit. Improvement plan is already in place with ward based stroke team to identify diabetics and ensure rapid referral, especially for those patients on enteral feed. The team are currently reviewing an update to the protocol for diabetes management (+ insulin/ fluid management) in enteral fed stroke patient to prevent Hyperosmolar Hyperglycaemic State.
BH	Emergency Medicine	Royal College of Medicine (RCEM) – Mental Health (Self-Harm)	Improvements identified: 1. Introduction of Symphony – Mental health triage now electronic with risk assessment mandatory. 2. Dedicated Emergency Department Mental Health Assessment Room. 3. Staff education sessions
LDH	Neurology	UK Parkinson's Audit 2019 Elderly Medicine (Service evaluation Plan)	Parkinson's nurse is now in post and reviewing inpatients regularly. Now have availability of information packs for patients in clinics
LDH & BH	Oncology	NOGCA - National Oesophago-Gastric Cancer Audit-SHORT REPORT	Improvement responses currently under consideration
LDH	Paediatrics	National Audit of Seizures and Epilepsies in Children and Young People - Epilepsy12	Key performance indicators 1, 2, 5-8, 10 and 11 (8 of the 12) have been successfully met and the service continues to perform well in providing care with experts in epilepsy, epilepsy nurse provision, diagnosis, investigations and comprehensive care provision. Tertiary referrals to be reviewed and to set up process to obtain school care plan for hospital notes.
BH	Paediatrics	National Paediatric Diabetes Audit	A high % of patients in service are assessed for need of psychological support. There has been an improvement in thyroid, feet and retinal screen checks over the last 5 years with an offering of additional Dietetic appointments Further improvements include: • Development of patient information leaflet re: albumin-to-creatinine ratio screening • Start to analyse HbA1c data monthly, focus on those with HbA1c between 58 – 68 mmols/mol, to ensure the service follows the East of England guideline recommendation for those with high HbA1c, to improve glycaemic control • Set up virtual group sessions for those with high HbA1c

Site	Specialty	Project Title	Quality Improvements
LDH	Respiratory	National Smoking Cessation Audit	Improvements include: • Prioritised smoking status assessment in admission care plans. • Improved availability of Nicotine Replacement Therapy products on ward level pharmacy stock and ICE referral platform for smoking cessation services.
BH	Respiratory	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) COPD clinical audit 2019/20	Current length of stay is 3 days compared with National average of 4 days. There is a lower mortality rate of 3% compared with Wales 4.9% / Scotland 5.7%. Respiratory review within 24 hours is at 70.5% compared with National average 66.1%. The audit of National Early Warning Score recording is at 96% of patients compared with National average of 74.1%
BH	Rheumatology	Fracture Liaison Service Database (FLS-DB) -	The service consistently met expected national standards and performed above the national average for: • Patient identification with spine fractures • Eligible patients followed up after recommendation of treatment (first follow-up). • Eligible patients followed up at a year.
LDH	Stroke	Sentinel Stroke National Audit programme (SSNAP)	Among 10 domains except stroke unit domain, the service has achieved A or B grades. The breakdown is as follows: Scanning compliance score, A, Specialist Assessments B, Occupational therapy A, Physiotherapy A, Speech and language therapy, MDT working B, Standards by discharge B, Discharge processes A
LDH	Trauma & Orthopaedic	FFFAP - Falls and Fragility Fracture Audit Programme -HIP FRACTURE	Improvement group is in place for fractured neck of femur Actions completed or on-going include: • Patient and family leaflets production • Creation of a Femoral fracture 'passport' • Evaluation of case adjusted mortality • Ensure that patients with a displaced intra capsular fracture are managed such that they are treated with total hip replacement • Incorporate femoral fractures to the pathway
LDH	Trauma & Orthopaedic	National Joint Registry	Improvements completed and ongoing : • A named person assigned to undertake real time data entry • Review time allocated to surgical team • Ensure surgeons fully complete forms (ensuring all implant/cement stickers and Body Mass Index data are included and handed over to person in-charge for safe keeping and data entry) • Encourage all patients to participate in this national audit. • Review timing of obtaining consent. • Review of Primary arthroplasty pre-assessment • Review pre planning for Fractured Neck of Femur. • Create awareness that National Joint Registry forms must be available in the wards and reinforce information • Review purchasing joints of implants in relation to improved quality and cost effectiveness

Site	Specialty	Project Title	Quality Improvements
LDH	Urology	NPCA - National Prostate Cancer Audit	Improvements include : Ensure the service MDT team complete the pro-forma accurately to ensure data collection is complete. This will support improvement in performance, which is hoped will be in line or out performing peers in the next audit.
BH	Vascular	National Vascular Registry Annual Report 2020	Pathways identified to take improvement activity forward: 1. Chronic Limb Threatening Ischaemia pathway 2. Carotid pathway 3. Abdominal Aortic Aneurysm pathway

LOCAL CLINICAL AUDITS

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	Acute Medicine	Quality of Discharge Letters done by the medical take team	It was found that the majority of patients seen by the team have their discharge letters done and completed. However further actions required include: • Ensuring a clear policy regarding completion of Essential Diagnostic Lists (EDL) • Arrange EDL training sessions for doctors new to the trust 3.Ensure a cycle of audit to check for further improvement and sustainability
BH	Acute Medicine	VTE Prophylaxis Prescription Following Positive Risk Assessment	Improvements completed or in progress include: • Extension of mandatory teaching on venous thromboembolism (VTE) Risk Assessment and Prophylaxis prescription to include non-foundation Junior Doctors joining the Trust. • Review on-going VTE teaching to include a focus on, and a demonstration of, correct usage of VTE assessment tool. • Increase usage of mechanical prophylaxis, especially where chemoprophylaxis is contraindicated. • Create awareness posters for key areas across the Trust • Ensure a team approach is promoted through increased scale of teaching, raising awareness to as many staff groups who will interact with patients, including Healthcare Assistants who are often able to raise a concern. • Involving Educational and Clinical supervisors with awareness to follow up constantly poor practice. • Organise re-audit
LDH	Anaesthetics	Survey on practice of epidural top up for LSCS among anaesthetists	Improvements completed or in progress include: • Introduce prompts on anaesthetic chart to improve documentation regarding epidural top up and testing • Conduct a survey to determine current knowledge & practice of epidural top up • Ensure information is shared
LDH	Anaesthetics	Ensuring compliance with the new protocol for confirming placement of nasogastric tubes on patients who are admitted to critical care	Meetings have been used to discuss and share protocol across MDT

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	Anaesthetics	To establish best practice in pre-operative fasting	Policy now in place actions include: • Raising awareness of policy to anaesthetic staff through relevant meetings and other forums • Posters/leaflets developed for distribution and display on paediatric wards.
LDH	Anaesthetics	Rapid Sequence Spinals (RSS) – How much do we know? Application in the era of COVID-19	Plans in place for further discussion and review regarding acceptance of RSS into clinical practice. This includes input from midwives and obstetricians as well as anaesthetics.
LDH	Anaesthetics	Audit of Parenteral Nutrition (PN) usage Adult Service combined 2 years data	Improvements completed or in progress include: • Escalation of the increase in referral numbers; PN days and number of patients commencing Parenteral Nutrition • Completion of Parenteral Nutrition Clinical Guideline • Look to improve membership of the MDT ward round for Parenteral Nutrition primarily Pharmacy and Biochemistry input • Consider using a PN Proforma for documenting in the patient's health records at each review • Investigate the use of PN Filters on all adult PN bags
LDH	Cardiology	Clinical indications of echocardiography in Luton and Dunstable Hospital in view of British Society of Endocardiography (BSE) guidelines	This has shown improvement in compliance for the service. The improvement work remains ongoing which is aimed to sustain this trend.
LDH	Cardiology	Local audit on secondary prevention of the management of Acute Coronary Syndrome (ACS)	Audit shows poor risk factors identification and an inadequate addressing of lifestyle modification which provides an opportunity for improvement activity. Also identified is a hesitancy to initiate angiotensin-converting-enzyme ACE inhibitor, **Angiotensin receptor blockers** ARB or aldosterone antagonist
LDH	Colorectal Surgery	Audit Assessing Effectiveness of Straight to Test (STT) Pathway For 2 Weeks Wait Colorectal Referrals During COVID and Its Comparison Pre-COVID	FIT Test in all patients referred through 2 weeks wait pathway identified.
BH	Critical Care	Management Patients on Airway Pressure Release Ventilation (APRV).	Improvements completed or in progress include: • Bedside teaching for staff by the Intensive Care Unit Education Lead • Teaching by Draeger specialist, supported and lead by ICU Education • Development of Trust Guideline
LDH	Dermatology	A comparison of current practice of documentation for Isotretinoin with BAD recommendations	Audit indicates need for stickers with documentation required support information to be added to the form folder in each clinical room. The results of audit discussed with all the clinicians about the results of the audit

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	DME	Audit on compliance of Comprehensive Geriatric Assessment (CGA) & Electronic Discharge Letters (NG56)	Improvements completed or in progress include: • Ensuring all of MDT cooperate and contribute to completing respective parts on CGA & EDL. • Use of monthly meeting for consultants and ward manager on wards to include monitoring the use of CGA & correct EDL as part of their data discussions. • Support staff that on filling EDL compulsory boxes they should be completed filled with full sentence • Frailty Specialist nurses (SpN) to encourage and guide junior doctors in ED /EAU regarding documentation on CGA Proforma. • Initial clerking doctor, Frailty SpN and PTWR Consultant to select DME EDL on the day of admission to avoid selection of wrong EDL by other anyone else. • Ensure regular induction on documentation for CGA Proforma
LDH	DME	Completion of Neck of Femur Fracture Pathway	Improvement activity continues, findings show that completion of AMT and then screening for delirium is well performed and also that average length of stay is less than national average.
BH	Emergency Medicine	Management of Patients with Fractured Neck of Femur	Improvements completed or in progress include: • Ensure education of doctors and nurses on significance of pain score and analgesia. • Early request of X-ray on arrival and co-ordination with radiology department to complete #NOF as priority. • DIP on symphony for ease of documentation • Referral to specialty at radiological diagnosis.
LDH	ENT	Preoperative vocal cord visualization audit.	The action required indicated that a monitoring tool would be helpful acting as a reminder to the booking surgeon in regard to the assessment of vocal cord function before completion of booking a patient for thyroidectomy.
BH	General surgery	Antibiotic Prescribing and Time to CT in Acute Diverticulitis	Improvements include the need for improved antibiotic stewardship in adherence to the guidelines, this is to be supported by a teaching session and use of educational posters to highlight the guidelines
BH	General Surgery	Requirements for Prescribing Antibiotics on Medchart	Plan in place to teach on NICE guidelines of antibiotic prescriptions
BH	General Surgery	Specialty to Specialty Referrals	Improvements completed or in progress include • Trail the use of e-referral system in the surgical departments • Re-assess once trail complete
LDH	General surgery	Pain control in acute pancreatitis	Improvements completed or in progress include • Use of pain management flowchart to standardize care across surgical department. • Re-audit to confirm pain relief is appropriately prescribed and impact on patient experience
LDH	General Surgery	Adherence to Trust Guidelines While Prescribing Antibiotics: A Re-Audit	Decision to cease use of concurrent use of Co-Amoxiclav and Metronidazole.
LDH	General surgery	Re-audit -Management of Pancreatitis with or without antibiotics-How are we performing?	Improvements identified around adherence to Trust & NICE Guidelines

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	General surgery	Improving surgical rota access for junior doctors	Improvements completed or in progress include • Ensure junior doctors are sent surgical weekly rota in order that they can see who they are working with, clinics and theatre lists. • Ensure access to the rota off site with a shared drive. • Notification for junior doctors in the morning from specialties.
BH	Maternity	MEOWS - Maternity Early Obstetric Warning System Audit	The audit highlighted that midwives were not always completing/ documenting woman's temperature. As part of improvements a review of equipment was made and more thermometers for the labour ward and day assessment unit have been bought.
LDH	Maternity	Doctors handover tool	Audit shows that target is met with minor improvements to update the daily data collection tool. Monthly audit to continue.
LDH	Maternity	BSOTS audit (Birmingham Symptom Specific Triage System)	Results show there has been improved management with easier handover using shared language. Patient satisfaction has also improved.
LDH	Maternity	Swab Count	This was a re audit and has shown further focus for needed on optimising swab counts during procedures that occur in the delivery rooms to deliver consistent 100% compliance.
LDH	Maternity	COVID-19 Maternal and Neonatal Outcomes at LDH	Audit showed that a MDT (multidisciplinary team) approach was taken to all deteriorating maternity patients. This approach is to continue when managing any deteriorating patients. Also, management plans for patients were found to be up to date with the latest recommendations as they were being set out and updated as pandemic progressed.
LDH	Neonatal	Audit of babies undergoing therapeutic hypothermia during 2019-2020	Improvements completed or in progress include • Plan to include neurological examination as a part of induction and in departmental teaching • Improving Nursing Care Plan (NCP) pathway to include agreed discharge neurological examination complete proforma as part of NCP 3 pathway (Hammersmith examination and Dubowitz scoring). • Ensure training at all opportunities for Junior doctors regarding the discharge neurological examination and its documentation • Ensure nurse training around use of nursing checklist and addition of completeness of NCP pathway (medical and nursing checklist) to discharge checklist from Neonatal Intensive Care Unit (NICU). • Ensure education session for medical team regarding the need to keep magnesium levels > 1 in babies undergoing therapeutic hypothermia. • Ensure awareness in respect to diagnosis of hypoxic ischemic encephalopathy (of one of the three grades, - mild, moderate, severe) to ensure it is put in discharge diagnosis for babies undergoing therapeutic hypothermia. Consultants not to sign discharge summary without HIE as diagnosis and completed medical and nursing checklist. • Ensure MRI brain requests are copied to admin staff who will ensure the report is scanned on Evolve system. • To ensure the scan nursing chart is in the correct nursing chart section

