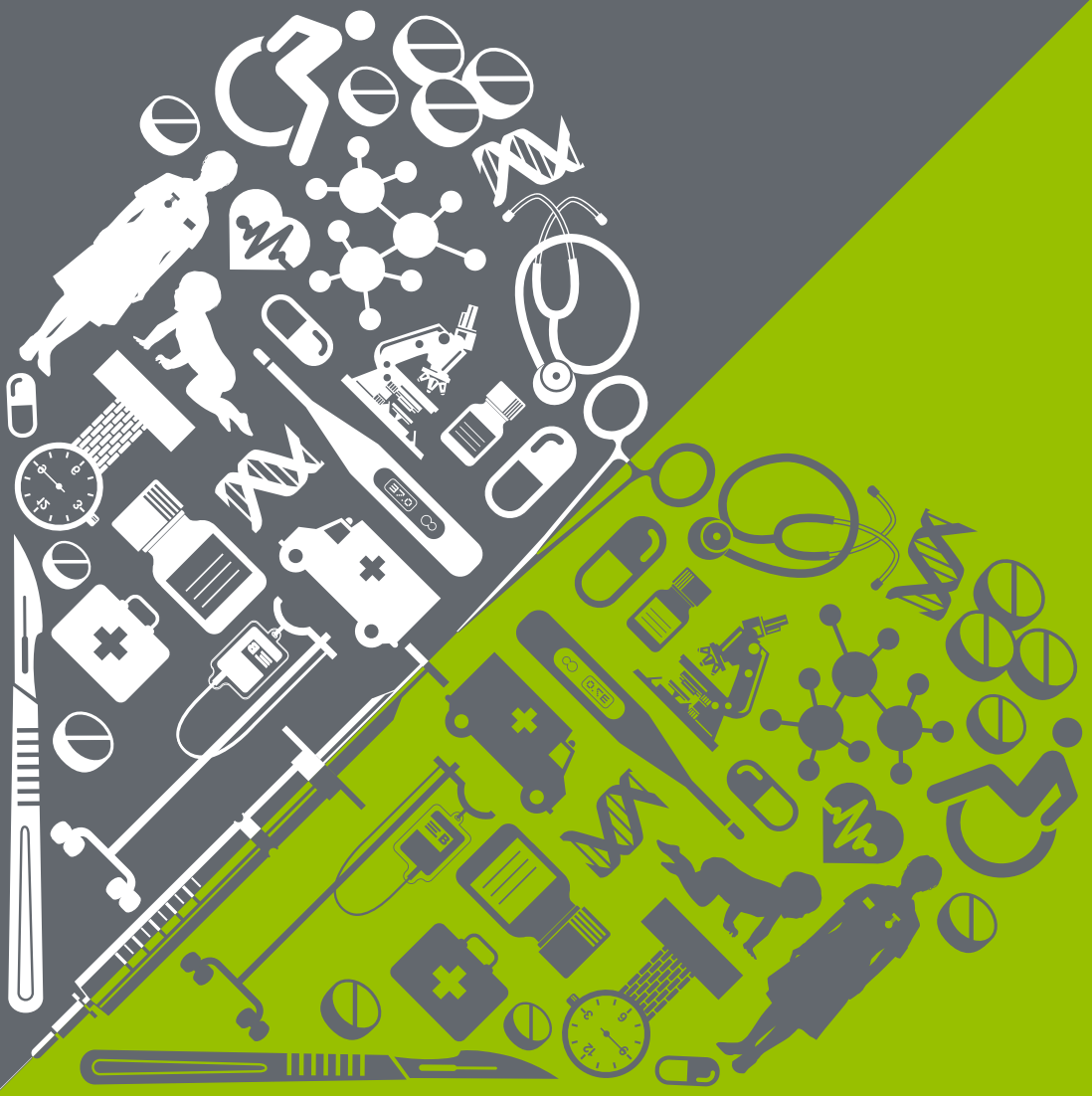
LUTON & DUNSTABLE UNIVERSITY HOSPITAL

Annual Report and Accounts

for the period April 2016 to March 2017
incorporating Quality Account



Luton and Dunstable University Hospital
NHS Foundation Trust

NHS

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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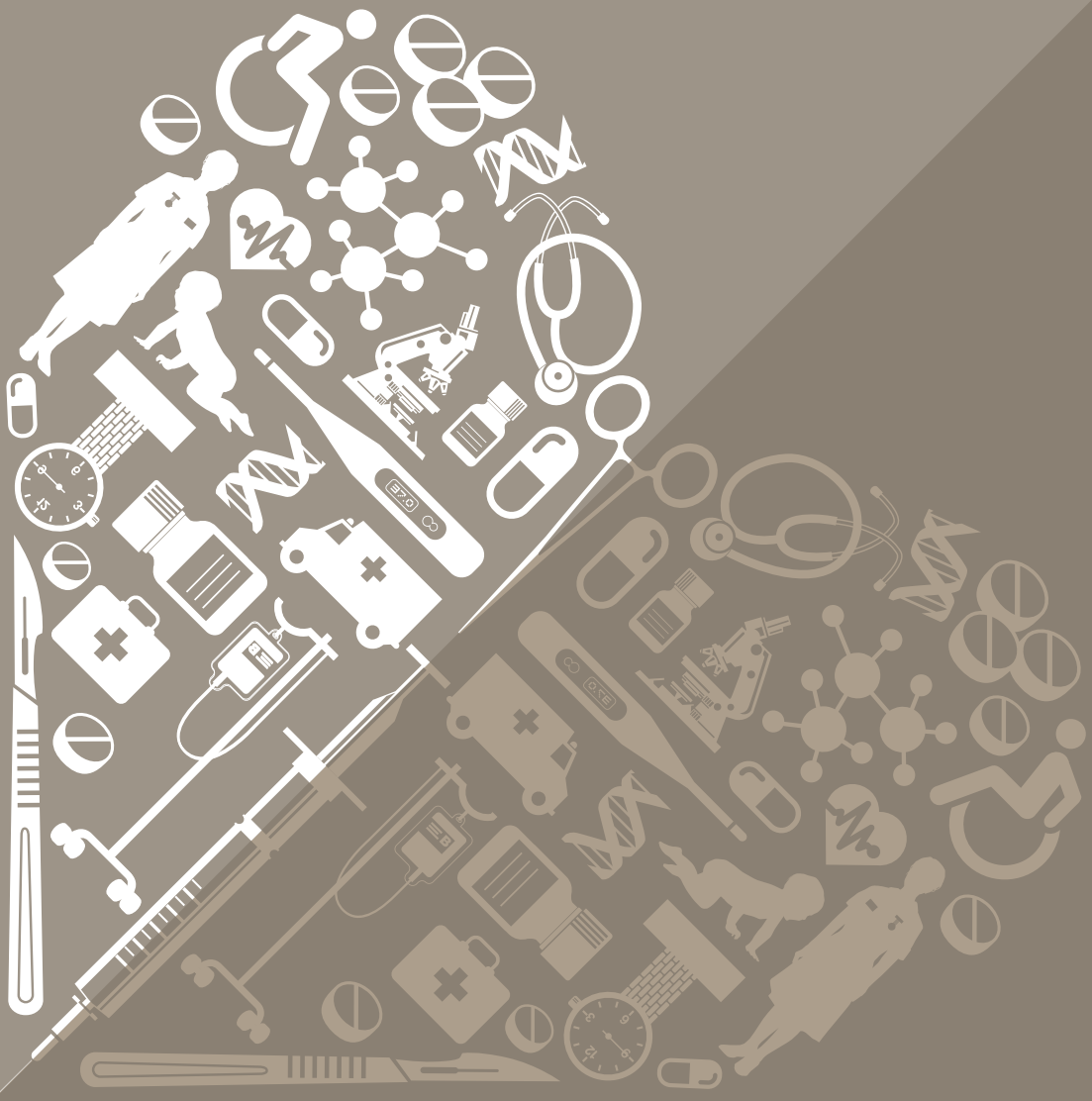


Awards and Congratulations

Our staff

Engagement 2016 – Good, Better, Best Events

During July and December 2016, two events were held to engage with and thank staff for all their hard work. They were extremely well attended and provided staff with the opportunity to hear feedback about the Trust's current direction and also participate in work to inform the future plans of the L&D.

We were also privileged to receive two excellent keynote speeches. The first speech was from Professor Sir Bruce Keogh who spoke about the NHS and patient safety from an NHS professional perspective. The second was from Margaret Murphy who talked about the tragic death of her son Kevin in Ireland in 1999. Since Kevin's death, Margaret has worked tirelessly to raise the importance of Patient Safety internationally.

Long Service awards

On 5th April 2017, the Chief Executive was delighted to spend time, along with other Trust Board members, in the company of staff celebrating their long service with the Trust. In recognition of this we enjoyed Afternoon Tea where many memories were shared about the hospital over the past 25 years. It was a lovely afternoon which was made even better by the enthusiasm and passion shown by these staff still today.

Marva Desir	Janet Mason
Julie Taylor	Jacqueline Dodds
Maureen Mayhew	Patricia Turner
Graham Fitzsimmons	Sally Morris
Christopher Travill	Linda Gardner
Martin Nye	Caroline Grummitt
Margaret Green	Cathy O'Mahony
Gill Mitchell	Betty Hatfield-Shaw
Sue Riley	Hashem Shojai
Helen Judkins	Pratima Tailor
Carla Burnett	Nasreen Lewis

Luton Community Service Awards - Healthcare Hero, Anne Thomson

Congratulations to Anne Thomson, the L&D's Lead Patient Safety Nurse, who was presented with a Healthcare Hero award at the Luton and Bedfordshire Community Awards held on Friday 14th October 2016.

Described as a 'true healthcare hero', Anne, a critical care nurse by background, mainly nursing in intensive care, has worked at the L&D for 25 years. In her current role, she is the lead nurse in the hospital for patient safety.

Anne is passionate about improving the safety of patients and is leading a number of Trust-wide quality improvement projects to improve the management of patients with severe infections (sepsis), acute kidney injury, and to ensure optimal care is given to deteriorating patients. Anne is also leading a project to reduce the incidence of hospital acquired thrombosis (blood clots). She demonstrates the highest level of commitment in the pursuit of learning and improving care to maintain safety for patients in the hospital.

Nursing & Midwifery Awards

At the Annual Nursing & Midwifery Conference held on 12 May - International Nurses Day - the following Annual Awards were presented:

Student Nurse of the Year **James Bartlett**

Student Midwife of the Year **Rebecca Sims**

MCA/HCA of the Year **Gemma Ricardo** Ward 17

Mentor of the year **Kartini Bardoorden** Ward 12

Most Promising New Graduate (The Aimee Varney Award) **Esther Redfern** Ward 18

Innovation in Care **Rebecca Dixon, Samantha Clough, Laurel Paul-Lockett** The Safe Project

Midwife of the Year **Tracey McGrath**

Nurse of the Year (The Erma Bristol Miller Award) **Laura Currie** Ward 16

Team of the Year **St Mary's Day Unit**

Paediatric and Neonatal - best East of England training department

Congratulations to our Paediatric and Neonatal departments who received the award for the best training unit in the East of England deanery on 10 February 2017, at the PAFTAs – the Paediatric Awards for Training Achievements.

National Midwife Champion's Award – Mary Edmondson

One of our midwives, Mary Edmondson, was honoured at the Royal College of Midwives Annual Awards in March 2017 with a Champion's Award for her work to promote training and development in the maternity unit.

Mary has re-galvanised the weekly maternity training sessions which now attract audiences of up to 30 midwives and other staff, and developed a learning leaflet and easy to use information for midwives on the new revalidation process.

Top Teacher Awards

Following student nominations at University College of London, the following consultants have been singled out for praise by the students and awarded Top Teacher certificates:

Dr Ritwik Banerjee, Consultant Physician & Endocrinologist

Miss Shahnaz Akbar, Consultant Obstetrician and Gynaecologist

In addition, Ms Su Gill has received a certificate as a Top Administrator.

Our volunteers

Outstanding Contribution Award – David McDonald

Central Bedfordshire Council, working in partnership with the Volunteer Centres as part of Central Bedfordshire's Together programme, held this years 'Cheering Volunteering Awards 'on 7th June 2016 at the Grove Theatre in Dunstable.

David McDonald, one of our Main Reception volunteers, was the recipient of an 'Outstanding Contribution' award. David has been volunteering on Main Reception for 13 years and is often the first friendly face that patients and visitors see. He has given us nearly 400 hours this year, and that is an incredible contribution that warrants recognition. We are proud that he is part of our hospital and feel he is richly deserving of his Award.

Volunteer Long Service Awards

On 4 January 2017, more than 100 volunteers attended our Annual Thank You and Volunteer Long Service Awards which were hosted by Trust Chair Simon Linnett. Our volunteers were treated to a sit down meal and entertainment was provided by Billy Lee, one of our Hospital Radio volunteers, who is one of the UK's finest Tom Jones tribute acts.