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	Neurology	Adult First Seizure Audit	Good findings from audit with only 2% of inappropriately referred for EEG patients so this is very good. Improvements include the implementation of a "2 week wait" for rapid access system for patients having "first fits". Also ensuring that a witness account is sought each time where possible. Accurate classification of seizure at first assessment should be recorded.
BH	OMFS	Neonatal Frenectomies - the effect of lockdown and compliance with NICE guideline	Improvements completed or in progress include • Designated appointments for lingual frenectomies to be carried out each week • An information leaflet to be given to parents post operatively
LDH	Ophthalmology	Visual assessment of patients at high risk of falls	• Implementation of bedside vision assessment
BH	Plastics	Assessment of Tendon Repair Outcomes in Plastic Surgery/ Laser Unit	• Consider the yearly audits on tendon repair as they incorporate wider regional data • Liaise with hand therapy team to understand data on rehabilitation process
BH	Radiology	Adequate Contrast Enhancement of CT Pulmonary Angiogram (CTPA) Re-audit	• CT radiographers to undertake a check the Hounsfield unit (HU) on CT to ensure it's at the level for optimal values
LDH	Radiology	Assessment and Comparison of the Quality of MRI Knee Requests from Orthopaedics and the Extended Scope Physiotherapy (ESP) Facility	• Consider use of proforma-based requesting and also further education sessions which may improve quality of requests and thus avoid unnecessary tests.
BH	Respiratory	Pneumonia Diagnosis and Management (CURB Score)	• Shows that use of CURB 65 score means a significant number of patients can be managed with oral antibiotics and discharged. • Audit shows that CURB 65 document and scoring together with adherence to the trust and NICE guidelines poor. • Improvement plan in place with a re-audit planned .
LDH	Rheumatology	Rheumatology GCA Fast Track Pathway, Year 3 Audit	The team's three-year audit cycle won the 2019 national British Society Rheumatology Award for vasculitis, for its progressive improvement in patient safety (sight loss), clinical effectiveness (secure diagnosis rates) with a cost saving due to reduction in temporal artery biopsy rate (biopsy is about £500 and ultrasound is about £50). The team are in the process of introducing a similar GCA FTP at the Bedford site.

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
LDH	Sexual Health	Early syphilis audit: Anglia region	• Audit shows the service standard 1-3 was 100% compliant against a regional/national average of 97%. • British Association for Sexual Health & HIV (BASHH) is nationally planning to change how contact tracing is done as per the LUSTRUM (Limiting Undetected Sexually Transmitted infections to Reduce Morbidity) project and is piloting this in different clinics across the country, there have been delays due to COVID-19 • Await British Association for Sexual Health and HIV to nationally feedback the result of this pilot and update local policy accordingly for contact tracing • A nationally held Health Advisors list is being compiled which will make it easier to communicate between sexual health clinics in regard to patients and their contacts
LDH	Stroke	Lipid management for secondary prevention of stroke NICE Pathway	Audit showed a reduced compliance in statin prescription, therefore the need to ensure high intensity statin prescription without delay following stroke was identified. Lipid monitoring was also non-compliant and baseline testing and GP follow up testing is deemed necessary for dose adjustment. A local guideline for ischaemic stroke lipid control pathway is being developed. Guidance for GPs is to be added to discharge letters requesting that they check and review lipid profiles at 3 months. These issues to be highlighted through a range of educational and other forum. Findings will also be disseminated to GPs.
LDH	Therapies	Laryngectomy length of stay	This evaluation's main objective was reviewing the length of hospital stay of laryngectomy surgery patients, to serve as a baseline measure for future re-audit once an Enhance Recovery After Surgery programme is established for this cohort. The evaluation highlighted the variability in patient length of stay for this cohort of patients. Actions required: • Ear Nose and Throat (ENT) consultants to identify appropriate patients to have open stoma after removal of tracheostomy tube. Patients with an adequate size of stoma (to be agreed) which does not occlude from submandibular swelling should be considered. • ENT consultants to identify appropriate patients to be assessed with day 5 Gastro-graffin swallow to promote early oral feeding. • Speech and language therapists (SLT) and Clinical Nurse Specialist teams to trial implementation of post-surgery pathway and changes to practice, including: - Develop protocol for management of stomal stenosis - Heat and Moisture Exchange placement – day 5 (hydrocolloid baseplate, dependent on healing/tissues) - Develop patient competencies for stoma care - Develop staff competencies for stoma - Day leave – consider day leave at day 9/10 if medically fit with a view of discharge following day.

Site	Specialty	Project Title	Quality Improvements and actions required to improve quality of care
BH	T&O	Management of Proximal Humeral Fractures in Adults	Improvements completed or in progress include • Documentation to be developed which should include the patient's dominant hand, Neuro Vascular status – focusing on axillary nerve. • Improvements to documentation.
LDH	T&O	Automatic Orthopaedic Implant Identification using Artificial Intelligence	Accurate identification of orthopaedic implant design is essential to pre-operative planning of nerve revision arthroplasty and verification of magnetic resonance imaging conditionality. Review found current systems not adequate and may be linked to poorer surgical outcomes, significant time burdens on clinical staff and increased healthcare costs. Plans for remedial action underway.
LDH	Theatres	Trends in booking and operating on emergency OMFS cases over 4 months in Emergency Theatre A	• Ongoing discussions with theatres & OMFS regarding how to improve OMFS service and efficiency. • Repeat of audit to understand if workload changes when improvements implemented
LDH	Theatres	Emergency Theatre Utilisation	• Re audit utilisation of emergency theatre workload given ongoing work pressures.

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 2021/22 and who were recruited during that period to participate in research approved by a Research Ethics Committee was 4170.

The Trust was involved in conducting 202 clinical research studies in 2021/2022 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 184 Portfolio studies, 7 Non-Portfolio and 11 COVID-19 studies.

The Trust's contribution to the COVID-19 pandemic Urgent Public Health (UPH) Trials, to which we recruited 2527 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.

Bedfordshire Hospitals NHS FT is working on an inclusion project with Eastern, the local clinical research network. The purpose is to assess how confident the clinicians recruiting to the RECOVERY trial felt approaching patients of all the ethnic groups admitted to hospital with COVID-19 and how the patients found the experience. This is an important study which will help to guide the department's actions to ensure wide ethnic participation in research at the Trust. The results will be disseminated in the R&D newsletter when available.

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 2021/22 continued to be suspended by NHS England due to the COVID-19 pandemic in order to release staff to provide frontline clinical support.

The 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 published CQuIN schemes for 2022/23 and these are reflected in Trust Quality Priorities for the year.

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 the 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.

These conditions have remained in place throughout 2021/22 during which time the Trust has continued regular engagement meetings with the CQC and continued work on implementation of the comprehensive improvement plan which was put in place to address those areas identified as requiring improvement. This improvement plan continues to be 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.

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.

3.6 Data Quality

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

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

Good quality data can be achieved by monitoring key data items and activity events, with the results being reported to the service lines responsible. Although reporting on errors and completeness within key data items is essential for reporting gaps, it is more effective and efficient for the data to be entered correctly first time. In order to achieve this, workplace procedures must exist for key areas processing information.

Standards are essential to ensure that;

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

2021/22 Data Quality Improvement

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

- Valid/Missing NHS Numbers
- PAS missing Data Reports – Demographic missing or invalid records i.e. gender, home addresses, telephone numbers
- Ethnicity Valid completeness
- Postcode assignment
- Purchaser assignment - missing/inaccurate General Practitioner
- Clinical coding completeness
- Outpatient Outcomes or Attendance Reports
- 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
- Reports identifying errors in Referral to treatment data

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

- Data Quality dashboards and reports from SUS
- NHS Digital Dashboards
- Data Quality Summary CHKS
- Challenges from Commissioners
- Case note audit
- Data Security and Protection Toolkit
- External commissioned audits

Over the past 24 months the Trust has continued to adapt and to transition following the merge of the two sites. Due to COVID-19 pressures on the Trust during this time the Clinical Information and Data Quality team has been required to review its way of working, its priorities and staffing requirements.

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

- 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.
- Implementation of a new automated Data Quality Dashboard so that data is accessible to all and is updated daily
- Worked closely with IT to build small user groups to tackle specific data quality and clinical system related concerns, E.g. Reference values, System upgrades
- Merged a number of site reports including the national commissioning data submissions to the secondary user services. Ensuring that data is being captured and reported consistently across the two sites.
- Reviewing of the Trust's Data Warehouse and reference data within clinical systems to provide assurance that data across both sites is being captured and recorded consistently.
- Merging of the Trust Data Warehouse so that there is one cross site repository for data, allowing for more consistent and accurate reporting
- Continue to work very closely with NHS Digital and ED to implement the ECDSv3 data set, increasing our data quality conformance.
- Increased batch tracing to enable better quality patient demographics and standardised the process cross site and worked with clinical systems training to incorporate summary care training into the HELM e-learning platform so demographics are checked by more staff at the point of arrival
- Reviewed existing reports cross site to ensure they are relevant, accurate and distribution lists are up to date.
- Automated reports and extracts to ensure more timely delivery of data to users and services

Action Plan for 2022/23 Data Quality Improvement

1 Reporting

- To continue to work on improving 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.
- Working with the Technical Analytics team to build new data reconciliation reports for CDS submissions and all other statutory returns, thus providing further assurance that all data that is being submitted externally is accurate and timely.
- 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 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 regularly audit the Trust's Data Warehouse to ensure that the data is consistent and as per clinical systems

2 Education and implementation

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

sites, not only to stress the importance of data quality but to ensure we have a consistent approach to data entry which will improve cross site reporting
- To continue to work with internal departments, spending more time with each service on the ground to offer advice and support on improving their data quality and capture.
- To review validation processes across site for RTT – with the increased need to fully understand the patients still waiting for treatment and to provide reassurance to external providers of our recovery plans it is essential that we review the data capture and flows across the Trust. We will have clear and consistent data that can be reported directly from source systems allowing more frequent and reliable reporting locally and nationally.
- To implement 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 meetings 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.
- To continue 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 and to hit national conformance indicators.

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

3.7 NHS Number and General Medical Practice Code Validity

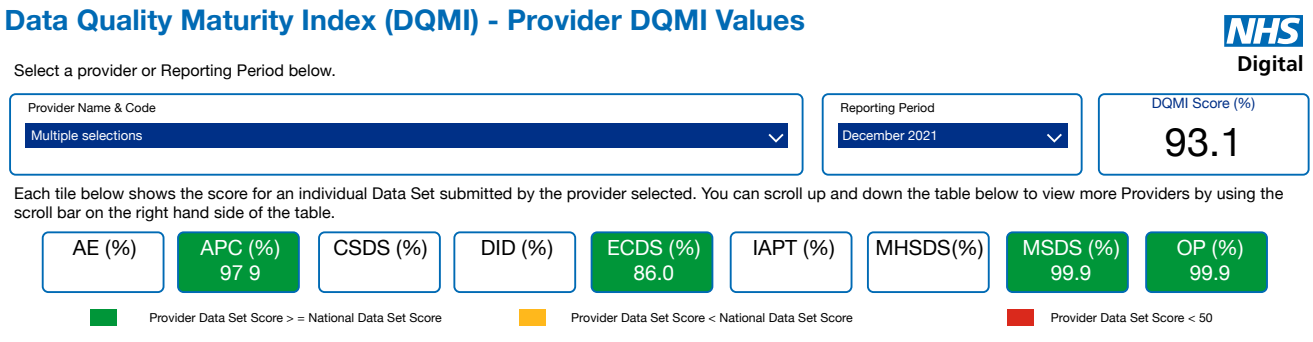
Bedfordshire Hospitals NHS Foundation Trust submitted records during the reporting period 2021/22 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
- Which included the patient's valid NHS number was:
  - 99.8% for admitted patient care
  - 99.9% for outpatient care
  - 98.1% for accident and emergency care

- Which included the patients valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 99.8% for accident and emergency care

Data Quality Maturity Index (DQMI)

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



3.8 Clinical Coding Error rate

For diagnoses and procedure coding the Trust achieved 95% and 91% accuracy rates respectively for the reporting period April 2020 – March 2021. The accuracy rates reported in the latest published audit for reporting period April 2021 – March 2022 for diagnoses and procedure coding were 94.4% and 92.5%, respectively.

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

Bedfordshire Hospitals NHS Foundation Trust submitted and published its DSPT assessment on the 9th August 2021.

The Trust's Position was 'Approaching Standards' however to achieve 'Standards Met' compliance the Trust must meet the requirements of all assertions.

More recently The Trust submitted a baseline assessment on the 15th March and again on the 23rd March with amendments.

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

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

The next submission of the DSPT will be published on 30th June 2022

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 7 reported incidents (using this tool) for the last year. Two of these required further involvement from the Information Commissioner's Offices.

- Unlawful access claim – Investigated, completed with no further action required
- Data breach, potential safeguarding concerns – Currently being investigated.

Audit

The Trusts external DSPT audit commences on the 19th April 2022

3.10 Learning from Deaths 2021/22

Introduction

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

The following sections provide the summary data which are reported quarterly at our Learning from Deaths Board, Clinical Quality Operational Board and the Quality Committee.

Key updates 2021/2022

Following the formation of Bedfordshire Hospitals NHS Foundation Trust in April 2020 the process for identifying, recording, reviewing and investigating the deaths of people in our care has now been aligned across both hospital sites in line with national guidance with a standardised and consistent approach focussing on learning.

Developments in 2021/22 include configuration of our Datix Cloud IQ (DCIQ) system. This allows all Medical Examiners (MEs) to document their reviews and escalation of any concerns for subsequent Structured Judgement Review (SRJ), completed on the same cloud-based platform. In addition, greater utilisation of DCIQ functionality supports triangulation with patient safety incidents, including Post Event Action Review and Learning (PEARL) panel outcomes.

The number of MEs has expanded in response to national drivers, including plans to review community deaths, with two GP MEs recruited to date which is ahead of this being a statutory requirement. Work is ongoing to access primary care health records, including via the clinical portal to support this development.

Recruitment of 4.2wte Medical Examiner Officers (MEOs) is underway. This role is integral to support the work of the MEs and is a core part of the national model, acting as a point of contact and source of advice for bereaved families, clinical teams and coroner and registration services.

In addition to the expansion of MEs the number of mortality reviewers has increased to 14 across both hospital sites. Demand modelling remains under review

to ensure the Trust continues to meet its statutory requirements, monitors and responds to step-changes in reviewer capacity and to plan for timely completion and sharing of SJRs to support learning from deaths.

All SJRs are shared with Clinical Service Line (CSL) management teams, providing a clinical viewpoint to inform case discussion with the wider team at governance forums, including mortality and morbidity meetings. A toolkit has been produced to support organisation and capture of case discussions including learning and quality improvements. This is currently being tested, facilitated by the CSL Quality Governance Support team.

Working with the clinical service lines is ongoing to ensure learning from deaths is embedded within their quality governance activities. The impact of this includes:

- an improved knowledge and understanding of the mortality review process
- dissemination of service line level mortality data and SJRs and sharing of findings where a cross service line theme is identified.

Monthly mortality reporting

Both hospital site specific and combined data is reported monthly to facilitate identification of themes, trends and areas for focus. Monthly reporting includes CHKS (Comparative Health Knowledge System) mortality alerts and national mortality indicators. In addition deaths within 24 hours are reviewed by the Deputy Medical Director and Associate Medical Director, Lead for Mortality and presented at the monthly LfD Board.

Monthly reporting also includes learning disability deaths; the system for LeDeR changed on 1st June 2021. Local governance structure and processes are in place and in depth reviews are completed if indicated at the initial review stage. Following completion, all LeDeR reviews will be presented to a system Quality Assurance panel (BLMK), to include representation by Lead Learning Disability Nurses from both hospital sites, with learning cascaded to safeguarding leads.

Learning from the latest report to the LfD report (March 2022) highlights the complexity of the cases reviewed and the opportunities for learning across provider organisations. Themes identified include the need to improve care planning and risk assessment, including monitoring of bowel function and constipation, aspiration and timely referral to external professionals. In addition the role and importance of hospital passports and use of 'all about me' documentation was highlighted.

National data submission

Table 1: Quarterly breakdown of the number of patients* who died at Bedfordshire Hospitals NHS Foundation Trust by hospital site in 2021/22

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals	**400 (12)**	**537 (21)**	**603 (14+2)**	**656 (11+2)**	**2196 (58 +4)**
Bedford Hospital	177 (3)	257 (7)	257 (5)	307 (3+1)	998 (18+1)
Luton and Dunstable Hospital	223 (9)	280 (14)	346 (9+2)	349 (8+1)	1198 (40+3)

Excludes stillbirths and child death:*

Total 2021/22 - 58 stillbirths (BH, 18, LDH, 40) and 4 child deaths (BH, aged 1 year, LDH
aged 2, 3 and 16 years)

Tables 2a, b: Number of Primary (a) & Structured Judgement Reviews (SJRs) (b) by quarter at Bedfordshire Hospitals NHS Foundation Trust by hospital site in 2021/22

Primary reviews (2a)

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals	**363**	**459**	**540**	**522**	**1884**
Bedford Hospital	123	133	150	156	562
Luton and Dunstable Hospital	240	326	390	366	1322

SJRs*(2b)

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals	**50**	**48**	**68**	**25**	**191**
Bedford Hospital	14	3	22	15	54
Luton and Dunstable Hospital	36	45	46	10	137

85.8% (1884/2196) of deaths had a primary (first review) across the Trust in 2021/22, of these an SJR was requested in 15.8% (298/1884) cases and to date 64% (191/298) have been completed.

An additional 107 (BH, 45 and LDH, 62 across Qs 2 - 4, 2021/22, as of 20/04/2022) SJRs have been allocated and are awaiting completion. A data refresh and update is undertaken as part of quarterly learning from death reporting to ensure all deaths, where it was considered

more likely than not to have been due to problems in care, are captured for inclusion and learning.

Table 3: Number of deaths by quarter where following a SJR it is considered that the death was more likely than not to have been due to problems in the care provided

	Q1	Q2	Q3	Q4	Total
Bedfordshire Hospitals	0	4	2	0	6*
Bedford Hospital	0	0	1	0	1
Luton and Dunstable Hospital	0	4	1	0	5

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

The 6 deaths where, following an SJR it is considered that the death was more likely than not to have been due to problems in the care provided, represents 0.2% (6/2916) of all deaths, 0.3% (6/1884) of all primary reviews undertaken and 3.1% (6/191*) of all completed SJRs in 2021/22.

Acknowledging 107 SJRs are awaiting completion (total no. deaths referred for SJR no.298).

Figures 1 - 3 illustrate the number and percentage of assigned avoidability scores for all SJRs completed in 2021/22 by Trust and hospital site

Figure 1
Bedfordshire Hospitals: 2021-22 SJRs (no. 191), assigned avoidability score

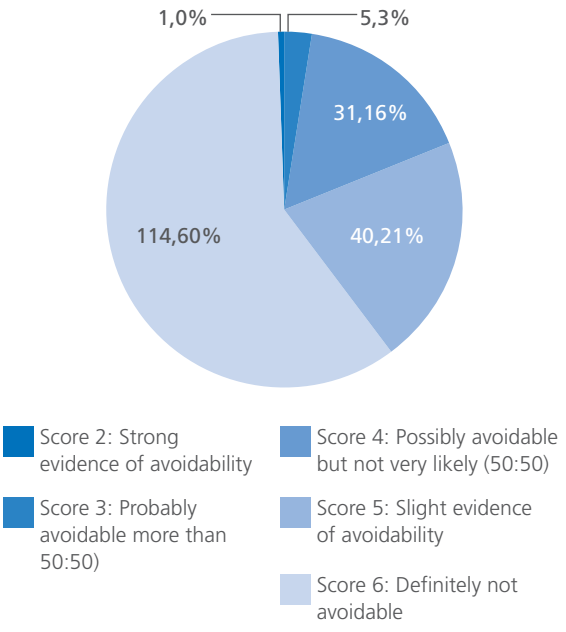


Figure 2
Bedford Hospital: 2021-22 SJRs (no. 54), assigned avoidability score

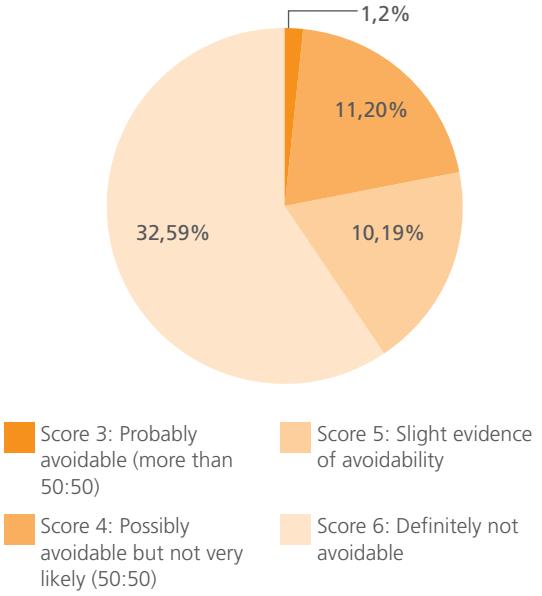
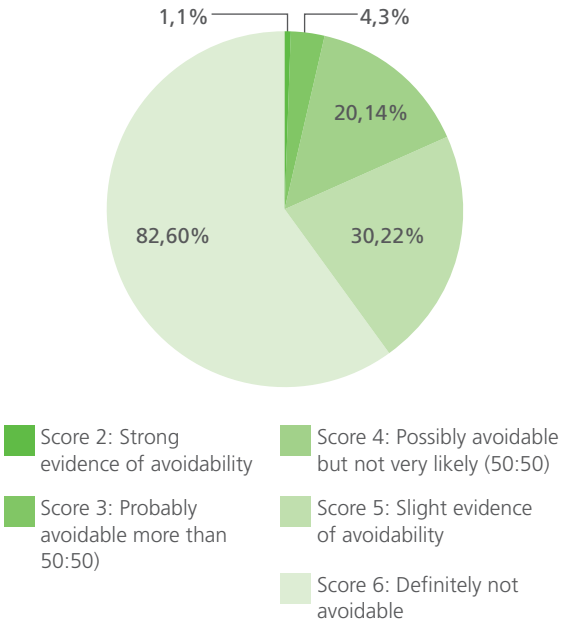


Figure 3
Luton and Dunstable Hospital: 2021-22 SJRs (no. 137), assigned avoidability score



Mortality review process

The National Mortality Case Record Review (NMCRR) methodology from the Royal College of Physicians in collaboration with the Healthcare Quality Improvement Partnership (HQIP) has been adopted across the Trust.

To ensure objectivity, case record reviews are, wherever possible, conducted by clinicians other than those directly involved in the care of the deceased. Deaths are scrutinised

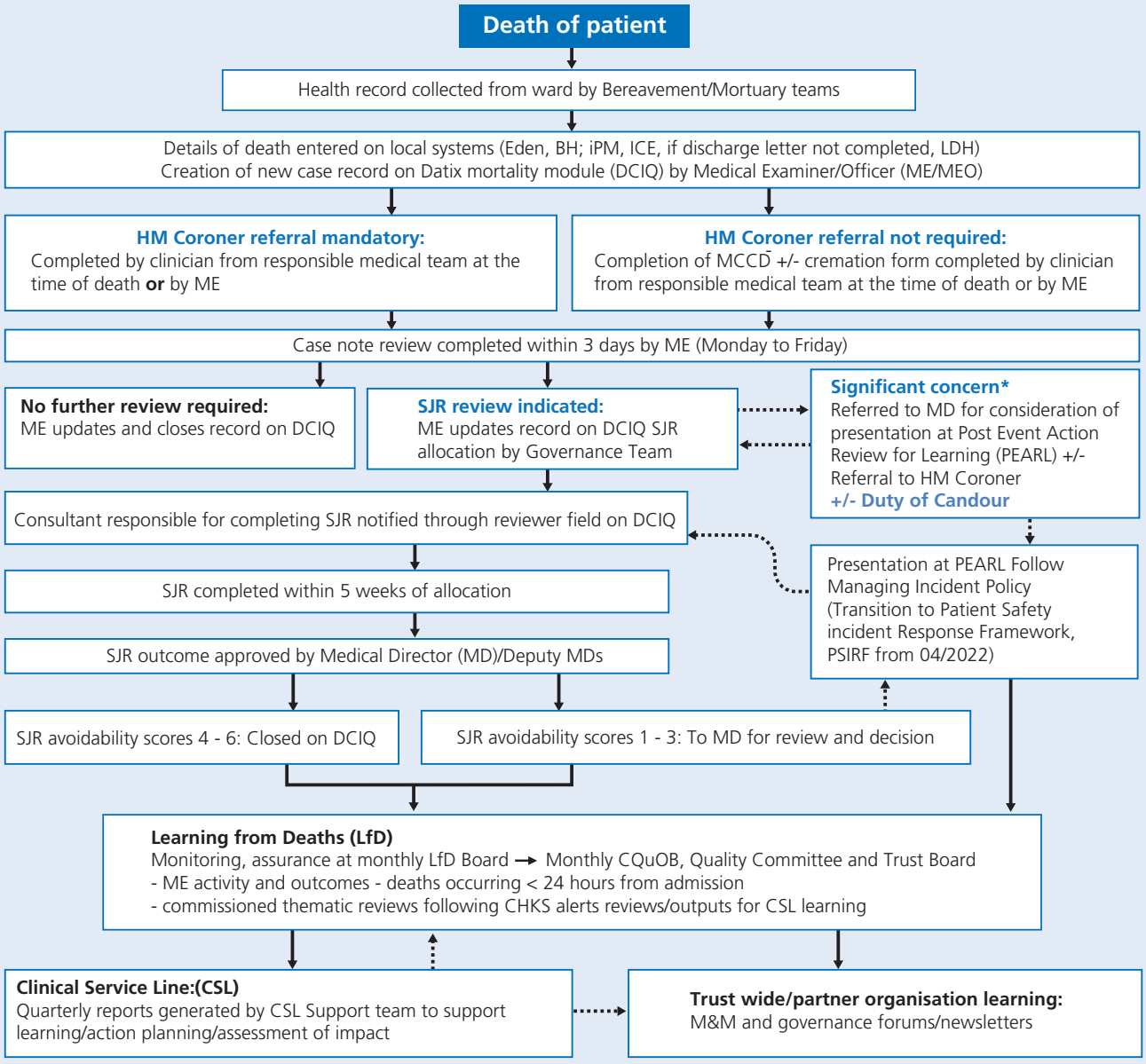
initially by the Medical Examiner (ME) (primary mortality review) who has accountability to HM Coroner for this aspect of their role as well as their professional accountability to the Medical Director. Reviews are directly entered onto the Datix Cloud IQ (DCIQ) system across both hospital sites.

The ME grades the potential avoidability of death with scores ranging from 1 (unavoidable, no suboptimal care) to 4 (suboptimal care, which might have affected the outcome i.e. probable avoidable death). The ME will then indicate whether a structured judgement review (SJR) i.e. full mortality review is required

SJRs are undertaken by a pool of mortality reviewers (14 in total across both hospital sites). Reviews are carried out using explicit judgements on the quality of care received in accordance with good practice during phases of care. Maternal and child deaths are subject to separate review processes and are not included in the SJR review.