Award recipients were:

5 Years Awards	
Joan Mackinnon	Carole Trott
Genet Burton	Paula Kane
Sandra Chesney	Heather Pickering
Martin Russell	Julian Towler
Eunice Ogundimu	Theresa Scarry
Winnie Jacob	Jan Green
Catherine Wendeler	

10 Year Awards	
Lorna Silver	**Maureen Summerson**
Anne Young	**Hilary Whetstone**
Diana Hewlett	**Julia Coote**

15 Year Awards	
Pam Brown	**Brian Perry**
Janice Neal (unable to attend the ceremony)	

Pam Brown

Brian Perry

A Special Award was presented by Rhona Harvey, the Trust's very first Voluntary Services Manager, to Jill Wills for her voluntary contribution to the hospital that spans over 50 years. Jill began her voluntary role here with the British Red Cross back in 1967, before becoming a Trust volunteer when the British Red Cross withdrew from the hospital around 1984.

Junior Medical and Dental Staff Awards

Following receipt of a number of nominations for a variety of awards the mess presidents & Director of Medical Education wish to congratulate the following people/teams & wards.

Award Category	Winners
Top Educator (medical & dental)	Joint winners:
	Dr Ritwik Banerjee
	Dr Anne Ingram
Top Educator (non-medical)	**Chris May**
Top Foundation Trainee	**Matthew Kimberley**
Top Core Trainee	**Devi Natarajan**
Top Specialty Trainee	**Hannah Weller**
Best nursing/ midwifery team	**Lung CNS team**
Friendliest Ward	**Ward 14**
Most supportive MDT	**Specialist Palliative Care MDT**

Well done to the winners and all those that were nominated. It is hoped that this will become an annual event to thank and recognise teams & individuals for their hard work & commitment.

Our Governors

The L&D became a Foundation Trust with a Council of Governors in 2006. Each Governor is able to stay for a maximum of three terms of office and during 2016, two of our Governors, Professor Brian Davidson and Mr Keith Barter reached the end of their third term which equated to nine years' service on the Council of Governors.

The Trust and the Council of Governors join in thanking them for all their hard work over the years. Their support by representing the views of the local people and staff, and helping the hospital to shape its plan for the future has been invaluable.

Keith Barter
Public Governor for Luton

Prof Brian Davidson
Appointed Governor for University College of London

Introduction

As I write this foreword, at a time when I am leaving L&D to be the National Director for Urgent & Emergency Care (secondment), I would like to reflect on the performance of L&D during recent years.

In my foreword to our 2015 Annual Report, I wrote "At the very heart of Luton & Dunstable University Hospital NHS Foundation Trust is a culture based on the conviction that to deliver the best clinical outcomes, the safest care and the highest standards of quality, that 'learning' and 'teamwork' are indispensable. The commitment has shown results. For a number of years the organisation has consistently delivered against national quality and performance standards while continuing to make financial surpluses".

My foreword for the following year includes the following: "I am therefore both proud and humbled to report that L&D has been able to deliver against national quality and performance targets, achieving a Monitor governance rating of green for the last 13 quarters and a financial surplus for the 17th successive year. This performance is down to the extraordinary commitment of our staff and volunteers. The support of our external stakeholders was also of fundamental importance. Nowhere was the tremendous spirit of our staff more evident than during our 'Good, Better, Best' events that took place in July and December, when over 70% of our staff came together to identify the areas of our work that we do well and they key issues that they wanted to focus on to improve the quality and safety of the care that we provide".

It makes me enormously proud to be able to confirm that these statements are as accurate today as they were at the time they were written. As in previous years, during 2016/17, L&D has been able to deliver against national quality and performance targets, achieve the highest standard set out in the NHSI new Single Oversight Framework and deliver a financial surplus for the 18th successive year. Again, the extraordinary commitment of our staff and volunteers has been truly inspirational and was palpable during our two 'Good, Better, Best' events attended by more than 75% of our workforce.

In June 2016, we were delighted to receive an overall rating of 'Good' from the CQC, we did not receive any mandated actions, however we have used their report as a basis for continuing development and learning.

During the year, we have spent a considerable amount of our time working closely with our neighbours, partners and external stakeholders with the BLMK STP. The vision and ambition evolving from the work is likely to facilitate BLMK being selected for fast track development as an Accountable Care system (as set out in the Five Year Forward View Next Steps published on 31 March 2017).

2017-2018 will almost certainly be another challenging year for the NHS, as I hand over the leadership of L&D to David Carter as the acting CEO, and Cathy Jones as acting deputy CEO, I am working with the Executive Team to complete a 'stocktake' exercise focusing on the risks and challenges the hospital will need to manage in order to deliver the objectives set out in our Operational Plan. Looking forward, I have every confidence that the Board of Directors will continue to work with our staff and external partners to overcome those challenges and to allow L&D to focus on opportunities that will ensure our patients receive the best possible care and treatment.

Pauline Philip
Chief Executive
24th May 2017

About this Report

The report follows best corporate practice reporting on the Trust's strategy and performance against the objectives. The report presents information on national targets and financial performance and also gives a review of the quality of services.*

The report is structured as follows:

Introduction

Statements from the Chairman and the Chief Executive

Strategy

The Trust strategic vision, performance against 2016/17 objectives and the corporate objectives for 2017/18

Operational Performance Report

Includes performance against national targets, Research and Development and sustainability.

Our Patients, Our Staff and Our Partners

Includes other information about patient care, staff, Equality and Diversity and working with partners

Governance Report

Includes details of the Board of Directors, Council of Governors and Foundation Trust membership

Financial Performance Report

Includes performance against financial targets and any risks for the future

Annual Governance Statement and Annual Accounts

Includes the Annual Governance Statement and the annual accounts

Quality Account

Includes details of the progress against quality objectives for 2016/17, the plans for 2017/18 and the annual quality statements.

* Pauline Philip was the Chief Executive for the period of this annual report. Therefore, although she went on secondment on the 1st May 2017, it was agreed with External Audit that she should still sign off the Annual Report (including the Quality Account) and Accounts.

Chairman's Statement

I am proud to present this Annual Report and Accounts to you. They make fascinating and warming reading. Once again this hospital has delivered a unique and consistently excellent performance record against all key indicators: A&E 4 hour, 18 weeks wait for treatment and 62 day cancer treatment as well as maintaining excellent quality indicators such as the reduction in pressure ulcers, falls resulting in harm and achieving one of the lowest C Diff infection rates in the country. These successes are not the product of any single individual or group of individuals. Our top A&E achievement depends clearly on the resourcing and the commitment of staff in our Emergency Department and we compliment them; but it also depends on the staff in our "control room" finding beds in "flow" to allow the patients to get into hospital smoothly, continually and efficiently and our discharge teams and ward staff who support the often very complex patients leaving this hospital safely. The success also depends on the redevelopment and finance teams in securing the delivery of services including space and the Trust has put in additional beds during the year to support the increasing demand on our services. So, our success is mostly dependent on all those who work so tirelessly and generously (according to all the surveys exceptionally so) to ensure that patients are kept safe and cared for in these new and our existing facilities. The whole hospital comes together to achieve all our aims and these successes are a tribute to all.

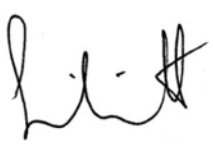
I pay particular tribute to our frontline staff. You will be able to read our staff survey results and will I hope read of the results of the investment we have made in staffing in numbers and in inclusion. We never forget that the two most important groups in our hospital are both human: the patients we serve and whom we encourage to leave and all the staff whether "front line" or those who check the finances, produce the medications, recruit the staff, ensure a patient gets the right passage through the hospital through multi-disciplinary team reviews and make sure the patient is fed while here –all staff play a critical role in delivering the patient care for which this hospital is dependably regarded. Unlike the patients, we do not wish this group to do other than stay and we have been rewarded over the last year with some improvement in staff retention.

It is easy to feel happy about being chairman of such a wonderful institution. I can see the quality for myself but, even if I can, it is always pleasing to receive external confirmation and over the year we received a "good" rating from the CQC. Anyone who reads their survey would understand that we are probably at the "very good" end of the inspection and close to the top accolade of "Outstanding". But, typically of this hospital we have not stood still; we have taken this report and have used it to inform staff debates both in and around the CQC process to learn and improve.

While this is a report on the past, the present can also guide the future. There has been a significant amount of executive lead time over the past year dedicated to the Governments vision of Sustainability and Transformation Plans. The Trust Chief Executive, Pauline Philip, has been leading the 16 providers from the hospitals, councils and commissioning, to develop sustainable plans for the future. The STP of which the L&D is a member, has also been identified within the Five Year Forward View Next Steps, as a potential Accountable Care System.

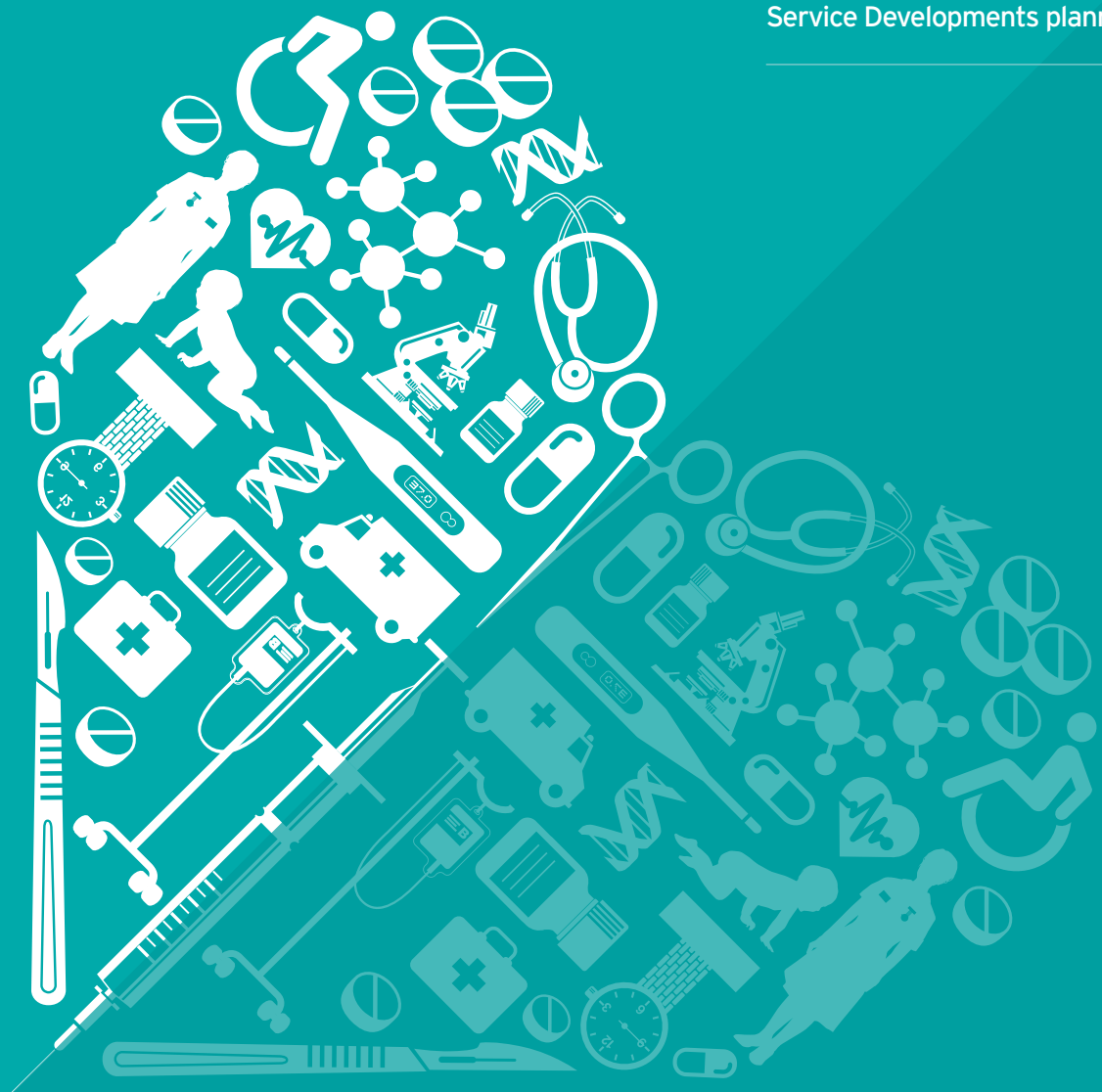
And, in that context, I would like to pay a concluding tribute to Pauline Philip who has been recognised for her immense contribution by now being placed on secondment with the NHSE and NHSI to improve emergency delivery across the country. David Carter, as CEO, supported by Cathy Jones as Deputy Chief Executive has joined the board, are acting up in her absence. We also were very sorry to lose over the year Pat Reid, our Chief Nurse who, for family reasons, left us to Poole Hospital's great advantage. We therefore welcomed Sheran Oke as the Acting Director of Nursing and Midwifery as Pat's replacement and also Marion Collict, Director of Transformation and Risk to the Board. Notwithstanding these significant changes in board responsibilities and the potential future direction for the NHS, I am convinced that this hospital will continue to be a beacon of high performance and we owe that, in its entirety, to those who work across the hospital.