The mortality review process is summarised in the chart below.

Learning from Deaths Process for Adult Mortality Review



All nosocomial deaths referred for a SJR. For nosocomial COVID-19 deaths follow process for: Investigation process for probable /definite hospital onset COVID-19 cases resulting in death* v10-11-2021 v1 10 November 2021

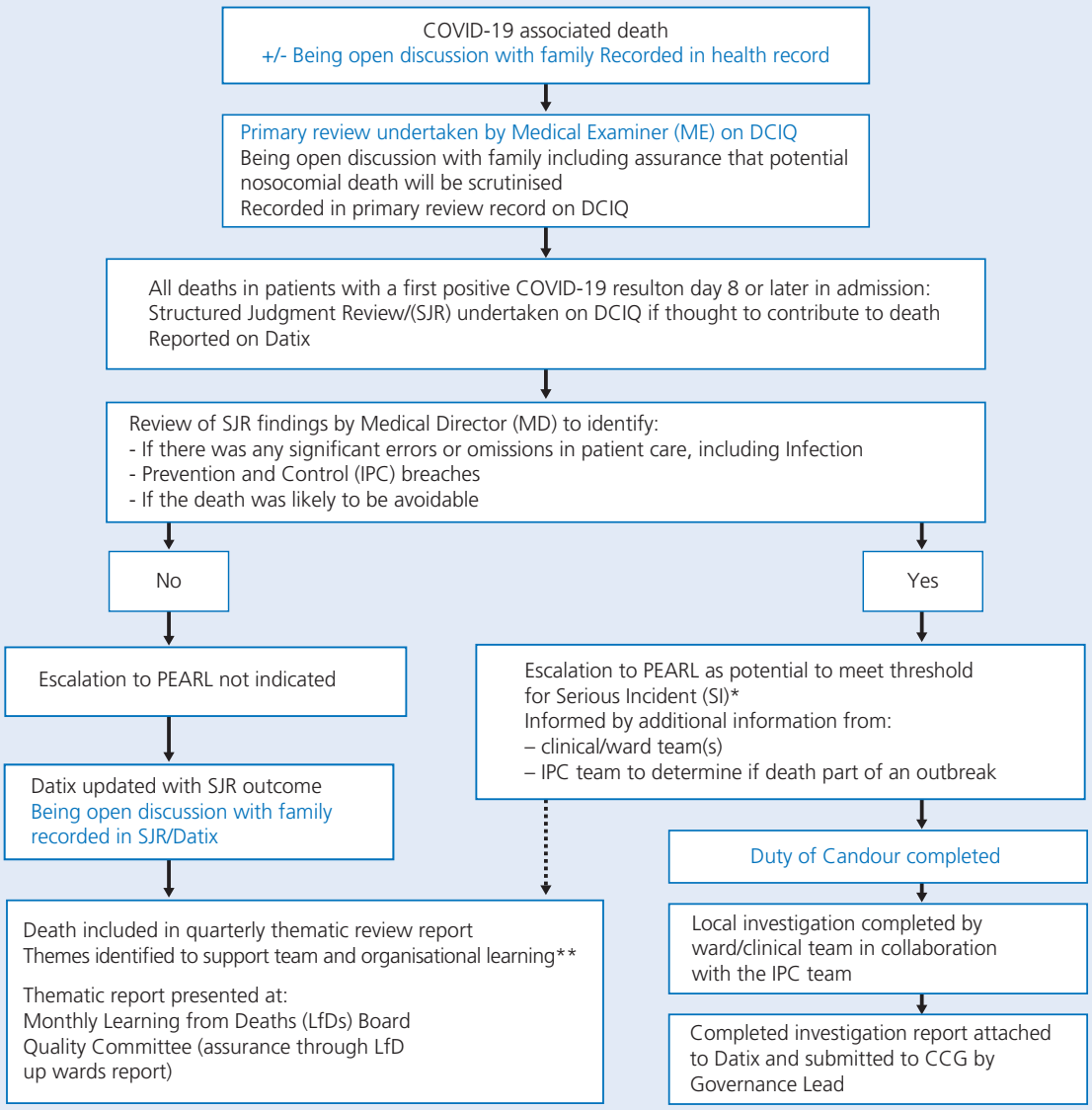
Structured Judgement Review (SJR)

It is hoped that most deaths in hospital will be unavoidable with good care given to the patient. Following scrutiny of the notes by an ME, the patient record can be put forward for a more in-depth review by one of the dedicated group of reviewers. This SJR allows for a standardised and systematic review of phases of care to support identifying opportunities for learning. An SJR identifies themes and addresses deficiencies in processes and patient care of adult patients who have died in all elective deaths, all HSMR outliers, all learning disability (LeD) deaths, selected non-elective deaths and local initiatives.

Cases that may require an SJR include:

- Family concerns
- Staff and/or ME concerns
- Learning disability or mental illness
- Trust mortality alert
- Unexpected death
- Special circumstances (i.e., sepsis, acute kidney injury)
- Fractured neck of femur
- Possible hospital-acquired (nosocomial) COVID-19, contributing to death (see below: *Investigation for probable or definite nosocomial COVID-19 cases resulting in death*)

Investigation process for probable or definite nosocomial COVID-19 cases resulting in death



Key opportunities for family and carer engagement

Key opportunities for family and carer engagement

* Transition to Patent Safety incident Response Framework, PSIRF from 04/2022

** Learning from Deaths, Process or Adult Mortality Review v10/11/2021

V2 updated 19 April 2022

Should there be particular concerns regarding a death following an SJR this may be discussed by a panel of reviewers for consideration as to whether a more detailed Serious Incident (SI) investigation is required and will be referred for SI decision panel consideration. In instances where deaths clearly meet the criteria for further investigation they are then reported and an investigation undertaken.

SJR forms consist of three elements. The majority of this form is free text, to allow clinicians the opportunity to document issues they highlight within phases of the patient pathway.

The first section documents basic demographic details of the deceased, details of their admission, and their death.

The second phase requires the reviewer to look at up to 5 phases of care received during the admission. Not all phases are applicable to all patients. The phases are:

- admission and initial management (up to 24hrs),
- ongoing care
- care during procedures (excluding iv Cannulation)
- perioperative care
- end of life care

Each phase is allocated a score from 1 (very poor care) to 5 (excellent care), allowing some comparison and analysis. The third phase reviews certain aspects of care which often give rise to concerns (fluids, drugs, oxygen therapy, VTE assessment and prophylaxis, resuscitation, etc.)

In the final phase of review, the reviewer is asked to provide a judgement about possible avoidability of the death. They are then asked to score the avoidability on a scale of 1 - 6:

1 - Definitely avoidable,
2 - Strong evidence of avoidability,
3 - Probably avoidable (> 50:50),
4 - Possibly avoidable (< 50:50),
5 - Slight suggestion of avoidability, and
6 - Definitely not avoidable.

Completed reviews are approved by the Medical Director. All reviews scoring <3 are reported on incident reporting system and considered against the serious incident framework. Where applicable the Duty of Candour process is also undertaken.

Learning themes are captured through the DCIQ reporting tool and tabled at the monthly LfDs Board, CQuOB and Quality Committee and through quarterly LfD reporting.

Summary narrative of learning from SJRs including any actions taken, impact

Of the six cases with an avoidability scores of 2 (no.1), and 3 (no.5) the following learning from the SJRs was identified and shared with the clinical teams. 5/6 cases were subject to additional scrutiny through an SI panel discussion, with 2 then investigated by SI investigation. 1/6 cases was included in a nosocomial COVID-19 thematic review.

Key learning identified from the SJRs included:

- Care needed when prescribing opioids, particularly in sick, elderly patients and when it is a Nurse Controlled Analgesia (NCA)
- Timely transfer once theatre send for the patient
- Consultant involvement needed in the context of a complex iatrogenic case
- Formal documentation of weight required on presenting to ED, particularly if the BMI appears increased, decreased on estimate
- Importance of daily review of medication and the timely review of blood results
- Timely escalation for consideration of higher level care was highlighted
- Importance of documentation, including following review of investigation findings
- Risk of nosocomial infection in patients where discharge is delayed was highlighted

Actions identified and implemented included:

- Review of current pharmacy support during the weekend
- Internal safety alert circulated across the Trust with regard to paracetamol dosage

Notable practice across the patient pathway was also identified and included:

Admission and initial management - good care
Excellent management on admission noted including comprehensive history taking, despite significant communication difficulties, including contacting relatives and a thorough physical examination

Ongoing care - excellent care
Multi-disciplinary approach to diagnosing and managing condition, including supporting higher level care needs in theatres in advance of bed becoming available on ITU.

Ongoing care - good care
Good ongoing care from various teams; urgent reviews and ongoing investigations for cause of admission issue. Also, with worsening respiratory symptoms, appropriate urgent chest imaging investigations were undertaken.

Perioperative care - excellent care
Patient frailty documented on anaesthetic chart. Operation notes completed with clear post-operative instructions.

Care during a procedure - good care
Right diagnostic pleurocentesis was undertaken under ultrasound guidance following consent and with local anaesthetic, with subsequent appropriate conversion to a chest drain.

End of life care - good care
Appropriate and timely decision making, including ceilings of care completed by the team. Recognition of the dying patient and discussions with family were appropriately undertaken.

End of life care was supported by a personalised care plan with anticipatory medications.

5.0 Refresh of review data for 2020/21
The following section provides an update on the previous reporting period (2020/21) (27.7)

Table 4: Number of primary reviews and SJRs completed for the previous reporting period (2020/21)

	Total no. Deaths (2020/21)	Primary reviews completed	SJRs completed
Bedfordshire Hospitals	2823	1788	57
Bedford Hospital	1206	512	17
Luton and Dunstable Hospital	1617	1281	40

Figures 4 - 6 below illustrates the assigned avoidability scores for all SJRs completed in 2021/22 by Trust and hospital site

Figure 4
Bedfordshire Hospitals: 2020-21 SJRs (no. 57), assigned avoidability scores

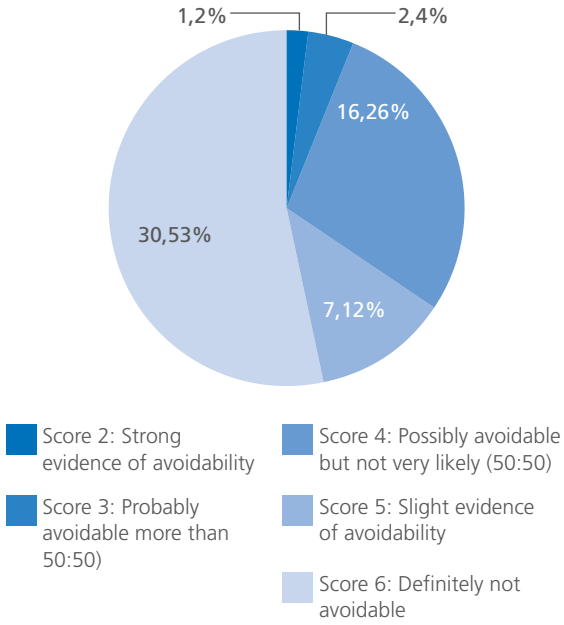


Figure 5
Bedford Hospital: 2020-21 SJRs (no. 17), assigned avoidability scores

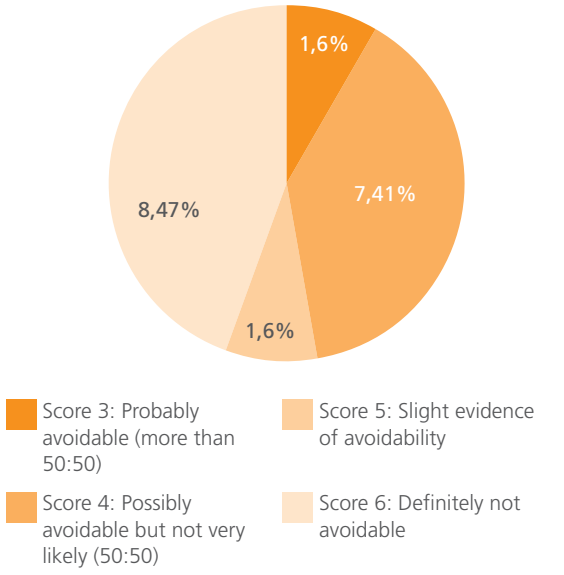
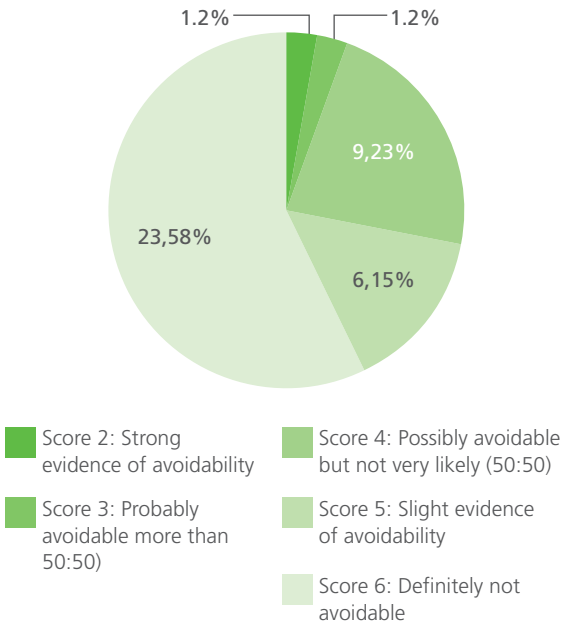


Figure 6
Luton and Dunstable Hospital: 2020-21 SJRs (no. 40), assigned avoidability scores



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 role of the Freedom to Speak Up (FTSU) Guardians is to work alongside the Trust Board to support Bedfordshire Hospitals in becoming a more open and transparent place to work, where all staff are actively encouraged, enabled and feel safe to speak up. This also includes all levels of leadership, managers and teams supporting a transparent and open culture where all staff including agency and temporary workers, students, volunteers, Governors and other stakeholders are able to thrive.