Kind regards



Simon Linnett
Chair
24th May 2017

Strategy



Strategic Vision

In June 2014, the Luton and Dunstable University Hospital NHS Foundation Trust (L&D) published a new five year strategic plan.

Vision statement

"The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise using the best technology available and with kindness and understanding from all our staff".

That vision has informed the hospital of what the L&D is and will continue to be during the next four years. Constantly striving to improve Clinical Outcome, Patient Safety and Patient Experience which is at the heart of everything we do.

The Trust has agreed a strategic vision for the next four years. The vision is the outcome of extensive work undertaken, including:

- the development of a clinical services strategy
- detailed analysis of the local health economy's requirements
- participation in the Healthier Together project
- a thorough review of emerging national policy, including the Keogh Report into Emergency Care, the Academy of Royal Colleges' report 'Seven Day Consultant Present Care' and the Better Care fund initiative
- joint working with local commissioners and other stakeholders
- an ongoing dialogue with our members and governors
- recognition that rising health care demand, rising costs and flat real funding means the Local Health Economy is facing a serious sustainability challenge.

Our vision is based on an understanding that patients will choose to receive acute hospital care from organisations that deliver:

- the best clinical outcomes
- a reputation for providing safe care
- high quality care
- care and diagnostics at the time of need

Our vision is consistent with:

- The overall focus and early direction of the Sustainability and Transformation Plan (STP)
- the knowledge available to us regarding the strategic intention of other providers
- the financial challenges facing our local CCGs
- the business development opportunities available to us to increase market share and to establish new services
- the strengths and weaknesses of the Trust

Our vision translates into a five year strategic plan, underpinned by six priorities:

1. Delivering Integrated Care, leading the work with external partners and stakeholders to ensure success in delivering care in the best place for patients.
2. Being a Major Emergency Centre; delivering 24x7 consultant-led A&E, emergency surgery, and acute medicine, supported by a level 3 critical care unit, enhanced trauma services and a specialist hyper-acute hub for vascular interventions, cardiac and stroke care.
3. Expanding our Womens and Children's Centre, with our maternity unit providing extended consultant cover, in line with Royal Colleges' Guidelines and 7-day consultant led care supported by a level 3 NICU along with inpatient Paediatric Services.
4. Growing our Elective Centre; attracting both complex and non-complex elective activity from across the Local Health Economy and offering a high quality and efficient service for inpatient and day patient care.
5. Providing diagnostics at the time of need to support the delivery of integrated care for outpatients and the best possible clinical outcome for inpatients.
6. Advancing our commitment to training and teaching by: developing all staff groups; drawing on our clinical case mix and areas of established excellence, such as Human Factors; enhancing our commitment to undergraduate and postgraduate training; and increasing the scope of training to educational commissioners.

Values

- To put the patient first, working to ensure they receive the best possible clinical outcome and high quality safe care with dignity and respect.
- To value the contribution of staff, volunteers, members, governors and other partners and stakeholders, working collaboratively and professionally to deliver high quality clinical care.
- To focus on continuous improvement in the pursuit of excellence, maximising development opportunities.
- To manage our resources in a co-ordinated way, with an emphasis on productivity, value for money and quality.
- To see the diversity of our people as a strength, through our commitment to inclusion, equality and human rights.
- To accept responsibility for our actions, individually and collectively, to meet our obligations and deliver our commitments.

Performance against Corporate Objectives 2016/17

This section of the annual report reviews our performance against corporate objectives set out in our Operational Plan 2014-2016 (updated March 2016). This also incorporates the work undertaken against the short term challenges facing the Trust. The progress that has been made against our quality priority objectives is reported in the Quality Account section of this document.

Objective 1: Deliver Excellent Clinical Outcomes

Year on year reduction in Hospital Standardised Mortality Ratio (HSMR) in all diagnostic categories

- Our 12 month rolling HSMR has been statistically high during 2016/17, but the monthly trend has seen five consecutive months of improvement within expected ranges (95.15 in December 2016).

- The Mortality Board commissioned an independent review into the Trust's HSMR performance in 2016. The review was undertaken by Dr Bill Kirkup CBE (Chairman of the Morecambe Bay Investigation in July 2013) and the terms of reference included how the Trust has responded to the deterioration as well as the possible reasons for the same. The report was supportive of the work that Trust had undertaken to date and made further recommendation for the ongoing programme of work. This included; a review of all deaths using a standardised Mortality tool; improving the access to specialist palliative care; establishing Mortality and Morbidity meetings in all of the Divisions and changes to coding. The Mortality Board monitors the progress against the review action plan and ensures learning is shared across the Trust.

- We have introduced daily screening of all deaths using a standardised format and any deaths that trigger a request for a more detailed review are forwarded to the appropriate Consultant and the outcome is reported through local Governance meetings and our Mortality Board.

Objective 2: Improve Patient Safety

a) Year on year reduction in clinical error resulting in harm

- We consistently achieved 98% harm free care and for six months we achieved more than 99% harm free care.

- We made exceptional progress in the reduction of hospital acquired, avoidable pressure ulcers over the past year. We achieved a reduction of 82% of grade three pressure ulcers and a reduction of 73% for grade two pressure ulcers.

- We have maintained a falls rate of 4.06 per 1,000 bed days which is below the national average with continued challenges from an ageing and more frail population with complex health needs.

- We have achieved the 95% or greater target compliance (with the exception of one month) of all VTE assessments.

b) Year on year reduction in Healthcare Acquired Infection (HCAI)

- We had one of the lowest C. Difficile infection rates in the country (eight in total) and are assured that none of these were due to cross contamination.

- We have maintained a low rate of MRSA bacteraemias with only one case during 2016/17.

Objective 3: Improve Patient Experience

Year on year improvement in patient experience demonstrated through hospital and national patient surveys, leading to upper quartile performance

At the L&D, the Friends and Family Test (FFT) feedback is collected in a variety of ways: on paper forms; online through the hospital website and through telephone calls made to patients by staff in our Patient Experience Call Centre.

The feedback tells us that between 90-5% of our inpatients would recommend the Trust and between 90-98% of outpatients.

We use the FFT to provide us with real time feedback from our patients and carers. The information continues to be reviewed for trends and themes across the organisation and at ward and department level. There were no particular trends or themes noted from the information collected.

The annual national patient survey is demonstrating limited improvements. We are within the normal range when benchmarked against other hospitals nationally in most of the areas. However, there are improvements required.

Objective 4: Deliver National Quality and Performance Targets

Delivering sustained performance with all CQC outcome measures

The Luton and Dunstable NHS Foundation Trust is fully registered with the CQC and its current registration status is **Registration without Conditions.**

No enforcement action has been taken against the Trust during the reporting period April 1st 2016 and 31st March 2017 and we have not participated in special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016. Although the CQC Inspection Report did not mandate any actions for the Trust, it did highlight a 'requires improvement' for safety.

As part of the Trust commitment to patient safety we:

- Took some immediate steps to improve the environment for patients within the High Dependency Unit.
- Reviewed our HSMR Action Plan and introduced new measures to understand variation and drive the learning across the Trust through Mortality and Morbidity Review meetings.
- Initiated processes to improve Continuity of Care and Needs Based Care which is a Quality Priority for 2017/18.
- Focused our Quality Priorities for 2016/17 on key areas for improvement e.g. VTE and Sepsis.
- Used patient safety as a focus for the Staff Engagement Events in both July and December 2016.
- Invited the Institute for Healthcare Improvement (IHI) to complete a diagnostic and help us develop our 'Advancing Safety and Quality Framework' and future strategy.
- Further collaboration with the IHI will be undertaken to support ongoing patient safety initiatives.
- Re-launched a wider more focussed programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete a cycle of visits every two months against one of the CQC domains, starting with patient safety. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team.

Delivering nationally mandated waiting times and other indicators

- During 2016/17, the L&D continued to consistently deliver against national quality and performance targets, achieving an NHS Improvement governance rating of green throughout the year.

In addition, the L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- Met the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in all quarters.
- Met all of the cancer targets for the year. The Trust has delivered one of the most consistent cancer performances in the country.
- Had excellent performance for C Difficile maintaining a low rate of 8 (one of the lowest in the country and below the de minimis of 12) but this did exceed the agreed contract threshold of 6.
- Reported 1 MRSA Bacteraemia which is also under the de minimis of six for reporting to Monitor.
- In 2016/17 the NHS Improvement Single Oversight Framework included the six week diagnostic target as a new part of the assurance process. The Trust has met the target for every month since it was introduced in October 2016.

Objective 5: Implement our New Strategic Plan

During 2016/17 a number of key strategic developments supported the delivery of the Trust's Strategic Vision.

a) Delivering new service models:

Emergency Hospital

- **Further developed the Ambulatory Care services** – In April 2016, the Ambulatory Care Centre (ACC) was moved to the front of the hospital to be co-located with the Emergency Department. This gave the service a larger area enabling more patients to be seen via the ACC. A seven day pilot commenced at the end of 2016/17 which, following its review, will determine permanent expansion to a seven day model in the second half of 2017/18.

- **Further progressed becoming a Hyper Acute Stroke Unit** – Central to the Trust's strategy of delivering hyper acute stroke services across Bedfordshire, during 2016/17 we have increased both therapies, physicians and clinical nurse specialist posts, improving leadership and ensuring performance targets are now improving. The Trust is now providing a consultant service to the acute stroke beds at Bedford Hospital.

Women's & Children's Hospital

- **Provided community midwifery clinics in Hemel Hempstead and Redbourn** – Extending the clinic practices in Hemel Hempstead and Redbourn has resulted in an increase in women choosing to have their maternity care at the L&D.

- **Continued to develop local specialist fertility and IVF provision** – The Division's ongoing collaboration with Bourn Hall, Cambridge, continues to provide a high quality service to local couples, with an increasing positive pregnancy rate.

- **Established a community based ultrasound service** – In support of maternity pathways, a new ultrasound service commenced in Leighton Buzzard in September, providing a local, one-stop ultrasound scanning service to patients in South Beds.

Elective Centre

- **Consolidated our regional Bariatric Service** - The Bariatric team recruited a 5th Consultant Surgeon to meet demand for the service and increased theatre sessions for bariatric surgery. This has increased capacity within the medical obesity clinic and increased surgical throughput by 120 cases per year.

- **Established inpatient Paediatric Orthopaedics services at the L&D** – The Division appointed a new Paediatric Orthopaedic Surgeon in order to establish local services for paediatric orthopaedic surgery. We continue to work with the other divisions to develop new care pathways and also are linking with tertiary partners to ensure a resilient service model.

Information Management and Technology

- **Became a Centre for Global Digital Excellence** - We were invited to apply to be one of 12 Centres of Global Digital Excellence, and following judgment by an international panel of experts, were awarded this status and £10 million of funding in January 2017, as announced by Jeremy Hunt, the Secretary of State for Health. The prerequisite is that we achieve a Digital Maturity rating of HIMMS Level 7 in 3.5 years, and we have described a delivery plan comprising of six work packages to achieve this. We are arranging the first meeting of the Programme Board to oversee its delivery. It will be heavily scrutinised by NHS Digital and the rest of the NHS, as it is the first programme of its type. It will also support the future training of Chief Clinical Information Officers and other clinicians such as Nursing Informatics Leaders and AHP's to be more involved in technology and utilise it more to provide safe and efficient healthcare. This is a superb achievement for the Trust, which now stands beside much larger Academic Health Centres as an equal.

- **Continued the pathology modernisation** – The implementation of the new Laboratory Management System (LIMS) was initiated in January 2017, with an anticipated completion date for November 2017. The new LIMS brings benefit to Pathology, the wider Trust and GP services in improving business intelligence, results analysis and facilitating future service developments

b) Implementation of our preferred option for the re-development of the hospital site.

- Re-development proposals for the site are set out in an Outline Business Case approved by the Trust Board in October 2015. Planning Consent for the proposals was granted by Luton Borough Council in April 2016.

- The Trust commissioned the first stage of detailed design for the new Services Block in October 2015. This work was delivered by a team led by AECOM in March 2016.

- Work began on developing the Sustainability and Transformation Plan for the Bedfordshire, Luton and Milton Keynes footprint in April 2016. Work on the re-development proposals for the L&D has been suspended pending the outcome of service delivery planning across the STP footprint.

- The Trust received a loan of £19.9m from the Independent Trust Financing Facility (ITFF) in June 2015 to support the delivery of enabling works required by the redevelopment plan.

- The Trust delivered a new Orthopaedic centre, two new theatres and refurbishment of part of the ground floor of the St Marys building to provide a new 28 bed ward in 2016/17.

- Further work to complete the refurbishment of the ground floor of St Marys to deliver an 18 bed ward, a 10 bed Haemato-Oncology ward and relocation of the Day Unit have been completed in FY 2016/17. In addition, the Therapies team have been relocated from St Marys to the centre of the hospital.