In practice, FTSU has two key strands: reactive work in supporting staff to improve patient care and the staff experience, and proactive work to raise awareness and embed the key FTSU messages making 'speaking up business as usual'.

The FTSU Guardian and Champion roles aim to:

- Improve patient safety
- Improve service quality
- Improve staff health and wellbeing, leading to lower levels of turnover and staff absence
- Improve staff engagement and retention.

Both hospital sites have well-established FTSU and Guardian roles. The communications team worked with the FTSU team during our Values weeks in December 2021 to promote our THRIVE values using video clips. During 'Speak Up' month in October 2021, there was a communication campaign including social media, trust-wide messages, new FTSU Booklets, Speak Up stands and pledges.

We now have a face-to-face presence at induction sessions covering Junior Doctors, Consultants and the MDT Corporate Induction (covering Nurses, Midwives, Pharmacists and Therapists). This is an opportunity for our new starters to meet the Guardian in person embedding key speak up messages from the start of their career at Bedfordshire Hospitals. An induction video is also available as part of our on-line virtual induction package.

We are in the process of recruiting more champions and are committed to developing a wider FTSU Champion network that is diverse and representative of our organisation.

The Freedom to Speak Up Vision and Strategy 2021-24 was created through engagement with staff across the organisation including Freedom to Speak Up advocates (Guardians and Champions), members of various trust diversity groups, discussions with staff who have raised Speaking Up concerns and those who were wanting to find out more about the process. The Freedom Speak Up self-assessment tool was also used to scope out the effectiveness and position of the trust and the level of Exec level engagement with the process which ultimately links in with the Well-Led domain.

Engagement focussed on:

- What does speaking up mean to you?
- What does speaking up look like at Bedfordshire Hospitals now?
- Where should we be in 3 years' time?

The strategy sets out the vision and strategy for Freedom to Speak Up and the proposed outcomes and measures. It should be read in conjunction with the Trust's Freedom to Speak Up policy, which provides guidance to all staff on the behaviours expected to ensure everyone is treated respectfully at work and a range of policies promoting health and safety at work for all staff. The strategy feeds into the into the developing People & Diversity and Inclusion Strategies, and the Trust values and leadership behaviours, which provide a blueprint for how we interact with each other and our patients.

The strategy has the support of the Trust Board and Non-Executive Lead. The Executive team and senior leaders will work closely with the FTSU Guardians to create an open and transparent culture across Bedfordshire Hospitals so that every member of staff feels that every member of staff feels able to speak up about concerns they have within the workplace.

The strategy aligns to the national context (NHS Long term Plan and Interim people Plan) to ensure an increased focus on how we support staff.

3.13 Guardian of Safer Working Hours Report Statement

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

Exception Reports

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

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

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

Guardian Fines

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

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

Bedford site

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

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

These were spread across specialities as follows*

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

Luton and Dunstable hospital site

The following exceptions (326) were reported for April 2021 to March 2022.*

Number related to Immediate patient safety	16
Number related to hours of working/pattern of work	291
Number related to educational activities	5
Number relating to service support available to the doctor	1
Number related to missed break	24
Number related to missed surgical opportunities	5

These were spread across specialities as follows*

Medicine	175
Surgery	87
Paediatrics	16
Emergency Department	1
Obstetrics and Gynaecology	7
Ophthalmology	20
Trauma & Orthopaedics	7
Ear, nose and throat	4
Urology	11
Neonatal medicine	1
Oral and Maxillofacial surgery	1

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

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

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

Review of Quality Performance

3.14 Review of clinical indicators of quality

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

Data for 2021 or 2021/22 is shown for Bedfordshire Hospitals NHS Foundation Trust overall, unless otherwise stated.

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

Performance Indicator	Type of Indicator and Source of data	2017* or 2017/18	2018* 2018/19	2019* 2019/20	2020* 2020/21	2021/ 2022	National Average
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	1	1	2	2	1	N/A
Hospital Standardised Mortality Ratio* (n)	Patient Safety CHKS*	105.1*	102.3	97.94	111.18	101.99	100
Number of hospital acquired C.difficile cases (n)	Patient Safety Trust Board Reports	9	5	42^	51^	64	N/A
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	12	14	5	33 (of which 1 was grade 4)	42 – none of which were grade 4	N/A
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	5	5	1	2 L&D	1 BH	N/A
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.08	0.72	0.94	1.08	0.85	unavailable
Average Length of Stay (LOS) (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.2 days	3.0 days	3.1 days	3.3 days	3.9 days	N/A
Rate of falls per 1000 bed days for all patients Rate of falls per 1000 bed days for 16+ no maternity***	Clinical Effectiveness Trust Board Report	3.97 4.73***	4.08 4.89***	4.0 4.78	5.04 6.32	5.39 per 1000 bed days (BH site) 3.4 per 1000 bed days (L&D site)	 6.63
% of stroke patients spending 90% of their inpatient stay on the stroke unit	Clinical Effectiveness SSNAP data	85.3%	79.9%	87.6%	80.5% for Dec 2020 (SSNAP data not available)	73.9 % (TBC)	Target of 80%

Performance Indicator	Type of Indicator and Source of data	2017* or 2017/18	2018* 2018/19	2019* 2019/20	2020* 2020/21	2021/ 2022	National Average
% 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%
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness CHKS****	50.8*	63.16*	67.82	94.71	80.82	100
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness CHKS****	100.3*	76.5*	74.91	69.91	96.33	100
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness CHKS****	7.00%*	5.8%	6.6%	6.3%	5.7%	unavailable
% Caesarean Section rates	Patient Experience Obstetric dashboard	31.2%	31.3%%	33.09%	35.4%	38.3% L&D 35.4% BH	25%
Patients who felt that they were treated with respect and dignity**	Patient Experience CQC National inpatient survey	9.0	8.9	8.9	2020 in pt survey not yet published	9.1	Range 8.6 – 9.9
Complaints rate per 1000 discharges	Patient Experience Complaints data and coded discharges	5.50	4.70	4.31	5.1	5.4	Unavailable
Patients disturbed at night by staff (n)	Patient Experience CQC National In patient Survey	8.1	8.2	7.6	2020 in pt survey not yet published	7.5	Range 7. – 9.
Venous thromboembolism risk assessment	Patient Safety Audit reported on Board Quality Report	Achieved >95%	Achieved >95%	>95%	96.5%^^	98.4%	National target >95%

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

* Denotes calendar year

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

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

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

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

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

3.15 Complaints and Patient Advice and Liaison Service

The Trust has continued to work towards streamlining processes and achieving goals set during a challenging 2020/21. 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.

Both the Complaints and Patient Advice and Liaison services have been restructured to reflect the change in organisational structure since the Luton and Dunstable and Bedford Hospitals merged and the charts below demonstrate this change in approach. In addition the Trust now has a single integrated Complaints Policy allowing a more consistent approach to complaints handling.

This change includes a requirement to respond to complaints within 45 working days. Whilst this has been challenging during the year due to the ongoing extreme operational pressures work continues to provide support to allow clinicians time to respond and is tracked fortnightly to ensure regular progress and identify where additional support is required.

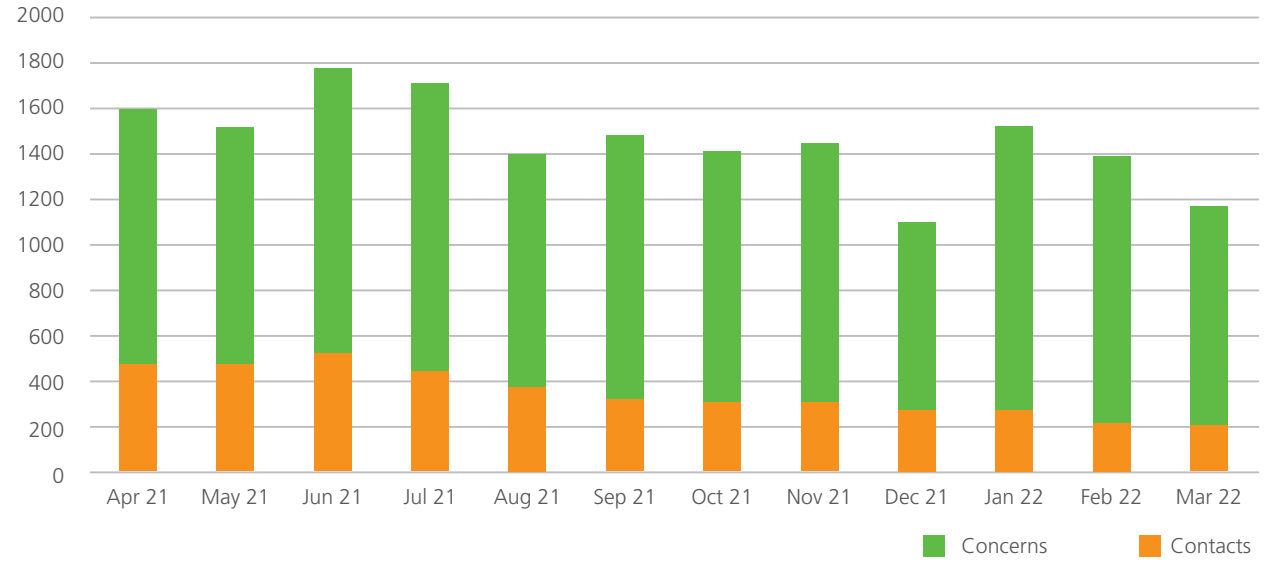
We endeavour to use learning from complaints in a positive way and this is reported through the new governance structure which is aligned to the Clinical Service Lines, enabling the central teams to monitor where improvements have been made.

The Parliamentary Health Service Ombudsman (PHSO) published a new complaints framework, which whilst still in the pilot stage, the Trust was involved in the early workshops as part of its development.

In respect to the Patient Advice and Liaison Teams (PALS) the workload across the Trust has remained largely unchanged in the last 12 months, with COVID-19 restrictions and prevalence continuing to impact on our operational work.

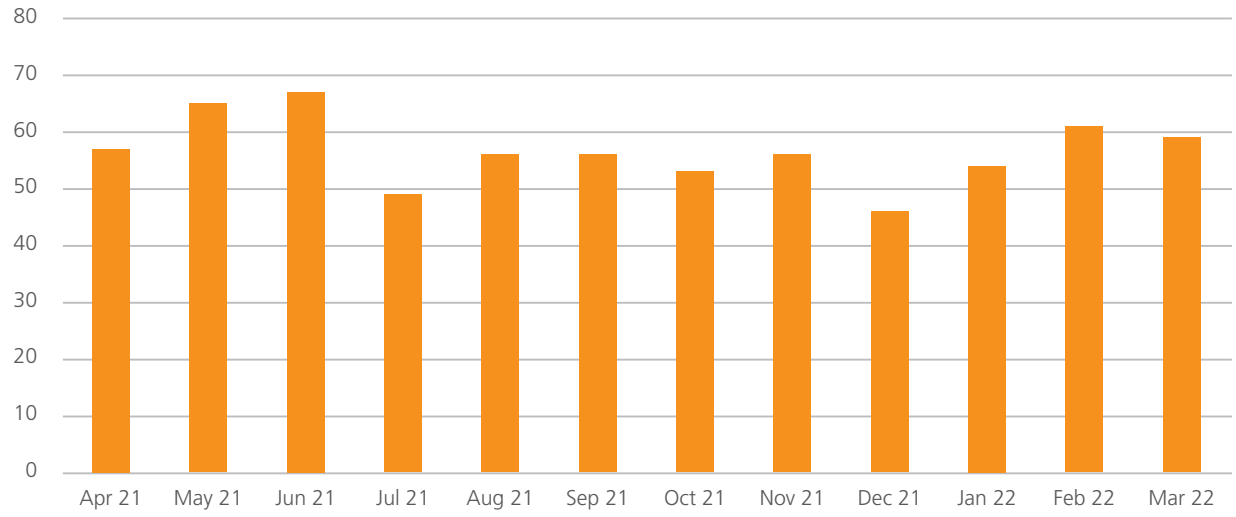
However a PALS service has been maintained on both Trust sites in the last year in order to provide access and a rapid resolution of issues raised where possible to avoid the need for a patient to escalate to a formal complaint. However most contacts have remained via email and telephone and during the year 2021/2022 the Trust received 4214 PALs concerns/contacts.