- An extension to Oral and Maxillo Facial Surgery is due for completion in 2017/18. This has required the conversion of the Nurses Home extension building to provide additional office space for staff displaced by this project.

- Proposals to deliver the Sexual Health Services clinic in the centre of Luton are being developed. The redevelopment team are also developing proposals for the provision of a helipad, the reconfiguration of Imaging and a potential requirement for additional theatre space.

Objective 6: Secure and Develop a Workforce to meet the needs of our patients

a) Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.

- We continue to recruit staff both locally, nationally and internationally. During the year we also recognised the national challenges in recruiting to band 5 Registered Nurse positions. One initiative that has been firmly embedded is the use of band 4 Assistant Nurse Practitioners (ANP). Currently we have 31 WTE ANPs employed in the Trust. They can be seen working in areas such as Medicine, Surgery and Paediatrics. These staff are vital in supporting our registered nursing staff to deliver safe, quality patient care.

- We continue to face a challenge when recruiting to band 5 registered nurse posts in particular. This is due to national shortages and changes in service requirements in order to deliver safe care in our acute hospital. This recruitment is monitored on a monthly basis by the Trust Board along with other hard to fill vacancies.

- Retention has been and continues to be a key component of our strategy and the Trust recently reviewed and re-launched its starter and leaver questionnaires so that we can understand better why staff join the Trust as well as why they leave. This will be developed further over the next year.

- The Trust has enrolled 77 new learners to an apprenticeship qualification since 1 April 2016 against a Health Education East of England target of 70 for this financial year. Currently the Trust has 137 staff enrolled to an apprenticeship. We are the first Trust in the East of England to offer a Chartered Management Institute Management and Leadership Level 5 Apprenticeship qualification, and building on the success of the first two cohorts, the third group will commence in May 2017.

b) Ensure a culture where all staff understand the vision of the organisation and are highly motivated to deliver the best possible clinical outcomes.

- At the heart of L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important are the large scale, Trust wide 'Good, Better, Best events'. The events were held over a week and over 80% of our staff attended each event in July and December. Both events engaged with our staff to provide them with key information about the Trust and gather their feedback about what the Trust does well and any areas for improvement with clear actions identified. We also receive assurance from our NHS National Staff Survey and our overall staff engagement score was 3.90 (on a scale of 1 - 5), this puts the Trust in the top 20% best performing when compared to all Acute trusts.

c) As a University Hospital, deliver excellence in teaching and research. Ensure that all staff have access to appropriate education and facilities to maintain their competence

- Medical Education continued to be a high priority for the Trust. In, 2016/17 we provided a high standard of both undergraduate and postgraduate training. All of our Educational Supervisors attended formal training to be appointed as Educators and have had an annual appraisal for their educational role. This process has strengthened the standard of training and the governance of the process.

Undergraduate

- The feedback from informal visits by the University continues to be positive. The Directors regularly review the student placements to allow for adjustments to be made to improve the student experience. Formal student feedback at the end of placement and following the student examplinations continues to rank the Luton and Dunstable University Hospital as one of the best placements. We have again successfully completed the final exams in March with good support from our in-house examiners.

Postgraduate

- We are committed to ensuring that the quality of training for postgraduate medical and dental trainees delivers the requirements of the curriculum. During 2016/17, we hosted Health Education East of England School visits for Medicine (Department of Medicine for the Elderly, DME), Obstetrics and Gynaecology (O&G), Paediatrics and Neonates, General Practice, Ophthalmology and Anaesthetics. Any required actions were either implemented immediately or have action plans in place to sustain improvements.

- After these visits, the main requirement that needed quick action was the placement of GP trainees in Trauma and Orthopaedics (T&O). This was appropriately managed with reallocation of the trainees into other clinical areas. There continues to be on-going work with the T&O team to support the changes needed to improve the training environment and thereby review the potential of re-allocating trainees to the department. For the other visits there were recommendations and requirements which are being addressed within the department with support from the DME team. The issues around Medicine and O&G have improved and work continues to be done to sustain the improvements.

Objective 7: Optimise the Financial position

Delivering our financial plan 2014-2016

Across the Trust we have a robust programme of financial management in place. Each Division manages the financial position within each service line. Divisions are responsible for tracking the success of each service line on a monthly basis and reporting their position to their Executive Board meeting. These reports feed into the Finance, Investment and Performance Committee and ultimately the Board of Directors.

Going forward, each business plan will be managed as a specific project with monthly tracking and reporting to their Executive Board meetings and performance meetings. This will provide additional structures and assurance to the Board of Directors.

To improve efficiency across the health economy we have continued to work closely with the Sustainability and Transformation Plans through the Collaborative Savings Initiative.

Service Developments delivered in 2016/17

During 2016/17, the Division of Surgery including Cancer:

- **Further developed Urology Services** – In 2016/17 a substantive 5th Urologist was appointed which has enabled the service to expand to increase the number of patients able to access the service.

- **Redesigned the surgical pre-assessment processes** – The Division invested in a significant improvement project to review and redesign the pre-assessment pathway and prevent patients having to be cancelled on the day of surgery, whilst optimising their pre-operative journey. The implementation of this programme is expected to be completed in 2017/18.

- **Successfully implemented Chemotherapy ePrescribing** - with access to chemotherapy treatment records across the consortium including Mount Vernon Cancer Centre to ensure both a timely transfer of information to enable more chemotherapy treatments to be undertaken locally and improve patient experience. This system will improve patient safety by electronically prescribing chemotherapy drugs, ensuring a consistency of care across the Consortium and ensure that the Trust meets the National guidance.

- **Explanded the Acute Oncology Service** – Following the successful embedding of the Acute Oncology Service, an additional nurse has been appointed to ensure service resilience across the week. This is an important part of the commitment to improving services for oncology patients particularly those who develop severe complications following chemotherapy.

- **Developed a Haemato-Oncology Unit** – The Cancer Services team have been key in supporting the development of the Unit by ensuring the needs of the oncology patients are met to enable for future safe delivery of inpatient chemotherapy within the Trust and that the National Cancer Peer Review (QST) standards are achieved.

- **Improved End of Life Care (EOLC)** – EOLC has continued to be a key priority for the Trust. Our end of life care received a CQC rating of 'Good' recognising the considerable improvements and commitment by staff to improve the patients and families experience. A comprehensive training package focussing on the recognition of the dying phase has been developed and delivered to 89% of the eligible priority staff. This has resulted in 141% increase in referrals to Luton and Bedfordshire services who provide a 24 hour advice and support helpline and coordination of palliative care for patients, families and carers to enable patients to remain in their preferred place of care. Working with the Hospital Chaplin and Voluntary Services the Volunteers Companionship has been introduced offering support for patients and families.

- **Further developed Specialist Palliative Care services** - With an additional Specialist Palliative Care Nurse appointed and with the support of Macmillan and End of Life Care Nurse to support the earlier recognition of End of Life patients and to be able to provide the appropriate support to patients, families and carers and facilitate faster discharge if appropriate.

- **Introduced the Cancer Recovery Package** - The Recovery Package is recognised in the Cancer Taskforce Strategy with a commitment to ensure that 'every person with cancer has access to the Recovery Package by 2020'(including Holistic Needs Assessment and Care Planning, Treatment Summary, Cancer Care Review, and Health and Wellbeing Events). Good progress has been made in the implementation across the Trust led by the Cancer Nurse Specialists. The roll out of these interventions will better support and improve the quality of life of people living with and beyond cancer.

During 2016/17, the Division of Medicine:

- **Developed support for performance monitoring and decision making** – Progress has been made during the year to enhance the governance processes within the Division. This has further strengthened the reporting and escalation through Medicine Executive and COB for executive guidance, to support strategy and decision making.

- **Implemented service line management/reporting** – Work has continued throughout 2016/17 to refine service line reporting to support service delivery and development of decision making.

- **Commenced Integrated Sexual Health Services for Luton Borough Council** – The service was established in April 2016 bringing benefits to the community through the establishment of additional clinics being provided across four locations in Luton. A high quality service is being delivered with plans being developed for a purpose designed Luton town centre hub.

- **Continued the implementation of all case mortality reviews** – During 2016/17, the Division introduced quarterly Mortality Forums to ensure outcomes and learning are embedded across the directorates and Trust wide.

- **Continued Rheumatology service development** - In 2016/17, a review of the investment in rheumatology services demonstrated that activity and clinical benefits were achieved. Going forward, further business planning is in progress to develop bone services in 2017/18.

- **Recruited an additional Inflammatory Bowel Disease Nurse** – An additional specialist nurse was recruited in 2016/17 to support the commencement of the use of Biosimilar drugs.

- **Developed the Prosthetic and Orthotic service** – During 2016/17 electronic Primary Consultations have been implemented to support information governance and sharing across clinicians within the wider area. The 'Cad Cam' is now in place.

- **Continued the transition to a Needs Based Care model** - In 2016/17, clinical engagement events were held across Medicine to establish service models across all specialties to develop Needs Based Care. As part of this work, the Cardiology bed base was increased and this has shown real benefits for patients and a reduced length of stay.

During 2016/17, the Division of Women and Children's Division:

- Extended the provision of community maternity services – Midwifery and scanning clinics have commenced with very positive feedback. Consultant Clinics are planned to during the first half of 2017.

- Increased resilience / capacity of Fetal Medicine service – We have successfully recruited a third consultant specialising in fetal medicine and are key members of national research projects to take forward safer births and support complex pregnancies locally.

- **Worked collaboratively with Primary and Community partners** – The Division have worked closely with public health and have built a collaborative approach to child wellbeing. This has been a key focus to ensure that every contact counts as an opportunity to give overall health messages.

- **Re-established parent and child involvement groups** – Uptake of events to engage parents and families has been challenging but the feedback we have been able to identify has been used effectively. This has included improving ward facilities for parents and renewed focus on collaborative fundraising for the services.

- **Continued collaborative work with local CCGs, Primary and Community paediatric services** – The team have worked jointly with primary care to implement GP connect services ensuring rapid access to specialist paediatricians enabling direct discussion, supporting the right care in the right place at the right time.

- **Continued to improve facilities for families** – The Division have been supported by successful fundraising. We have been able to redesign storage and provide a dedicated parents' lounge area and a refitted refreshment kitchen enabling parents to have a space to meet and talk.

- **Further optimised the use of theatre sessions** - The Division has continued to work closely with clinicians and the theatre teams to ensure the best and safest use of theatres and valuable operating time. All Gynaecology procedures have been moved from the obstetric theatres in recognition of the increased demand for supported deliveries.

- **Continued collaborative working with Surgical Division to support the resilience and further development of local Children's surgery** – Joint training events between surgery and paediatrics have had very positive feedback across the teams ensuring further improvement in communication, service planning and delivery. The team have welcomed increased support through the appointment of additional surgeons and anaesthetists supporting paediatric services.

- **Continued collaborative working with Medical Division**– the Paediatic Team has continued to work closely with the Medical Division to further improve pathways for children in Children's ED and to also further enhance care of Diabetes in pregnancy in line with new guidelines.

- **Further developed transitional pathways** – The services have worked together in a focused way to take forward transitional pathways. This included looking at combined clinics providing access to social and emotional support as well as the routine clinical review.

During 2016/17, the Diagnostics, Therapeutics and Outpatients Division:

- **Improved treatment and management of Haematological disorders** – A new 10 bedded Haemato-oncology unit, providing dedicated inpatient facilities, has been built for the specialist management of patients with blood disorders and cancers, sickle cell and thalassaemia.

- **Introduced PCR technology** – New rapid diagnostic technology has been introduced to the Trust via the Microbiology department, enabling faster detection and treatment of a range of infections and contributing to shorter length of stay.

- **Supported cancer pathways and performance** – During the year, both Imaging and Cellular Pathology have continued to support both Medicine and Surgery in improving access to MRI and expanded diagnostic techniques in support of prostate and lung cancer treatments

- **Increased consultant radiologist and reporting radiographer cohort in Imaging** – Over the course of this last year, in support of increased demand for diagnostic Imaging services, the Trust has appointed additional consultant radiologists and invested in training to extend the professional scope and role of radiographers, sonographers and mammographers

- **Restructured workforce in Imaging and introduction of e-rostering** – The introduction of electronic rostering has improved the efficiency and deployment of staff resource within the department, whilst the appointment of senior modality leads to MRI, ultrasound, main x-ray and CT/Nuclear Medicine supports ongoing staff and service development opportunities

- **Improved attendance rates in Breast Screening** – A number of initiatives have been successfully implemented in Breast Screening to increase the volume of women attending screening and to reduce those who do not attend their appointment, including the introduction of an appointment reminder system and improved recycling of cancelled appointments, collaborative working with CCGs/GPs to identify women within the practice and encourage conversations on the health benefits of the service.

- **Continued Trustwide roll out of partial booking** – Outpatients, in collaboration with service managers across the clinical divisions, are near to completing the Trustwide roll out of partial booking. This has contributed to a reduction in DNA rates and multiple hospital initiated rescheduled appointments, improving patient experience.

- **Enhanced therapy support to stroke services** – The Division has increased dietetic, physio, OT and speech and language therapy support to hyper acute stroke services within the Trust, to enhance care and specialist neurological rehabilitation to national stroke standards

- **Developed a new Therapies Hub** – Therapies facilities have been improved with the provision of a centrally located hub providing staff and patients with new treatment rooms. Phase one of the work is completed, and phase 2, including a new gym area, is due for completion in June 2017.

- **Supported BLMK Sustainable Transformation Programme (STP)** – The Division has been actively involved in the scoping work across Imaging, Pathology, Pharmacy and Therapies to identify and develop new collaborative ways of working across organisations to promote increased efficiency in the utilisation of resources, a more flexible use of workforce and cost savings through joint procurement. This is an ongoing programme aimed at delivering benefits to the Trust and local health economy over the next 2-3 years.

- **Supported the development of Needs Based Care in Medicine** – Pharmacy and Therapies have worked in collaboration with Medicine in the reconfiguration of wards and services, including the provision of a satellite Pharmacy in St Mary's Wing, to best support the introduction of Needs Based Care in Medicine, with the purpose of optimising and aligning resource to enhance patient care.

During 2016/17, corporately we:

- **Advanced the IT Infrastructure and Service Desk** – We are still experiencing growth in the number of calls processed through the IT service desk. This increase relates to the additional hardware deployed for projects such as hospital re-development or ePMA and our aging PC and printer suite. During the rollout of Virtual Desktop Infrastructure (VDI) we are re-commissioning or replacing aging hardware including PCs and networking all Printers, we are also adding additional staff to the service desk to help with the transition from our old PC suite to the new VDI environment that will mean staff access information through a central hub rather than desktop PCs. The role out VDI will continue throughout the year. We have carried out a short survey to gauge the satisfaction level with the current service, and we now have a new survey on the new IT portal.

- **Implemented E-Prescribing and medicines administration** – We have continued to roll out the ePMA JAC system throughout the Trust, and are now preparing to launch the system in the final areas including the Emergency Department, Maternity and Outpatients. We have carried out a full upgrade of the system and are planning a further data cleanse and modifications to integrate it with Symphony, the A&E system.

- **Implemented Unified Communications** – This has been an extensive programme of work, focussing on the infrastructure, switches, UPS' and the resilience telephony system to ensure we can continue to communicate in emergency situations. We now have 3 SIP trunks giving us a triangulated phone system to also increase the resilience and we are trialling baton phones for on call teams. The new wireless network will be completed in May 2017, following a large programme of cable installation. This will support the push for mobility on wards and the use of mobiles devices to collect clinical data. The other functionality available to us, such as web collaboration, is being trialled in key areas driven by the Clinical Unified Communications Board, chaired by Miss Sandhu. We have trained a number of UC Clinical Champions now and will continue this programme of training and support.

- **Implemented Chemo care** –the Chemo care chemotherapy prescribing application and its complex architecture and interfacing was configured and installed on our site during late 2016, going live in March 2017. This allows us to be an accredited Chemotherapy centre, and provide local high quality services to our patients. A fantastic achievement by all involved, as this is a regional Cancer Network project working with 3 stakeholder Trusts, and it this multi-disciplinary multi-sited aspect to the project made it even more complex than usual.

- **Procured a new pathology system** –The Trust has awarded the contract to Clinysis and the new Pathology IT system should be implemented by the end of 2017/18.

2017/18 Strategic Approach

In line with NHS England's planning guidance, a draft Sustainability and Transformation Plan (STP) was submitted on 21 October 2016. The Senior Trust Executive have been playing a leading role in the development of this plan to restore clinical and financial sustainability of the local health and social care system. It is centrally involved in planning and developing proposals for transformational change across a planning footprint covering the resident populations of Bedfordshire CCG, Luton CCG, and Milton Keynes CCG (BLMK patch). There is close and active involvement from the four local authorities (Luton Borough Council, Central Bedfordshire Council, Bedford Borough Council and Milton Keynes Council) in the transformation planning. Given BLMK's current and projected distance from financial equilibrium, there is active oversight and challenge to ensure that planning, agreement and executing the necessary transformation in BLMK proceeds expeditiously. It should be noted that agreement of proposals will include both formal and informal consultation with the public as required.

The plan has been informed by population health analysis commissioned by STP Partners. This has been used to add precision to transformational solutions that will enable current and projected demand to be redirected from hospital into community settings and self-managed care. These solutions have been trailed extensively with primary care colleagues, at GP practice level, at CCG level and via cross-BLMK clinical engagement events.

The STP plan proceeds across 2017-2019 via user-facing initiatives, in the areas of prevention, primary, community and social care and hospital services, with enabling work, designed to create the right tools (e.g. digitally communicable care records), levers and incentives to support the transformation process. Considerable effort has gone into refining BLMK's five STP priorities. The L&D has processes in place to be part of this collaborative work.

Priority	Description
Priority 1	Impactful health Improvement and illness prevention
Priority 2	High quality, scaled and resilient out of hospital services
Priority 3	Sustainable secondary care services
Priority 4	Delivering Digitisation
Priority 5	Re-engineering the system of demand management, commissioning and service provision

All relevant NHS parties (i.e. both NHS commissioners and providers) across BLMK have expressed an appetite for the principle of adopting an accountable care approach to commissioning and delivering NHS services. Such an approach will continue to see care designed and delivered at the locality level (typically 30,000 to 50,000 population), sensitised to the needs of different localities, and in a way that list-based general practice remains front and centre. Some functions and activities would operate in patches co-terminous with local Council boundaries - others, such as health population analytics, information and communications systems and technology and administration will operate across the BLMK footprint.

The Trust is intimately involved in Priority 3 from a Secondary Care perspective, but is working alongside system partners to develop proposals for transformation and is committing considerable resource to its delivery.

Within the STP we are developing a greater level of trust and commitment whereby, with support of Collaborative Savings Partner, we will be able to develop realistic practical attempts to support delivery of reduced baseline of acute activity to continue to provide services in more cost effective ways. This model will need to accommodate varying pressures that could arise, and will build out of the ongoing work within Priority 2 – Out of Hospital Care. This opportunity to jointly design and develop transformational interventions within BLMK is being embraced by the Trust. We are surfacing jointly designed and deliverable interventions. In many areas this collaborative approach unleashes clinical staff to resolve cross institution issues that have frustrated desired quality outcomes for some years. We see this as a valuable opportunity to begin local delivery of cross system transformation, and have sufficient leadership, aligned with procured third party support, to work at pace to develop a robust Collaborative Savings Plan to which all parties can agree.

On the 31st March 2017, the NHS Five Year Forward View Next Steps was published by NHS Improvement (NHSI) and NHS England (NHSE) with the support of the arms length bodies. It outlines progress on the ambitions

set out in the Five year forward view since its original publication in October 2014, it defines what still needs to be achieved over the next two years, and how this will be achieved. It also outlines priorities for the service specifically in 2017/18 as follows:

1. Deliver financial balance across the NHS

2. Improve A&E performance

3. Strengthen access to GP & primary care services

4. Improve cancer and mental health services

The Five Year Forward View document provides more clarity on the future plans of the STP and provides two main functions:
1. Outlining key areas of clarification for STPs (now referred to in the document as Sustainability and Transformation Partnerships), accountable care system and accountable care organisation integration models
2. Outlining new policy changes associated with these models

Luton, with Milton Keynes and Bedfordshire, features as one of the health and care systems in the country to be supported by national health regulators to explore a move towards becoming an Accountable Care System (ACS).

The introduction of ACS, announced in the NHS 'Next Steps on the Five Year Forward View', will see local health and care organisations supported by NHS England and NHS Improvement to work more closely together to provide joined up, better coordinated care

Exploring the option of becoming an ACS supports local system leaders' aims to bring services together around patients; with care and services planned and delivered to meet local health needs now and in the future.

Exploring a move towards becoming an ACS supports our commitment to work together; and to bring people, professionals and care together to focus on the patient as well as the individual organisation providing the service. Becoming an ACS won't mean an overnight change rather it is a commitment to do more, more quickly, with the support of NHS England and NHS Improvement, in working together to design and deliver change that will really improve health and care services locally.

Maintaining Performance

The Board of Directors recognises the importance of sustaining the level of delivery against national quality and performance targets delivered by the Trust in recent years. During the last year, the organisation has demonstrated an exceptional ability to maintain operational performance whilst also focussing on strategic planning and change. This will be particularly important in coming years.

Maintain and Develop Key Clinical Specialties

- Maintain key specialties to secure our future in terms of clinical excellence, financial sustainability and reputation.
- Develop clear strategies for key specialties.
- Ensure that specialty plans give consideration to the 'necessary volume' to ensure the economies of scale required for the delivery of seven day services and financial and clinical sustainability.

Explore Opportunities for Growth

- Actively engage other stakeholders including the CCGs and local authorities in rethinking models of community care, embedding L&D expertise services in the heart of the major localities.
- Explore opportunities for synergy with existing services e.g. the development of restorative dentistry to support maxillo-facial surgery
- Strengthen the relationship with tertiary hospitals to enhance and develop a range of hyper-acute services, in particular paediatrics, cancer, stroke and trauma.

Ensure Sustainability

- Continue to improve the patient experience and safety, for example, through improving communication and the provision of information to patients and greater access to consultant-led care.
- Ensuring the maximum use of information to deliver safe and efficient care by using an electronic patient record, and support information systems at all levels of the organisation.
- Directing our capital resources at those service changes which will allow sustainability of performance
- Maintain financial sustainability, delivering a comprehensive programme of efficiency projects which meet the need for tariff efficiency and the financing of the redevelopment programme.
- Embed the new structures in the medical and surgical divisions to allow greater focus at specialty level in order to benefit fully from service line management and bring forward a new generation of clinical leaders.
- Continue to review and strengthen performance by the use of internal and external expert review.

Corporate Objectives 2017/18

This document updates our 2014-2019 Strategic Plan and our 2017/19 Operational Plan.

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

1. Deliver Excellent Clinical Outcomes	• Year on year reduction in Hospital Standardised Mortality Ratio in all diagnostic categories
2. Improve Patient Safety	• Year on year reduction in clinical error resulting in harm • Year on year reduction in Hospital Acquired Infection
3. Improve Patient Experience	• Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance
4. Deliver National Quality and Performance Targets	• Deliver sustained performance with all CQC outcome measures • Deliver nationally mandated waiting times and other indicators
5. Implement our New Strategic Plan	• Deliver new service models: – Emergency Hospital – Womens and Children's Hospital – Elective Centre – Academic Unit – Implement preferred option for the re-development of the site.
6. Secure and Develop a Workforce to meet the needs of our Patients	• Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention. • Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes. • Deliver excellent in teaching and research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.
7. Optimise our Financial Plan	• Deliver our financial plan

Improving Quality

Approach to Quality Improvement

Each year, improving clinical outcome, patient safety and patient experience underpins everything we do at the L&D. Our key quality priorities are integral to an overarching Quality Framework which is developed to encapsulate national priorities, local priorities and those identified through a comprehensive large scale bi-annual staff engagement event. The priorities sit broadly under the following categories:

1. CQC Quality standards
2. Safety priorities
3. Trust CQUIN programme
4. Patient Experience
5. Transforming Quality through Technology

The purpose of this framework is to monitor and provide assurance to the organisation regarding the standard of care delivery and identify and prioritise areas for improvement. The Quality Improvement Framework is a dynamic programme and responsive to emerging issues and plans to address them. It is underpinned by the STP transformation programme.

There is a strong focus on learning particularly from serious incidents and on sharing learning and improvements through a variety of means including a patient safety newsletter and weekly staff briefings.

Monitoring is carried out through the Clinical Outcome, Safety and Quality Committee and Finance, Investment and Performance Committee. Reports to the Board are overseen and analysed by the Medical Directors, the Chief Nurse, Director of HR and the Head of Quality. Quality Improvement capacity and capability will continue to be developed within the organisation. We will continue to develop our quality improvement and patient safety leadership capacity through our active involvement in the UCL Partners Patient Safety Collaborative. The aim of the partnership is to embed safety improvement into routine daily work to reduce avoidable harm and improve quality of care. The engagement of L&D staff will enable the Trust to further build improvement knowledge to develop capability and capacity in quality of care.

The Trust plans over the next 2 years to better integrate a number of workstreams in order to further develop a culture of learning and continuous quality improvement. This will include: continuing to deliver quality improvement education and support programmes with a strong focus on sustainability; the development of a faculty of After Action Review Conductors to support prompt learning in a supportive environment following critical events; improving our patient safety incident reporting system to better facilitate reporting, analysis and learning from all levels of patient safety incidents; continue to develop and publish the Patient Safety Newsletter; to deliver culture change programmes at team and departmental level; to better integrate human factors into patient safety investigations and the learning and action from incidents. The advancing quality wheel demonstrates how all of these issues are integrated.