Concerns and contacts reported to PALS BHNHSFT April 21 to March 22

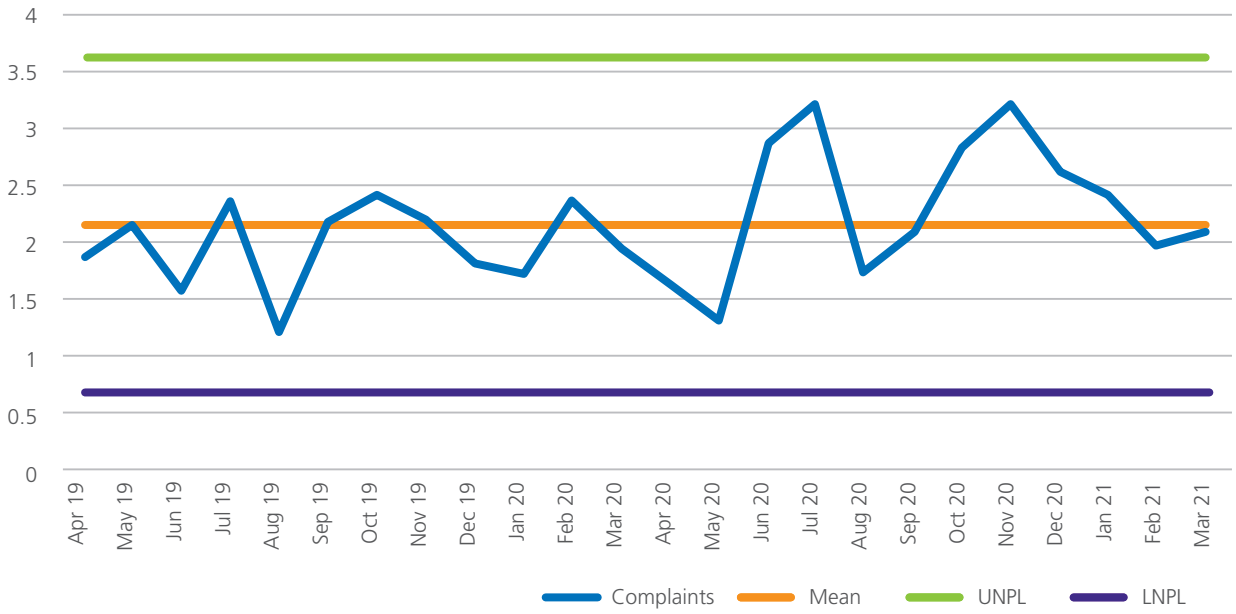


During 2021/2022, the Trust received 698 formal complaints. This is a decrease in number and it is hoped to be due to the immediate access to the PALS team in addition to the efforts of management and clinical staff during the year who responded swiftly to complaints as they arose, thus avoiding formal escalation.

Number of complaints reported by Month BHNHSFT 2021-22



Number of Complaints per 1000 bed days, both sites combined



Learning from Complaints

The top five themes emerging from complaints relate to Clinical Treatment, Communication, Patient Care, 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, seven complainants asked the PHSO to review their complaints.

At the time of writing, no complaints have been upheld by the PHSO although a number are still going through the review process.

During the year learning from complaints at service level through the revised governance processes has started to see improvements. Below are examples of some of the improvements made:

Case study 1: End of Life Care

Following the sad death of his wife a gentleman wrote to let the Trust know how some actions and communications had left him feeling following her death.

This was considered not only by the clinical team and ward but also picked up by the End of Life Steering Group. As a result the information is being used to shape a revised End of Life Strategy document.

In particular it was noted that where sharing difficult news is an everyday occurrence there can be a tendency in some instances for staff members to appear to lack compassion in their direct communication. The Palliative Care Team has spent time considering the importance of adapting conversations dependent on the situation.

In addition a further work programme has been set up to look more broadly at effective communication with a particular emphasis on communication sensitively with families or individual who do not recognise that their loved ones are dying

Case study 2: Ensuring accurate information

The parents of a young baby were given incorrect information in respect to administration of a medication. In addition some of the discharge care plan notes and instructions were not provided to the family on discharge.

The family contacted the unit and were invited to pick up the information immediately and the correct information regarding dosage was provided.

This compliant has resulted in a change to syringes provided to families with young babies to ensure greater clarity when administering small doses of medication.

In addition, the family were later provided with prefilled syringes. The clinical team are reviewing care plans for future paediatric patients requiring the same medication regime, particularly those under 1 year and under 3 months.

Compliments

The Trust also maintains a log of all compliments and, if received centrally, relevant staff or the clinical service is provided with the feedback.
We received 4208 compliments and below are examples of some of the compliments received:

ENT services

Thank you to Dr T who performed a surgical procedure and all the members of the ENT team for their exceptional care and service. Patient has expressed that the service provided was to the highest level.

Maternity

Patient emailed to thank staff on ward 34 along with junior doctors, theatre and recovery staff, who were caring and compassionate. Patient would also like to thank the Early Pregnancy clinic for their care.

Ophthalmology

"I would like to express my sincere thanks to Staff Nurse N for the kindness and sympathy she showed to my elderly mother and myself yesterday afternoon. My mother underwent a cataract procedure and Nurse N was so understanding and helpful throughout (prior to the procedure, during and after) putting my mother at ease. Nurse N is a credit to the hospital."

Medical short stay ward

"Normally I only give feedback for a bad experience or rubbish service but credit where credit is due but I am now going to relate a very good experience I had in Ward 4. I was admitted to Ward 1 in early hours of Sunday 03/04/22 and then moved to Ward 4 that same evening before being moved to Ward 16 on the evening of 06/04/22. As usual there were a lot of sick and scared people on the Ward, me included, and all the nursing staff were absolutely brilliant in looking after everyone and getting things done. One person however really stood out in my mind and I would appreciate if you can thank her on my behalf. She was a Nurse called D and her effervescent personality seemed to pick up all the patients. Googled her name and it means "Gift from God" and that is exactly what she was. Hopefully I am now on the mend now but will always be grateful for the fantastic care I received in my 3 days stay in your Ward. Please pass on my thanks to all your staff but in particular Nurse D."

ITU and General Surgery

"My husband DM had an operation and I would like to thank the surgeon and all the Colorectal team especially the colorectal nurse and Mr S. Also, everyone in ITU especially Nurse B. Also, everyone on ward 22 for the care and kindness shown to my husband. When I left him for his surgery I thought I would never see him again, but now I have him home and he is doing so well. To be honest I cannot thank everybody enough."

3.16 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.

In May 2021 a single system was implemented across both Trust sites and now patient facing areas (including clinics and wards) have iPads and QR codes to enable patients to provide feedback more easily and at a time convenient to them.

The impact of COVID-19 has continued to be significant; however, in the last quarter of the year increased focus was put on recording FFT results.

The Trust is looking to re-introduce texting FFT feedback in areas where patients have a limited stay and will be rolled out in both Emergency Departments (ED) initially.

Within the Maternity service a Patient Experience specialist midwife was appointed toward the end of 2021. The aim of the role is to drive forward the patient experience agenda and improve FFT results. The appointment has already shown an impact with reporting figures increasing significantly in March 2022.

The Trust continues to collect information from the following clinical areas:

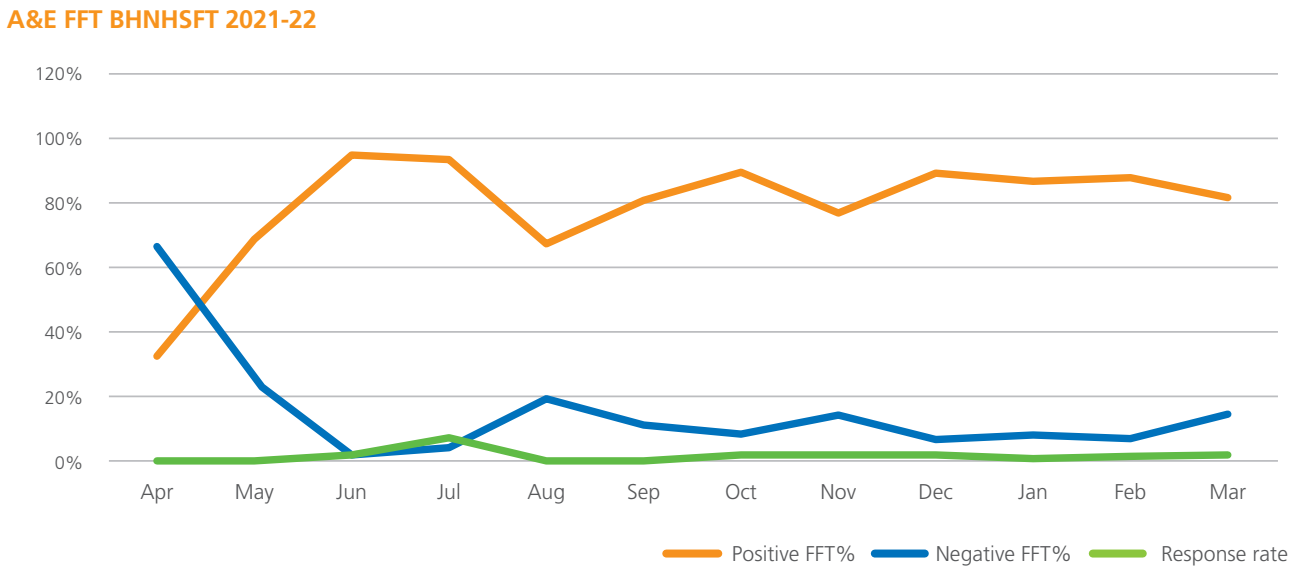
- Inpatients and Day Case Patients
- Maternity Services
- Outpatient Service
- Emergency Department (ED)

Weekly reports are sent to ED and Maternity Services. Clinical Service Lines also receive their FFT results as part of their clinical governance review processes.

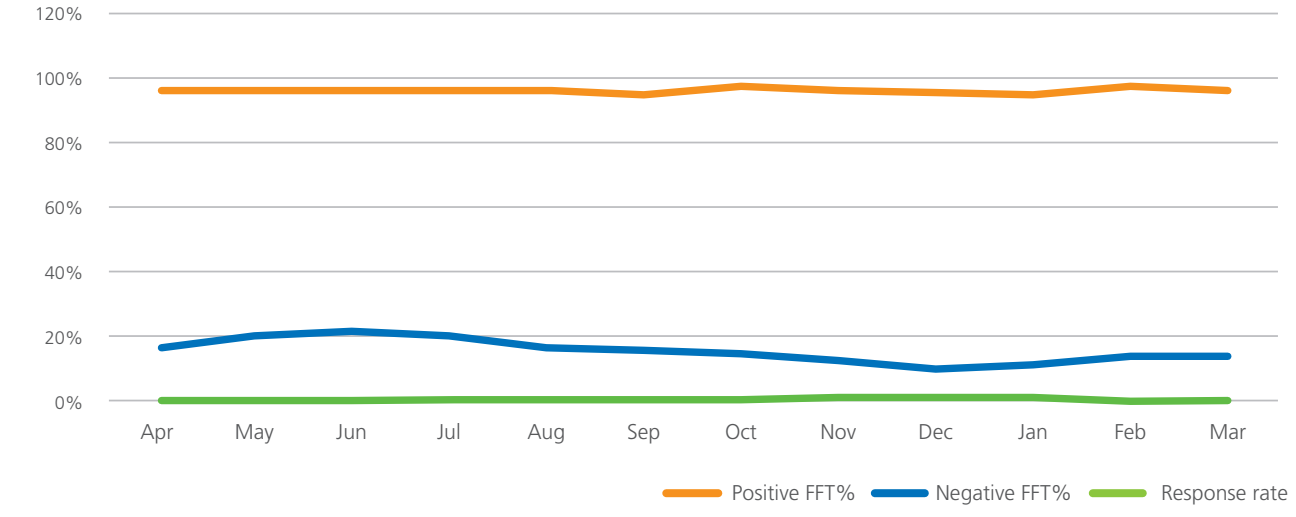
The corporate Patient Experience Team provides quarterly reports to the Clinical Quality Outcomes Board and Quality Committee.

Patient stories are also presented to the Quality Committee on a quarterly basis.

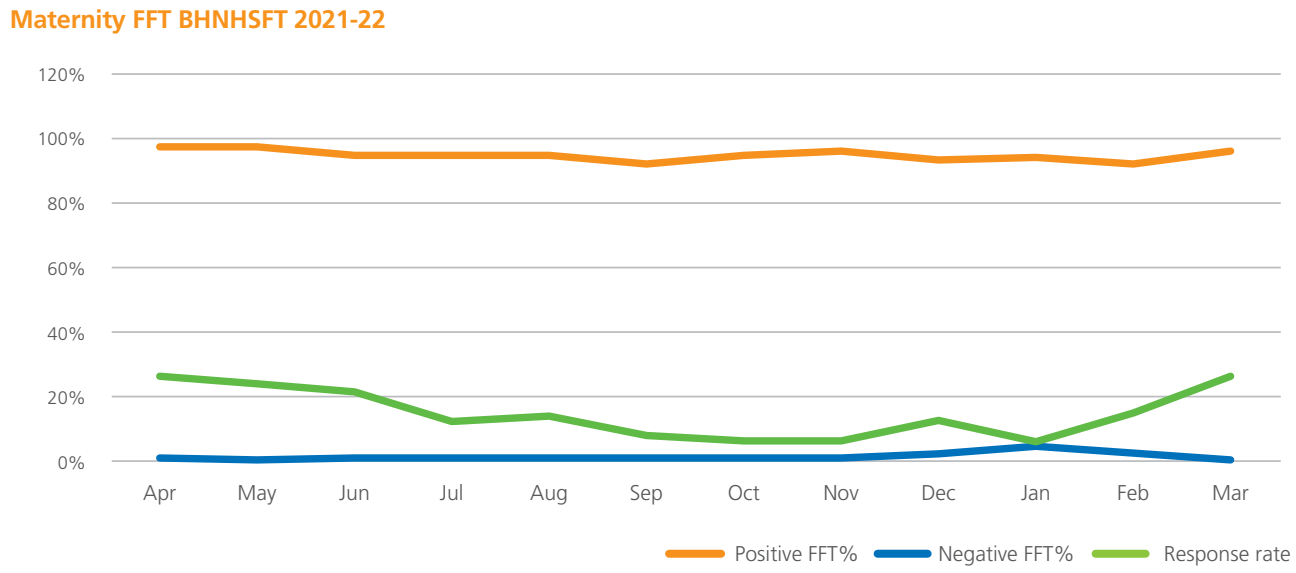
Trust wide FFT Results Emergency department