Our ratings for Luton and Dunstable Hospital NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Overall	Requires improvement	Good	Good	★ Outstanding	★ Outstanding	Good

Our quality improvement plan

The CQC report was published in June 2016 and although the CQC Inspection Report did not mandate any actions for the Trust it did highlight a 'requires improvement' for safety.

As part of the Trust commitment to patient safety we:

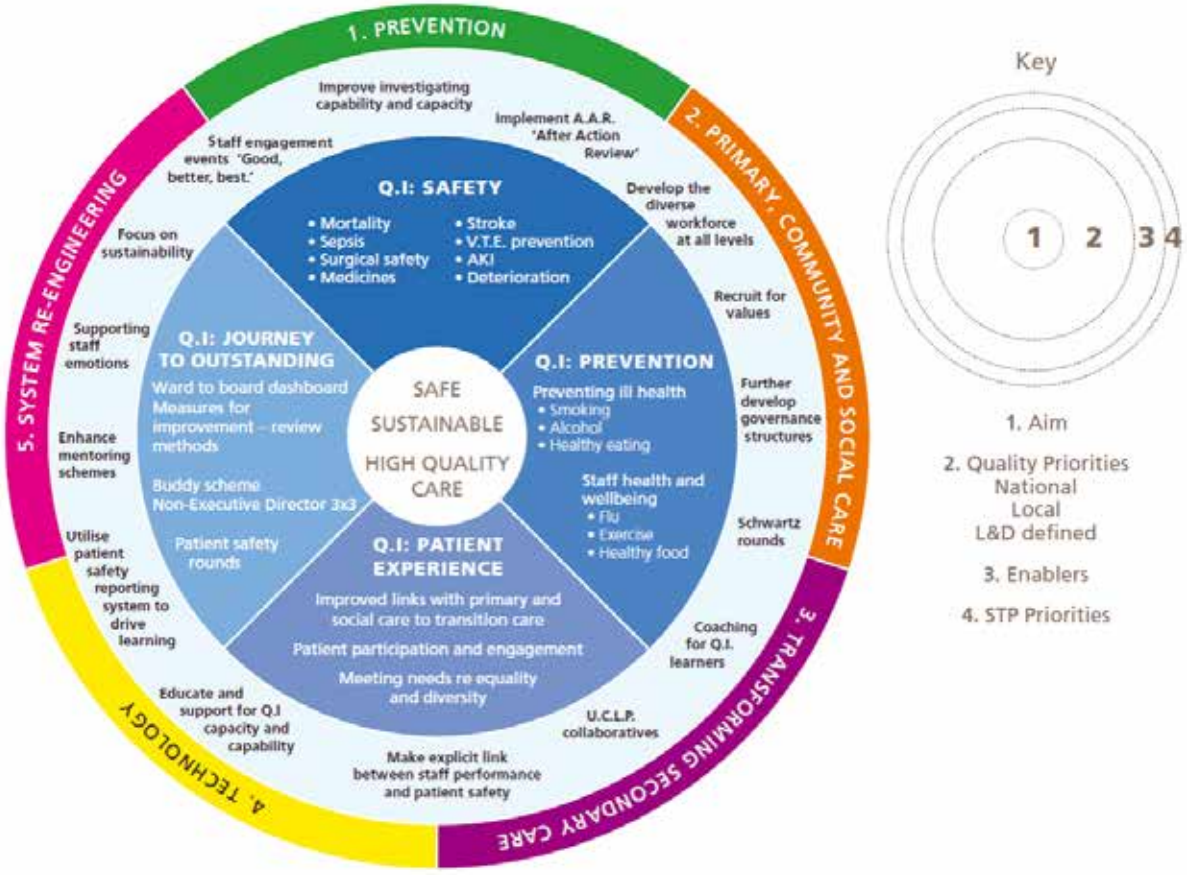
- Took some immediate steps to improve the environment for patients within the High Dependency Unit
- Reviewed our HSMR Action Plan and introduced new measures to understand variation and drive the learning across the Trust through Mortality and Morbidity Review meetings.
- Initiated processes to improve Continuity of Care and Needs Based Care which is a Quality Priority for 2017/18.
- Focused our Quality Priorities for 2016/17 on key areas for improvement e.g. VTE and Sepsis
- Used patient safety as a focus for the Staff Engagement Events in both July and December 2016.

- Invited the Institute for Healthcare Improvement (IHI) to complete a diagnostic and help us to develop our 'Advancing Safety and Quality Framework' and future strategy.

- Further collaboration with the IHI will be undertaken to support ongoing patient safety initiatives

- Re-launched a wider more focussed programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete a cycle of visits every two months against one of the CQC domains, starting with patient safety. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team.

Our 'Advancing Safety and Quality Framework', the 'Quality Wheel', outlines the key five core themes with specific action areas needed to achieve our strategy for safe and high quality care. These provide a mechanism for refocusing current safety and quality improvement activities and designing goals for health service improvement.



Our Quality Impact Assessment process

The Trust has a Quality Impact Assessment procedure in place. All Cost Improvement Programmes (CIPs) and service change proposals are subject to a Quality Impact Assessment (QIA).

The CIPs / QIA processes:

- Provide robust assurance to the Trust Board that work is being undertaken to deliver the key financial sustainability targets, within a context that does not compromise delivery of clinical quality and care;
- Provide a means of holding to account those accountable for safe and effective delivery of CIP;
- Manage the delivery of sustainable financial balance through the Cost Improvement Programme;
- Provide a robust but fair challenge to the planning and performance of the programme ensuring that all projects have clear objectives, performance indicators, key milestones, savings targets (including phasing), timescales and accountability;
- Provide summary reports that highlight areas of concern and resultant contingency plans that have been implemented to mitigate the risks associated with the delivery of planned savings.

The Trust's position for undertaking risk assessment is outlined in the Risk Management Framework. The Trust's top 5 risks for 2017-18 are detailed in the Annual Governance Statement. With regards to the risk assessment of CIPs and associated QIAs, this includes an outline of the programme in detail and the associated assessment of the likely quality impact and financial impact, in line with NHS Improvement recommendations. The Executive Board oversees the programme. Internal Audit periodically review the process.

The triangulation of quality with workforce and finance

Scrutiny of triangulated data of quality, workforce and finance is undertaken at ward/departmental level, Divisional Level and by the Trust Board, with the analysis being used to prioritise quality and efficiency improvements.

Quality, Workforce and Financial indicators are shared and discussed at the Quarterly Public Board of Directors meeting and published on the Trust website www.ldh.nhs.uk/boardpapers. Furthermore, each month, there is detailed scrutiny of triangulated data by the membership of The Clinical Outcome, Safety and Quality Committee (COSQ - a sub-committee of the Trust Board and Chaired by a Non-Executive Director lead for Quality). Membership of COSQ and the Finance, Investment and Performance Committee include cross membership to ensure that there is oversight of each of the agendas through any decision making process.

The Trust continues to consider how information can be better presented to more clearly articulate to our Board and the public, the actions in place to address any areas requiring improvement.

The Trust uses the information collated to effectively make informed, evidence based decisions about future developments. For example, two major initiatives underway to address quality and efficiency and deliver better services for patients include the establishment of a haemato-oncology unit and the restructuring of our non-elective pathway to provide Needs Based Care.

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

Our Quality Improvement Implementation

The Quality Wheel was presented to staff attending the Good, Better, Best Event in December 2016. The central aim is to deliver of safe, sustainable, high quality care. Around this aim sit four quality improvement (QI) domains namely: Safety; Prevention; Patient Experience and Journey to Outstanding. These four domains of quality improvement encompass a broad range of workstreams, many of which are already in progress or soon to begin and have been identified through national, local or Trust initiatives.

A number of enablers are identified as being required to support the quality improvement to gain maximum benefit for patients, staff and the organisation. It is vital to get the enablers in place and right for staff so that they are supported in their endeavours and that their endeavours are targeting Trust priorities and objectives. The Trust sees the benefits and rewards that staff gain from being involved in quality improvement programmes integral to how we value our workforce.

A number of developments are already underway including:

Schwartz Rounds: a review has been undertaken and a plan made to continue with further development over the next year.

University College London Partnership (UCLP) collaborative: The Trust has committed to work with the Sepsis and AKI collaborative led by the UCLP for an extended period, until June 2017.

Educate and support for QI capability and capacity: A number of Trust staff are undertaking a national QI programme with the intention to train as trainers. Within the Trust, a first cohort of QI trainees is underway, the programme being led by our own accredited trainer supported by trainers from UCLH.

Utilise patient safety reporting system to drive learning: an extensive quality improvement programme is underway to redevelop and redesign the incident reporting system to create a system that is more streamlined and user friendly for both reporters, incident investigators and for those responsible for reviewing trends, themes and sharing the learning. The Head of Clinical Risk and Governance now manages the complaints team which will afford a more robust approach to triangulating the learning from incidents, complaints, claims and litigation.

Development of a Quality Improvement Faculty:
The first steering group meeting has been held to consider our ambition to create a Faculty for Quality Improvement. The key aims of the Faculty were agreed as supporting:

- The development of groups of skilled individuals to undertake improvement projects.
- Coordinated approach to Service Improvement.
- Processes that will enable Divisional Governance Structures to support the Quality Improvement progress.
- Prioritisation of improvement activity with a focus on delivering the corporate objectives.
- the alignment of quality improvement work to key themes such as reduction in mortality and harm; improving the patient and staff experience; building a safety culture.
- the use of recognised QI methodology to help staff deliver tangible outcomes.
- the development of systems that provide support to those undertaking quality improvement, to include Improvement buddies, mentoring, coaching and celebrations of success.
- Oversight of improvement projects – all individuals carrying out an improvement project should submit a project brief to ensure it is using established improvement methodology and consideration and support are given to help ensure success.

The Faculty will enable the realisation of the following enablers from the Quality Wheel:

- Focus on sustainability
- Coaching for QI learners
- Enhanced mentoring schemes
- Educate and Support for QI capability and capacity

After Action Review

This established system for learning and staff support is to be adopted from its origin in UCLP. Four questions are asked by skilled facilitators: What should have happened? What actually happened? Why was there a difference between what should and what did happen? What is the learning? There are strict ground rules to support a meaningful experience for those participating. A plan is in development for the implementation over the next year coordinated by the Director for Medical Education and the Associate Director of Nursing (patient experience and quality).

Engagement Events – 'Good Better Best'

At the heart of the L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important was the large scale, trust wide 'Good, Better, Best' events where all staff came together to identify quality priorities and monitor progress in improving clinical outcome, patient safety and patient experience. The events also provided the opportunity to feedback the progress on quality, reflect on patient safety and the patient experience and hear about new initiatives for health and wellbeing and the Freedom to Speak Up Guardian.

Raising Concerns and Freedom to Speak Up Guardian

We have continued our focus on encouraging our staff to raise any concerns. In October 2016 we appointed a Freedom to Speak Up Guardian. The new role was presented to over 2000 staff at the Trust Engagement Events. The role has a dedicated email and telephone number so that staff can access it confidentially. A report is made to the Board of Directors and an oversight of the process is reviewed by the Audit and Risk Committee.

Service Developments planned for 2017/18

Strategic and Corporate:

- **Become a Centre for Global Digital Excellence (GDE) and STP Digitisation** – The GDE Programme will allow us to improve many of the systems our clinicians and staff are currently using, and allows further integration to deliver a more user friendly interface. As we are an e-Hospital our ward rounds and other consultations are captured and supported by electronic records, and the current paradigm is disjointed necessitating the need to view a number of media at the same time to obtain the whole clinical picture and capture actions. The new systems we are implementing will allow a more holistic view of the patient record, and also allow access away from the hospital to allow continued care by the same or other multi-disciplinary teams. We will be choosing our new systems and also upgrading our e-records system to allow more intelligent indexing and key word searching to navigate the record more intelligently.

- **Further develop the electronic prescribing system** - The e-Pharmacy system will be further developed to link bar codes to patients and to drug administration, increasing the safety of the end to end process and also linking this to procurement and stock control to improve our drug wastage and intelligent management of our pharmaceuticals. We will be further advancing the Unified Communications platform to integrate with our clinical systems so we can have closed loop functionality to support the linkage of alerts to responses. We will be continuing the work on the infrastructure to ensure an up to date environment for hardware, and ensure all of the systems are upgraded in a timely way so we can keep ourselves ahead in terms of functionality and reliability.

- **Participate in further work with our STP Partners** - We are also working with the STP Digitisation group to link our systems up to our other STP partners to support our new ways of working. Bedford Hospital will be a fast follower for our GDE Programme and this will mean the two IT platforms are aligned, allowing greater record sharing and interconnected working for our patients. We will continue with our planned upgrades and the programme of work, including the delivery of our new Pathology information System, crucial to the delivery of the Trusts clinical services.

Surgical Division:

- **Expand Oral and Maxillofacial Surgery** - Work is due to start in May 2017 to expand the Oral and Maxillofacial Surgery (OMFS) department. This will involve the creation of five new clinical rooms providing much needed capacity for both Oral Surgery and Orthodontics. This will enable the L&D to continue to act as the centre for the OMFS network which covers Bedfordshire, Hertfordshire and part of Buckinghamshire as well as providing the capability for future additional services (such as Restorative Dentistry) to be provided from the department. The work is expected to be completed in August 2017.