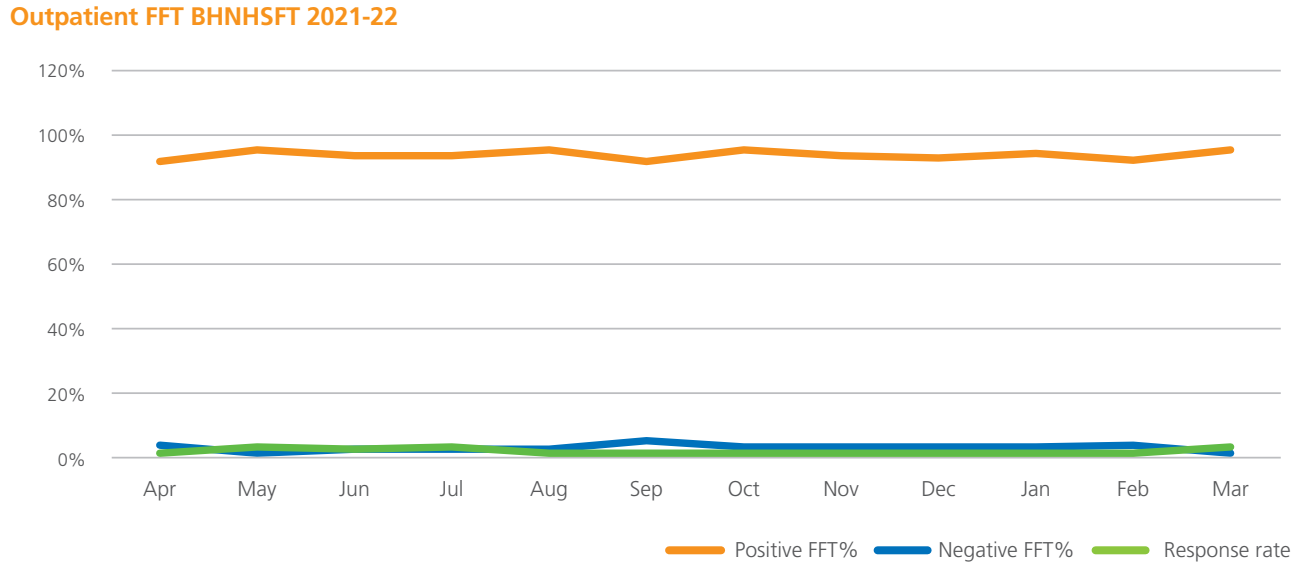
Trust Wide In Patient FFT Results



Trust Wide FFT Results Maternity



Trust Wide FFT Results Outpatients



3.17 National Surveys CQC

Following suspension due to the COVID-19 pandemic all national patient surveys were reinstated in 2021. The Trust undertakes five national surveys, 4 annually and 1 on alternate years. The services covered are as follows:

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

The reinstatement of national surveys meant that 2021 was the first year that these were undertaken post-merger and therefore results cannot be compared with the previous reports. However, the reports provide the Trust with a benchmark for future surveys and improvement actions.

The adult inpatient survey response rate was 22% and the results identified four key areas for improvement:

- Length of time patients had to wait for a bed
- Disturbed sleep due to noise from staff
- Cleanliness of ward/room
- Being given conflicting information

These results have been shared with the relevant service lines to develop improvement plans ahead of this year's survey which will occur in October 2022.

The Children and Young People's Survey response rate was also 22%. The key areas for improvement were around communication and being listened to.

This has been shared with the clinical team and actions include the creation of a group called "Voice of the Child". The Trust's Complaints Policy has also being revised to include a section around supporting children to speak out in a safe way.

The Maternity Survey produced our best response rate of 56%, this was 3% above the national average. There were six areas identified for improvement from the survey, these were:

- Allowing enough time at antenatal check for women to ask questions
- Involvement of partner or significant other during labour and birth (note the survey was completed during COVID-19 restrictions)
- Contact number for Health Visitor or Midwife when home with new baby
- Being able to speak to a Midwife as much as needed
- Changes to mental health provision after birth

The Trust has a newly appointed Patient Experience Midwife who, working alongside the Director of Midwifery, will address issues raised and monitoring will be undertaken as part of the wider Maternity quality improvement programme.

The Urgent and Emergency Services Survey response rate was 20%, which, whilst it was below the national average, did not identify any specific areas for concern. Work is underway within the service to understand the low response rate and look to improve this for the next survey.

The annual Cancer Services Survey response rate was 56% compared to the national average of 59%. Whilst scores and findings did not demonstrate any overall significant change in the experience of cancer patients from previous findings, there was one improvement of note. This related to patient's experience of waiting, which indicated a larger volume of patients felt that the length of time for attending clinics and appointments was about right.

All the survey outputs have been interrogated by the Palliative Care Team who are sharing results with relevant clinical teams.

Where improvements were identified as a result of the national surveys, corresponding questions are added to our own local surveys and local FFT surveys allowing teams to monitor in real time the impact of their actions.

Visiting restrictions

Visiting restrictions have remained in place, throughout 2021/22 due to COVID-19, however during the year they were subject to regular review and adapted to facilitate more family and next of kin visiting for all patients.

Special exception visiting has continued to be in place for patients at end of life, dementia, learning disabilities or complex care needs. In addition special exceptions were I place within the Maternity Unit and Paediatric wards.

Patient Experience Strategy and Council

Work has continued in 2021 to align the patient experience agenda across the Trust. This has included the launch of the Patient Experience Strategy, which concentrated on four key drivers;

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

The key drivers have underpinned the Patient Experience Team work plan, which has been reviewed by the Patient Experience Council. This is a Trust wide group, which includes key stakeholders, patient and public representatives and trust staff. The group's purpose is to ensure the Board is assured that patient experience and feedback forms a core element of quality improvement.

3.18 National Staff Survey

The NHS staff survey is conducted annually. This year, for the first time, the questions have been grouped in to nine themes, the seven People Promises plus Staff Engagement and Morale. Nationally the staff survey has seen a decline across all metrics.

The survey ran from the beginning of October to the end of November 2021 and was published on 30th March 2022.

The survey was a full on-line staff survey; with paper copies available for those with no digital access, 3,283 surveys were completed. The response rate for Bedford was 50% and 36% for the L&D with an overall response rate of 42%. There was an overall increase of 6% points from our previous response rate. The national average response rate for our benchmark group was 46%.

National Results

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

2021			2020			2019		
	Trust	Benchmark Group		Trust	Benchmark Group	L&D	Bedford	Benchmark Group
We are compassionate and inclusive	7.1	7.2	Equality, diversity and inclusion	8.9	9.1	8.8	9.0	9.0
We are recognised and rewarded	5.7	5.8	Health and Wellbeing	5.9	6.1	6.1	5.9	5.9
We each have a voice that counts	6.6	6.7	Immediate Managers	6.6	6.8	7.0	6.8	6.8
We are safe and healthy	5.9	5.9	Morale	6.0	6.2	6.3	6.0	6.1
We are always learning	5.2	5.2	Quality of Appraisals	N/A	N/A	6.2	5.8	5.6
We work flexibly	5.7	5.9	Quality of care	7.5	7.5	7.8	7.6	7.5
We are a team	6.5	6.6	Safe environment – bullying and Harassment	8.0	8.1	7.9	8.0	7.9
Staff engagement	6.9	6.8	Safe environment – violence	9.4	9.5	9.4	9.6	9.4
Morale	5.7	5.7	Safety culture	6.7	6.8	6.8	6.8	6.7
			Staff engagement	7.0	7.0	7.3	7.0	7.0
			Team working	6.4	6.5	6.8	6.5	6.6

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

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

- Reporting last experience of harassment/bullying/abuse
- Opportunities to show initiative frequently in my role
- Not experiencing harassment/bullying/abuse from managers
- Team members have a set of shared objectives
- Not feeling pressure from manager to come to work when not feeling well enough.

There are areas for improvement and analysis indicates five main themes for us to focus on in the coming year:

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

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

NHS People Promise Progress

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

Our People Plan provides the means by which we will recruit, develop and retain a Bedfordshire Hospitals' workforce that's fit-for-the future - supported, equipped and inspired to give of their best. However, our culture is the enabler to achieving excellence.

"The organisations culture is important because it is at the heart of a safe, high quality Hospital. Only if our staff are supported, comfortable in their role, treated as equals by their peers, will they feel safe to do the right things; speak up and be open when things go wrong, live and breathe our values and strive for excellence" David Carter CEO

Our vision, clinical vision and values provide the framework for developing the culture of Bedfordshire Hospitals.

Our vision:
To employ the best people and develop and value them, so that the teams they work in provide outstanding care to the local population.

Our clinical vision:
To continue delivery of safe, sustainable and high-quality services for the people of Bedfordshire and to develop the services so that they are all either "Good" or "Outstanding".

Using the Staff Survey as the principal way to measure progress will enable our teams and departments, as well as the whole organisation, to review progress and take action to improve. The following shows our 2021 staff survey results based on NHS People Plan indicators.

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > **Overview**

NHS

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.7	6.6	5.9	5.2	5.7	6.5	6.9	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,085	3,175	3,032	3,066	2,941	3,149	3,106	3,179	3,171

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

We are compassionate and inclusive	Continued work embedding our values and developing our people including: • Values master classes • On line skills booster learning • Talent processes and career development • Working with our teams
We are recognised and rewarded	Staff focus: Continued monthly staff awards Staff engagement events both in the virtual and physical space
We have a voice that count	A listening focus: • Development of further staff networks • Further resourcing of peer listeners • Replay back to staff using "you said, we did".
We are safe and healthy	Maintaining our environment: • Health & wellbeing check ins as part of one to one activity • Developed programme of health & wellbeing activities • Promotion of internal and external listening services
We are always learning	Review and continuous improvement: • Values led appraisals with higher completion rates • Strengthening of giving and receiving feedback skills to staff • Promoting innovation & curiosity
We work flexibly	Playing to our strengths: • Promoting and using the agile working policy • Constantly reviewing our staff feedback
We are a team	Linking directly to our values: • Embedded team behaviours via values master classes and online learning • Shared team objectives • Continued and accelerated integration activities across all of our teams

3.19 Site Redevelopment

There has been significant progress made on developments of both sites over the last year.

Emergency Department upgrades

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

Bedford Hospital

Last year, building works to the Bedford Hospital Emergency Department were completed, which saw additional same day emergency beds on Victoria Ward, additional paediatric and adult capacity. A two-storey extension provides appropriate waiting space and a new reception.

The Trust was successful in obtaining a further £750k to support the second phase of the project, which is also being supported by Bedford Hospital Charity & Friends and Trust funds. This includes a new CT imaging facility within the department to ensure rapid assessment for patients, and the re-provision of staff facilities.

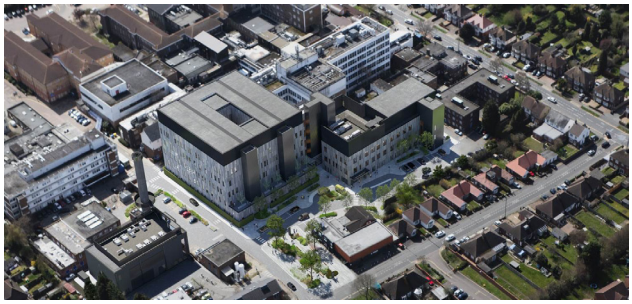
Luton and Dunstable University Hospital

On the L&D site, works to upgrade and expand the ED are continuing with a noticeable difference externally, with the installation of the steel frame for the extended area. Once complete, the project will deliver an expanded and refurbished ED with increased capacity, a new and fully segregated Paediatric ED, a CT scanner located within the department, additional waiting room capacity, dedicated mental health facilities, and a re-modelled main entrance and patient drop off area.

Acute Services Block and New Ward Block at the L&D

In January, The Trust received final approval of the £168.6m capital scheme from the Department of Health and Social Care (DHSC) for an Acute Services Block and New Ward Block on the Luton and Dunstable University Hospital (L&D) site. This has allowed the Trust to enter into contract with Kier, who started works on site in January 2022 as planned. The works are due to complete in 2024.

The five-storey Acute Services Block and three-story New Ward Block will house modern and enhanced facilities for maternity services, a level 3 neonatal intensive care unit, critical care and 8 new operating theatres.



To mark the commencement of this significant construction project, a small number of staff from the project team joined together to celebrate the funding approval and the start of works. The team were joined by Andrew Selous MP, who has supported the hospital over the years.

Energy Centre at the L&D

Work on the new Energy Centre, which supports the Trust Green Plan, continues and is expected to complete in 2023. This will deliver a substantial reduction in energy consumption and increased resilience across the site. The L&D site will become one of the most environmentally friendly hospitals in the country.

Over the past year there have been major key deliveries. This has included the chimney flue, steel frame, combined heat and power (CHPs), boilers, generators and chillers.

Developments at Bedford Hospital

Additional Outpatient facilities

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

The project will provide 27 additional Outpatient rooms, four e-consult rooms and three treatment rooms. The increased capacity supports the Trust to reduce the waiting lists built up through the pandemic, allowing patients to be seen earlier so that care and treatment plans can be put in place quickly.

Work is well underway on this project, and is programmed to complete at the end of June 2022.

Upgrading electrical infrastructure

To allow for the planned strategic developments to take place, developing the infrastructure at Bedford Hospital is fundamental, particularly the electrical capacity. Furthermore an investment in infrastructure supports site resilience and a more efficient use of resource, paving the way to become a net zero carbon site.

Within the Trust planning, designs are synchronised with the NHS' Net Zero carbon vision – to improve the Trust carbon footprint and reduce the environmental impact of services.

Other projects

On the Bedford site, additional projects include a bid to the centre to gain financial support in delivering additional surgical capacity (clinic space and an operating theatre), as well as ambulatory capacity to support same day care for patients. We will share further plans on this as they progress.

3.20 Maternity Improvement

In response to the Care Quality Commission rating of Inadequate and in response to finding from enquiries the Maternity service has been undertaking a large programme of quality improvement activity.