- **Develop Ear, Nose and Throat (ENT) services** - ENT will be replacing the equipment in two of its Outpatient clinical rooms with modern workstations allowing for a full range of diagnostics to be conducted. Currently work is underway to look at the feasibility of expanding this project to include a third room.

- **Improve the pathway for Emergency Surgery** – The Division has established a working group to improve pathways across emergency admissions to reduce length of stay and improve outcomes and patient experience. Specific workstreams include discharging patients home earlier in the day, improving effectiveness of the surgical ward round and improving the productivity of our emergency and trauma theatres.

- **Develop an E-referral in Urology** – The first surgical service to go live with e-referral will be Urology. This will allow faster turnaround of referrals. It will also streamline the outpatient element of the pathway by enabling consultants to easily order tests in advance of the first appointment.

- **Repatriate Breast Genetics Service** – In 2017/18 the breast surgery service is planning to repatriate the genetic counselling service which is currently being provided by The Royal Free. This will enable patients to have their genetic counselling provided by the same consultant who has been managing their surgical care.

- **Develop Paediatric Surgical Services** – We are looking to build on the appointment of the paediatric orthopaedic surgeon and further expand our paediatric surgical services by appointing a consultant paediatric general surgeon towards the end of 2017/18. We will be developing links with Great Ormond Street Hospital to offer more complex surgical treatment for children closer to home.

- **Develop an Integrated Pain Service** – In order to reduce waits for patients with chronic pain a multi-disciplinary triage service for chronic pain referrals is being developed. This team will triage and stream all pain referrals received by the Trust to the most appropriate service for individual patients, including consultant and nurse led pain services as well as physiotherapy and psychology services in order to minimise unnecessary appointments for patients and ensure all referrals are seen by the most appropriate clinical team first time.

- **Develop the Haemato- Oncology Unit Staffing** – To support the delivery of inpatient chemotherapy following successful recruitment, a training and competency programme is underway to develop the nursing workforce. The chemotherapy and haemato-oncology units will work closely to ensure effective clinical governance across both units.

- **Improve the patient and family experience in End of Life Care** – The End of Life Care team will continue to focus on the ability to access the community electronic record (via SystmOne) to enable access to the advanced care plans, ongoing delivery of training programme to improve communication and decision making with patients and families, as well as improved symptom management and spiritual care, and to continue to listen to what really matters to patients and families.

- **Further develop chemotherapy e-prescribing** – The cancer teams will further develop e-prescribing to ensure full 'roll out' to all clinical areas and identify the opportunities to offer shared care with Mount Vernon Cancer Centre and enable some patients to be treated locally (adults).

- **Continue to develop Specialist Palliative Care services** - The services will be continue to be developed to support further improvements in the delivery of End of Life Care, and to adopt a whole system approach and develop a greater resilience in Consultant Palliative Care cover arrangements.

- **Implement the 'Amber Care Bundle'** – The Bundle is a systematic approach to managing the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in one to two months. This contributes towards patients being treated with greater dignity and respect, enabling patients to achieve their preferences and also having a positive impact on multiprofessional team communication and working.

- **Complete the roll out of the Recovery Package** – The full recovery package includes a Holistic Needs Assessment and Care Planning, Treatment Summary, Cancer Care Review, and Health and Wellbeing Events. The Division plan to roll this out to all tumour sites to better support and improve the quality of life of people living with and beyond cancer.

- **To achieve access to System One** - The Division are aiming to ensure that the community patient electronic record which enables key people to access important advanced care plans and preferred place of death information is accessible to the relevant staff within the cancer team.

Medicine Division:

- **Continue to develop support for performance monitoring and decision making** – The continued development of directorate dashboards will be maintained through the year including appropriate escalation through Medicine Executive and Clinical Operational Board for executive guidance to support strategy and decision making.

- **Further implement service line management/ reporting** – Work being progressed will see further refinement with Service Line Reporting utilisation for financial planning including Cost Improvement Plans and Finance Recovery Plans.

- **Commence reviews of the Integrated Sexual Health Services for Luton Borough Council** – The service was established in April 2016 and during the year further monitoring and reporting on the effectiveness and quality of the services will continue.

- **Continue the implementation of all case mortality reviews** – Quarterly mortality forums will continue to identify contributing factors and themes for improvement and to increase awareness, reduce variability and share areas of best practice. Audits will continue to be taken based on triggers.

- **Continue Rheumatology service development** – Further business planning is in progress to develop bone services to support patient care and experience.

- **Further progress towards becoming a Hyper Acute Stroke Unit** – Work will continue on specific challenges such as increasing specialist nurse recruitment and psychological care will further improve our overall unit performance.

- **Further develop the Ambulatory Care services** – A 7 day pilot commenced at the end of 2016/17 which following its review will determine permanent expansion to a 7 day model in the second half of 2017/18.

- **Continue transition to a Needs Based Care model** - An overarching business case will be drawn up to support the progression of the Needs Based Care model. This will include further formalisation of 7 day working through job planning, specialty in reach and Needs Based Care. Planned implementation is in August 2017 to align with the junior doctor contract changes.

- **Approve new decontamination equipment** – Endoscopy is integral to diagnoses and ongoing surveillance of gastro-intestinal cancers and a wide range of non-cancer related conditions. A business case for a new decontamination facility, a fourth endoscopy procedure room and additional equipment to support an increasing demand is underway.

- **Continue clinical engagement with Medicine across the STP** - Work is underway with individual medical specialties across the STP to engage them in discussions around planning and developing future services, which is already producing positive results.

Women & Children's Division:

- **Make further improvements to the Neonatal unit** – The Division plan to redesign and re-commission the high dependency nursery to enhance infection control standards and improve the experience for parents and staff in the unit. Work will also be completed to improve expressing and breast feeding facilities on the unit.

- **Further improve community based services** - The gynaecology service is working closely with Luton and Herts Valley CCGs and other local providers to ensure there are effective community based services working collaboratively with primary care to effectively manage demand for services.

- **Develop the GP/Consultant connect service** - The paediatric service will take forward the newly established GP/Consultant connect service to ensure there are responsive pathways of care to reduce where possible the demand for secondary care provision.

- **Implement the Better Births and Saving Babies Lives programmes** - Maternity Services are at the forefront of plans for the effective implementation of Better Births and Saving Babies Lives programmes. The Division will work in partnership across the STP and local stakeholders to map out options for future service delivery.

- **Develop an ambulatory service for patients in early pregnancy** – The early pregnancy team will take forward plans for an ambulatory service to enhance patient experience and reduce inpatient stays through the development of services such a community hyperemesis management.

- **Develop the gynaecology nursing roles** – The gynaecology nursing team is taking forward opportunities for nurses to develop enhanced nurse led procedures in urodynamics and hysteroscopy.

- **Further develop the scanning access within the fertility service** – The Fertility Nurses will complete competency testing in scanning to enable them to provide independent scans for our fertility and IVF patients.

- **Recruit a paediatric nurse specialist for haematology** - The paediatric team have been successful in their application for two year funding for a Roald Dahl (Roald Dahl nurses support children living with a variety of serious, rare and undiagnosed conditions) paediatric nurse specialist for haematology. This post will be recruited in 2017/18 and provide much needed support for children and families managing complex blood disorders such as Thalassaemia.

- The Womens and children's team are working closely with the Five to Thrive team in Luton to introduce the Baby Buddy Mobile App ensuring accredited information is available to parents locally.

Diagnostics, Therapeutics & Outpatients Division:

- **Invest in new scanning equipment** - The Imaging department will replace the two existing MRI scanners with new digitised equipment. In nuclear medicine the gamma camera will be replaced with CT SPECT technology that will improve service resilience and efficiency while also enabling a wider range of scanning functionality, and improved image quality.

- **Continue improvements to 7-day services** – Pharmacy are introducing a 7-day clinical service in acute medicine, while imaging is expanding access to outpatient x-ray at weekends and inpatients needing non-vascular interventional procedures will benefit from improved access daily, Monday to Friday.

- **Continue improvements to outpatient facilities** – Zone B will be benefiting from some redevelopment and refurbishment works to meet increased demand and provide more clinical space, while the outpatient administration office is being relocated to facilitate expansion of Maxillo-facial outpatient services

- **Develop a joint Breast Surgery and Screening Unit** – a collaboration between Breast Screening and Surgery is looking at the potential to expand clinical services iwn to the old squash court facilities adjacent to Breast Screening. Patients will benefit from co-located services, freeing up outpatient accommodation within the main department for much needed service growth.

- **Improve therapy services to patients** – the Division is committed to improving both staff experience and service resilience, and is progressing the in-sourcing of Speech and Language Therapy services through direct employment of staff to the Trust.

- **Improve mortuary services** – in recognition of demographic changes within the population, mortuary capacity is being expanded, with new storage facilities to improve service resilience.

- **Continue the development of Haemato-oncology services** – having established a dedicated inpatient unit, training to support and develop staff in oncology inpatient management is being progressed, as is the development of a specialist adult sickle cell and thalassaemia nurse.

- **Implement the Pathology Laboratory Information System** – the new laboratory information system (LIMS) implementation is underway and on completion, will facilitate further service developments and opportunities to consolidate Pathology services.

- **Improve anticoagulation services** – a nurse prescriber led novel oral anti-coagulant (NOAC) clinic is being established, to support patient education and choice in anti-coagulation therapy.

- **Support sustainable transformation (STP)** – the Division is actively involved in the BLMK STP programme, progressing opportunities for collaborative working for improving the effective and efficient use of resources across Pathology, Imaging Pharmacy and Therapies.

Operational performance report

Principal activities of the Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital 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 90,000 admitted patients, nearly 400,000 outpatients and Emergency Department attendees and we delivered over 5,300 babies.

We serve a diverse population most of whom are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile. There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 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 L&D has developed a range of specialist services including cancer, obesity, neurophysiology and oral maxillofacial (jaw) surgery. We have the responsibility for treating the most premature and critically ill newborn babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

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

The Trust has a strong and robust clinical management culture; all clinical services are managed by Clinical Chairs, Divisional Directors, supported by Clinical Directors, General Managers and Senior Nurses.

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 2016/17 Divisional Directors, General Managers and Executive Directors met in the Executive Board.

Divisional Executive Meetings are also in place with each of the Clinical Divisions in order to increase clinical accountability at specialty level.

Other Executive meetings are dedicated to the Clinical Operational Board that reviews the clinical performance of the Trust and Re-Engineering programmes that focus on the quality improvement programmes and efficiency including financial recovery plans.

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

Review of Operational Performance

Key performance targets 2016/17

We assess our own operational performance against external national targets published by the Care Quality Commission (CQC), the NHS Improvement Risk Assessment Framework, Single Oversight Framework and other locally agreed contracts, with the support of external peer review and other external expertise.

Activity

- During 2016/17, the L&D continued consistently to deliver against national quality and performance targets, achieving an NHS Improvement governance rating of green throughout the year.

In addition, the L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- Met the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in all quarters.
- Met all of the cancer targets for the year. The Trust has delivered one of the most consistent cancer performances in the country.
- Had excellent performance for C Difficile maintaining a low rate of 8 (one of the lowest in the country and below the de minimis of 12) but this did exceed the agreed contract threshold of 6.
- Reported 1 MRSA Bacteraemia which is also under the de minimis of six for reporting to NHS Improvement.
- In 2016/17 the NHS Improvement Single Oversight Framework included the six week diagnostic target as a new part of the assurance process. The Trust has met the target for every month since it was introduced in October 2016.

The table below summarises how our operational performance described above is interpreted against the national objectives by CQC and NHS Improvement.

L&D Performance against CQC and NHS Improvement Targets

	Threshold				
Total time in A&E - ≤4 hours (Whole site %)	95%	Q1	Q2	Q3	Q4
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:					
Surgery	94%	Q1	Q2	Q3	Q4
anti cancer drug treatments	98%	Q1	Q2	Q3	Q4
radiotherapy	94%	N/A	N/A	N/A	N/A
Cancer: two week wait from referral to date first seen (7), comprising either:					
all cancers	93%	Q1	Q2	Q3	Q4
for symptomatic breast patients (cancer not initially suspected)	93%	Q1	Q2	Q3	Q4
All cancers: 31-day wait from diagnosis to first treatment (6)	96%	Q1	Q2	Q3	Q4
All cancers: 62-day wait for first treatment (4), comprising either:					
from urgent GP referral to treatment	85%	Q1	Q2	Q3	Q4
from consultant screening service referral	90%	Q1	Q2	Q3	Q4
Referral to treatment waiting times - Incomplete pathways	92%	Q1	Q2	Q3	Q4
Clostridium Difficile - meeting the Clostridium Difficile objective of no more than 6 cases/year	6 (12 diminimus)	Q1	Q2	Q3	Q4
MRSA - meeting the MRSA objective of no cases/year	0 (6 diminimus)	Q1	Q2	Q3	Q4

Achieved

Regulatory Quality CQC Performance

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

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

The Luton and Dunstable University Hospital NHS Foundation Trust is fully registered with the CQC and its current registration is **Registration without Conditions.**

No enforcement action has been taken against the Trust during the reporting period April 1st 2016 and 31st March 2017 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

The CQC monitor, inspect and regulate care services to ensure patients receive safe, effective, compassionate, high quality care. To really measure the patient's experience of care, they have identified five key questions based on the things that matter to patients. The CQC will ask these questions of every service.