This is outlined in the infographics left and will be ongoing during 2022/2023.

3.21 National Core Set of Quality Indicators

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

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

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

Indicator: Summary hospital-level mortality indicator ("SHMI")

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. It includes deaths 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
	Published May 22 (Jan 21 – Dec 21)	As expected	As expected			2
% Deaths with palliative care coding	Published Feb 19 (Oct 17 –Sep 18)	36.1	33.6	59.5	14.3	N/A
	Published April 20 (Dec 18 – Nov 19)	41	37	59	1	N/A
	Published May 21 (Jan 20 – Dec 20)	35	37	61	8	N/A
	Published May 22 (Jan 21 – Dec 21)	35	36	60	9	N/A

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.

Bedfordshire Hospitals NHS Foundation Trust has put in place the following actions to improve this score, and thus the quality of its services, by:
- On-going Use of "Structured Judgement Reviews" led by our team of 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
- Membership of our Learning from Deaths Board includes 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*
	2021/22	Not Avail*	Not Avail*	Not Avail*	Not Avail*

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	0.39	0.47	0.57*	0.39*
	2021/22	0.37	TBC	Awaited	Awaited
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	0.23	0.31	0.4*	0.18*
	2021/22	0.33	0.34	Awaited	Awaited

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

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

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

Indicator: Responsiveness to the personal needs of patients

This measure is taken from the National Inpatient Survey and is scored based on the response to five key questions:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

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

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

- The source of the data is the National In-Patient Survey. 2019/20 data relates to the survey of people who were inpatients in July 2019, who responded

*The data for this indicator for patients responding to the 2020 and the 2021 inpatient survey has not yet been published on NHS Digital (as at 7th June 2022). The 2020 survey would have provided the first available data for the new Bedfordshire Hospitals NHS Foundation Trust.

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 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%
	2021/22	64.9%	66.9%	89.5%	43.6%

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.

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 developed our THRIVE values (see FTSU section).
- Provided information and training at the Staff Engagement Event in July and December 2020 to staff, and regular leadership forums to keep staff updated about the ongoing integration and development work within the newly merged organisation.

- Engaged staff in quality improvement across the Trust and shared learning from QI using a wider range of communication methods.

Indicator: Risk assessment for venous thromboembolism (VTE)

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

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

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 pandemic.

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 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 *C. difficile* infection reported within the Trust amongst patients aged 2 or over	2016/17	3.6	13.2	0	82.7
	2017/18	3.9	13.6	0	91.0
	2018/19	1.7	12.2	0	79.7
	2019/20	25.0	34.5	0	136.0
	2020/21 HOHA COHA	 8.3 7.1	 17.0 7.7	 0 0	 76.1 33.3
	2021/22 HOHA COHA	NHS Digital data currently unavailable			

- 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

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 are subject to a root cause analysis. A practice compliance assessment is also undertaken to establish any "lapses of care or testing". This then forms the basis of future learning for our organisation. 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			
	April 20 – Sep 21	59.1 (Merged rate)			
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
	Oct19 – Apr 19		0.3	1.4	0
	April 2020 - March 2021	n= 17 .34%	0.3	1.6	0
	April 2021 – March 2022 (Merged data)	n=37 0.31%	0.3		

Bedfordshire Hospitals NHS Foundation Trust has

- 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
- Data should be viewed with caution due to the impact of COVID-19 during the reporting period

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

All serious incidents are investigated using root cause analysis methodology; although we recognise that this requirement will change when the new Patient Safety Incident Response Framework (PSIRF) is introduced. We work closely with commissioners and the 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.

NRLS will be replaced by the Learning for Patient Safety Events platform during 2022/23. We continue to use the outcomes of investigations into patient safety incidents to drive improvements to the quality and safety of our services.

3.22 Performance Against National Priorities

		2018/19	2019/20	2020/21	2021/22	Target 20/21
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	5	42	51	64	
MRSA	To achieve contracted level of 0 cases per annum	1	2	2	1	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	100%	100%	97.3%	97.1%	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	87.6%	88.7%	73.7%	69.8%	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.8%	93.9%	90.4%	76.7%	93%
Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	100%	100%	92.6%	95.1%	94%
	Anti-cancer Drugs	100%	100%	97.4%	98.9%	98%
Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	91.1%	89.8%	68.6%	64%	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.1%	**	**	**	95%
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	0.8	1.04*** 0.6 (M1-11)	30.5% ***	25.4% ***	<1

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

Glossary

Term	Description
Acute Kidney Infection (AKI)	A painful and unpleasant illness caused by bacteria travelling from your bladder into one or both of your **kidneys**
Antimicrobial	An agent that kills microorganisms or stops their growth
BAME	Black, Asian and Minority Ethnic people
BAUS	British Association of Urological Surgeons
BLMK	Bedford, Luton and Milton Keynes integrated care system
BLS	Basic Life Support – the immediate resuscitation given to people who are not breathing and may not have a pulse
BTS	British Thoracic Society
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively
CCG	Clinical Commissioning Group
CHKS	A company that provides healthcare intelligence and quality improvement services. The Trust uses data through systems provided by CHKS to review our mortality statistics.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
Continence	Ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.
CQUIN	Commissioning for Quality and Innovation – these are quality improvement targets set nationally or by the CCG where the Trust receives a financial incentive if it achieves these quality targets
Delirium	**Delirium** is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment.
DME	Division of Medicine for the Elderly
DNA	Did Not Attend
DNACPR	In the right circumstances, a Do Not Attempt Cardio-pulmonary Resuscitation **(DNACPR)** order helps ensure that a patient's death is dignified and peaceful.
DQIP	Data Quality Improvement Plan – all NHS organisations must continually review and improve the quality of data they collect, store and use
DQ	Data Quality
EBI	Evidence Based Interventions
Elective	Scheduled in advance (Planned)
EOL	End of Life

Term	Description
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
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 areus)	MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means that infections with MRSA can be harder to treat than other bacterial infections.

Term	Description
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Needs Based Care	Inpatient adult wards are organised by patient need rather than age for example a cardiac ward, respiratory ward
NELA	National Emergency Laparotomy Audit
Neonatal	New-born – includes the first six weeks after birth
NEWS2	NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012, which advocates a system to standardise the assessment and response to acute illness.
NICE	The National Institute for Health and Care Excellence (NICE) publish clinical guidelines which recommend how healthcare professionals should care for people with certain conditions. The recommendations are based on the best available evidence.
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
NRT	Nicotine Replacement Therapy is treatment that can be prescribed and administered to help people who smoke or vape avoid the withdrawal effects if they stop smoking or vaping
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	Degenerative disorder of the central nervous system
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
PEARL	Post Event Action and Review for Learning (PEARL) – this is the name that we use at the Trust for our panels which are used to review incidents to determine if they meet the criteria of a Serious Incident. They were renamed as part of our move towards a just culture to try and eliminate some of the worry that staff feel about a 'serious incident' by focusing on the learning.
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
PPE	Personal Protective Equipment – consists of masks, gloves, aprons, visors which are worn by clinical staff to protect themselves from the risk of infection
PPH	Post-partum haemorrhage – a term used to describe blood loss after childbirth
Prevalence	The proportion of patients who have a specific characteristic in a given time period
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

Term	Description
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
SHMI	Summary Hospital-level Mortality Indicator **(SHMI)** is an indicator which reports on mortality at trust level across the NHS in England using a standard
Sialadenitis	Inflammation in the salivary glands, usually cause by a virus or bacteria.
Sialoendoscopy	A minimally invasive procedure that allows for salivary gland surgery
Somatosensory	The **somatosensory** system is a part of the sensory nervous system. The **somatosensory** system is a complex system of sensory neurons and pathways that responds to changes at the surface or inside the body.
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit.
STEMI	ST Elevation MI (STEMI) – is a specific type of heart attack
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply
Structured Judgement Review (SJR)	A review methodology based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.
SUS	Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
TEP	Treatment escalation Plan
Two week wait	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
TRUS	Transrectal ultrasonography – a method of creating an image of the organs in the pelvis, most commonly used to perform a guided needle biopsy of the prostate gland in men.
TTPB	Transperineal Template-Guided Prostate Biopsy
TURBT	TransUrethral Resection of Bladder Tumour
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins
WHO	World Health Organisation

Research – Glossary of terms

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

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

Statement of Directors responsibilities for Quality Account

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

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

- the content of the Quality Report meets the requirements set out in the *NHS foundation trust annual reporting manual 2020/21* and supporting guidance *Detailed requirements for quality reports 2021/22*.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2021 to May 2022;
  - papers relating to quality reported to the Board over the period April 2021 to May 2022;
  - feedback from commissioners dated June 2022
  - feedback from governors dated (suspended requirement);
  - feedback from local Healthwatch organisations dated June 2022;
  - feedback from Overview and Scrutiny Committee has not been received at the time of publication this year;
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 –
  - the national patient survey
  - the latest national staff survey dated
  - the Head of Internal Audit's annual opinion of the trust's control environment
  - CQC inspection report dated 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

June 2022

Simon Linnett
Chairman

June 2022

David Carter
Chief Executive

Stakeholder Feedback

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group

Statement from Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group (BLMK CCG) to Bedfordshire Hospitals NHS Foundation Trust (BHFT)

Quality Account 2021 – 2022

BLMK Commissioning Group acknowledges receipt of the draft 2021/2022 Quality Account from Bedfordshire Hospitals NHS Foundation Trust (BHFT) and welcomes the opportunity to provide this statement.

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

2021/2022 has continued to be a very challenging year for the system, with the on-going impact from new COVID-19 variants, support for the mass vaccination and neutralising monoclonal antibodies (nMAb) programme, and system wide pressures, all whilst working towards recovery of services affected by the pandemic. It is positive to see that all system partners across the Integrated Care System (ICS) are continuing to adapt and develop to deliver safe care to our patients, both at Place and across the wider ICS footprint. We would like to extend our gratitude to staff for their commitment and hard work during this time.

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

Due to the requirement to ensure the Quality Account meets the publication date this statement has been based on information and data which was available within a draft version received from the Trust on 16/5/2022.

The Quality Account is a well-constructed document which clearly evidences the improvements and innovations made during the year along with areas of focus for 2022/2023.

It is positive to see that progress and improvements have been made against the 2021/2022 priorities despite the challenges, and that there are plans to continue to embed and develop the priorities which are not being taken forward as Quality Account priorities for 2022/2023 - 1.2 Rapid Rule out Protocol for suspected acute MI (excluding STEMI), 2.2 Modified Obstetric Early Warning Score (MOEWS) for pregnant women presenting in non-maternity parts of the Trust, 3.1 Safe and Effective discharge arrangements and 3.2 End of life care. Considering the on-going demands on in-patient services we will be particularly interested in how the system can work together to ensure a positive experience of the discharge process for patients and their families. We also appreciate the work being undertaken to clear the backlog of Serious Incident Final reports.

As reflected in last year's Commissioners Statement maternity services remain a key national and local area of focus and it was therefore encouraging to see the work undertaken around MOEWS. The CCG anticipate continuing to work collaboratively with the Trust to support on-going developments across the Local Maternity and Neonatal systems (LMNS), the work being undertaken at the Bedford Hospital site in relation to its CQC Maternity Improvement Plan, and the action plans resulting from the initial, and recently published Final Ockendon Review. At the time of writing this statement the Maternity Improvement section was not completed but we know that the work with the Local Maternity Neonatal Board (LMNS) will further reflect the on-going work across both Trusts sites and the wider system.

The CCG is supportive of the Trusts 2022/2023 Quality Account priorities, several of which align closely with the National Commissioning for Quality and Innovation (CQUIN) requirements.

It is reassuring to see that support for staff remains a priority, and that the Trust will continue to build on the work the CCG are aware is already in place. Also, that there will be sustained focus on elective care recovery including the aims to eliminate waits of over one year by March 2025, and waits of over two years by July 2022, reduce diagnostic waiting times, with at least 95% of patients receiving tests within 6 weeks by March 2025, deliver the cancer faster diagnosis standard, with at least 75% of urgent cancer referrals receiving a diagnosis within 28 days by March 2024, and returning the 62 day backlog to pre-pandemic levels by March 2023. The CCG are aware of the on-going challenges around recovery and diagnostics, particularly Echocardiograms (ECHO),

the work being undertaken by the Trust to ensure the prioritisation and safety of patients waiting, and the joint work on diagnostic recovery.

We also look forward to working closely with the Trust on the implementation of the National Patient Safety Strategy.

The National Staff Survey results are the same as or very close to the national benchmark scores. We anticipate that the Quality Account priority to implement the Trust's People Plan will help the Trust to maintain and improve on these scores.

Whilst the Trust acknowledge the diverse population they serve we all appreciate there is more work that needs to be undertaken to ensure equity of service provision, and that it is essential to reflect the experience of all service users in order to reduce inequalities.

2022/23 will be a period of transition for the CCG as it becomes an Integrated Care Board (ICB), but we continue work together to ensure safe and effective care for our patients. We expect that this will reinforce the joint working already in place and enable the 2023/24 Quality Account priorities to reflect the ICB quality and population health priorities.

We hope the Trust finds these comments helpful and look forward to continuous improvements throughout the coming year

Anne Murray
Chief Nurse/Executive Director Nursing

healthwatch Central Bedfordshire

Feedback from Healthwatch Central Bedfordshire on the Bedfordshire Hospitals NHS Foundation Trust's Quality Account 2021/22

Not available at time of publication

Luton

Luton Council comment on the Bedfordshire Hospitals NHS Foundation Trust Quality Account 2021/22

Not available at time of publication

BEDFORD BOROUGH COUNCIL

Bedford Borough Council comment on the Bedfordshire Hospitals NHS Foundation Trust Quality Account 202/22

Not available at time of publication

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