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?
- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?
- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs. **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.

Our ratings for Luton and Dunstable Hospital

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Urgent and emergency services	Good	Good	Good	★ Outstanding	★ Outstanding	★ Outstanding
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	★ Outstanding	Good	Good	★ Outstanding	★ Outstanding
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	★ Outstanding	★ Outstanding	★ Outstanding

- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 formally to inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016. The CQC Inspection Report did not mandate any actions for the Trust. However, it did highlight a number of areas for further improvement. Each Division was asked to undertake a detailed review of the inspection report and develop an action plan paying particular attention to the "Requires Improvement" ratings within Medicine and Critical Care.

Progress against specific action plans is monitored through the various Divisional Governance processes and oversight of compliance and progress is monitored through the Clinical Outcome, Safety and Quality Sub-Committee of the Board. Any key areas have also been included in our Quality Priorities for 2017/18.

Medicine

1. A number of the key areas highlighted for improvement formed part of the Trust's quality priority for 2016/17. These included the timely administration of antibiotics for patients with sepsis and completion of VTE assessments. Ongoing audits are in place to monitor progress and have demonstrated an improvement in performance.

2. Another of the key areas for improvement was the medical model of care within Acute Medicine and Elderly Medicine. The report highlighted the number of Consultant handovers that resulted in a lack of continuity of care. The Trust has committed to an ambitious programme that will see the Trust move from an Age Based to a Needs Based Care model that has continuity of care as its key principle. This work will continue in 2017/18 and will be considered across all specialties and forms one of the Quality Priorities for 2017/18.

3. A comprehensive Stroke Action Plan was further developed to incorporate feedback from the CQC report. The actions have been aggressively progressed with significant improvements across all the component parts. This is also monitored at each meeting of the Board of Directors to monitor compliance.

4. Mandatory training compliance, particularly for conflict resolution, safeguarding children level 3 and infection control has improved with clear expectations and monitor processes in place.

5. The report raised some concerns with the inconsistency in the recording of medicine administration and delays in dispensing discharge medication. The Trust has invested in an electronic prescribing system that has removed the inconsistency in recording medicine administration and this has been rolled out to the majority of clinical areas. A pilot project was run that used pharmacists on ward rounds to write take home medications which resulted in a reduction in the discharge delays. A business case has been prepared to support the roll out across all wards.

6. The rising Trust HSMR was a key area of concern raised by the Trust to CQC in the preparation for the Inspection. Within the Inspection Report a number of recommendations were made to support the ongoing work on the Trust in relation to this matter. At the time of the inspection Mortality was discussed as part of their governance meetings within Medicine. However, the Division agreed to ensure that these have more focused attention and quarterly Mortality Meetings are in place where case reviews are shared and learning takes place. Mortality meetings are held in all Divisions within the Trust. The Mortality Board oversees the review of deaths across the Trust, monitors trends and receives reports from any alerts raised through the Dr Foster benchmarking system. We have also maintained HSMR as a Quality Priority for 2017/18.

7. Delays to discharge were highlighted as an area for further improvement. A Discharge Hub has been developed to provide a focus on understanding the delays within the patient pathways and expediting and escalating any delays in patient progress through the pathways or barriers to discharge. Daily meetings with Executive level oversight are in place to monitor progress. Reducing length of stay will form part of our Quality Priority for 2017/18

Critical Care

During the inspection concerns were raised in relation to the environment and bed spacing within the High Dependency Unit. Immediate action was taken at the time of the inspection and the number of beds reduced from 15 to 11.
A further concern was raised in relation to the lack of a clear policy on the sedation of patients with delirium in HDU. This was investigated immediately and before the end of the inspection process we had ensured that all staff had signed up to the Trust Policy.

This immediate response was commended by the CQC.

The Inspection process provided opportunities to further improve systems and processes within the HDU;

1. Electronic prescribing and pharmacist rounds in critical care were introduced and the recruitment of a practice development nurse improved training opportunities.

2. A blood gas analyser was made available on HDU and the training was put in place accordingly.

3. Clinical management model has changed making it easier for staff to know who had clinical ownership of the patient.

A number of improvements remain in progress:

1. Discharging patients from the Unit during working hours remains challenging due to the high bed occupancy across the clinical specialties. Every effort is made to step patients down from Critical Care during working hours however it is not always possible. The Critical Care Outreach team has been expanded to provide 24/7 cover for the wards. This mitigation is in place to support the late transfer out of patients while work is ongoing to reduce length of stay and bed occupancy.

2. The importance of HDU contributing to the ICNARC database was raised within the report. This is planned for 2017/18

3. It is recognised best practice to offer a Rehabilitation of the Critically Ill Patient follow up clinic to patients who have been treated in Critical Care. Unfortunately this service is not currently commissioned by the CCG however the Trust is working with the CCG to agree how we might be able to deliver these clinics.

Other Service Improvement

The CQC Inspection Report provided opportunities to make further improvements. This included areas that had been given a Good or Outstanding rating. The following improvements have been achieved in 2016/17:

- The End of Life Care Team put in place regular audit processes to review the patient's preferred place of dying and monitor whether that was achieved. The results are fed back into a working group. There is one ongoing action for full access to System One to view all the Advanced Care Plans completed in the community and to share changes made during admission to the Trust. This forms part of the surgical division plans for 2017/18.

- Maternity and Gynaecology metrics and parameters were agreed for the gynaecology dashboard; a substantive bereavement midwife is now in post; information leaflets in relation to terminations are now provided in other languages and CCTV has been installed throughout the maternity unit.

- Surgery teams have made good progress with their action plan ensuring that audit data is complete before submission and that the audit results, incident reporting and friends and family scores are shared at their Clinical Governance meetings. There has been good progress ensuring that the VTE re-assessments are completed. A number of actions remain ongoing for delivery in 2017/18:

  - New guidance on consent has recently been received from the Royal College of Surgeons regarding standards when consenting patients for theatre and this has delayed the changes planned following the CQC visit. The Trust Policy has now been updated and it is anticipated that the new consent form will be available in other languages in early 2017/18.
  - High bed occupancy rates within surgery lead to delays in patients leaving theatre recovery and this in turn is not a good patient experience. Work is underway to look at a number of measures that can be implemented to improve the flow from recovery. A recent workshop between Patient Flow and theatres has ensured joint ownership and further actions have been agreed.

- Infection rates for knee replacement are higher than the national average. A key component of the patient's care is to provide rapid assessment of patients with potential infections (via rapid assessment clinic). The teams began a pilot in quarter 4 of 2016/17 to address this issue and recommendations for the future service will be agreed following this pilot.

- Outpatients, Diagnostics & Imaging team has ensured that cleaning schedules are visible in all clinical areas and have refurbished imaging and the outpatients staff room that were in need of modernisation. Partial Booking has been rolled out across the Trust and this has had a positive impact on the number of cancelled appointments and the number of patients not attending their appointments.

- A Children and Young People electronic prescribing system has been implemented in paediatrics. The Surgical and Paediatric teams have worked together to agree a process that ensures a Paediatric nurse is present in theatre and this post is currently open for recruitment.

- The Urgent and Emergency Care team have improved processes to ensured there is always consistency between the electronic and the paper record in ED in relation to the information they hold on safeguarding. Recording of ambulance arrivals was improved with an interim solution and in March 2017, the Symphony system was upgraded to allow this to be recorded electronically.

Transforming Quality Leadership 'Buddy' System
We re-launched a wider more focussed programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete a cycle of visits every two months against one of the CQC domains. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team. The results are reported to each Board of Directors meeting.

Non-Executive Assessments (3x3)
The assessment process is further enhanced by Executive and Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.

Quality of Governance

We have ongoing monitoring of quality governance through the committee structure which is detailed in the Governance section of this report. Further information about how we review quality is contained within the Quality Account section of this report. Assurance in relation to our Assurance Framework and internal control is contained within our Annual Governance Statement.

Regulatory Performance Ratings

NHS Improvement, which regulates all NHS Foundation Trusts, allocates risk ratings for each quarter against their risk of breach of authorisation as a Foundation Trust.

NHS Improvement monitored the Trust from April - October 2016 using their Risk Assessment Framework and from October 2016 - March 2017 using their Single Oversight Framework.

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation
The Trust is in segment 1. This segmentation information is the trust's position as at 7th April 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources
The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	2	1
	Agency spend	3	3
Overall scoring		**2**	**1**

We had no formal interventions.

Activity Performance Analysis

The table below identifies those areas where demand has changed by comparing the actual contracted activity to that planned.

Point of Delivery	Currency	FY16/17 Plan	FY16/17 Actual	FY17/18 Plan	Y2Y Change
Elective	Spells	37,422	35,818	38,245	6.78%
Emergency	Spells	35,953	37,947	39,066	2.95%
Non Elective	Spells	21,389	20,807	21,565	3.64%
Maternity Pathway	Pathways	11,288	11,391	11,394	0.03%
First Outpatients	Attendances	71,290	75,914	77,547	2.15%
Follow up Outpatients	Attendances	179,535	181,431	186,434	2.76%
Outpatient Procedures	Procedures	104,818	108,416	109,570	1.06%
Same Day Chemo	Attendances	3,957	4,117	4,220	2.50%
Unbundled Imaging	Images	38,693	38,239	38,437	0.52%
Direct Access Radiology	Images	60,825	59,765	61,498	2.90%
A&E	Attendances	96,546	101,027	107,059	5.97%
Critical Care	Days	22,157	19,701	20,543	4.27%
Direct Access Pathology	Tests	1,052,231	1,072,473	1,107,687	3.28%
Pre - assessment	Attendances	13,962	14,768	15,262	3.35%
Breast Screening	Screens	54,648	56,820	58,489	2.94%

In 2016/17 our commissioners anticipated substantial CIP reductions. Despite their endeavours planned reductions on activity did not occur and emergency activity, in particular, has shown a significant increase in non-elective work. In the latter stages of the year we have seen a reduction in elective referrals, although referrals from Hertfordshire continue to rise.

The Hospital performed well to accommodate this unplanned activity without compromising a range of national target indicators, increasingly services such as hospital at home and ambulatory care to absorb the demand. However, this activity could not be provided within existing employed staffing levels and consequently the Trust incurred substantial temporary staffing costs.

Research Performance

Ongoing clinical excellence at the Luton and Dunstable University Hospital NHS Foundation Trust is supported by high quality research and a robust evidence base. The Trust's aim is to undertake high quality research that addresses issues of concern to the local population and to the NHS as a whole. High quality research provides the evidence with which to practise 'evidence based-medicine'. It provides the evidence that contributes to patient safety while providing a 'gold-standard' reference.

The current NHS Five Year Forward View (October 2014/19) states that:

'Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine'.

The Trust's research strategy emphasises strengthening research through collaboration with the Department of Health funded UK Clinical Research Network (UKCRN), the National Institute for Health Research (NIHR) in England via the Clinical Research Networks (CRNs), local Clinical Commissioning Groups and Academic links. The Trust is a member of **CRN: North Thames** whose remit is to provide researchers with the practical support to facilitate clinical studies in the NHS and increase research across England.

This practical support includes:

- Reducing the "red-tape" around setting up a study.
- Funding the people and facilities needed to carry out research "on the ground" so research activity does not drain core NHS resources.
- Helping researchers to identify suitable NHS sites to recruit patients to take part in research studies.
- Advising researchers on how to make their study "work" in the NHS environment.

Recruitment to NIHR Portfolio studies at the L&D for 2016/17 was 938 as compared to our projected target of 605. In CRN North Thames the bar is set high in respect of recruitment and quality but we are confident we are up to the challenge, particularly with the additional funding from CRN North Thames to appoint research nurses.

Research issues and studies approved to be undertaken at the Trust (via the Research & Development Department) are presented at the quarterly Division of Medical Education and Research (DMER) Committee meetings. There are currently 140 active research studies in which 38% of our consultants are involved.

The Trust's Annual Academic Report for 2016/17 will be available from September 2017. However, the Annual Academic Report for 2015/16 reported that, in addition to the 157 ongoing research studies during that year, publications by Trust staff included 85 Scientific Papers; 31 Abstracts and 9 Books or Chapters in Books.

Education and Performance

Medical Education

Medical Education continues to be a priority for the Trust. Over 2016/17 we have provided a high standard of both undergraduate and postgraduate training. All of our Educational Supervisors have had to attend formal training to be appointed as Educators and have had an annual appraisal for their educational role. This process has strengthened the standard of training and the governance of the process.

Undergraduate

The feedback from informal visits by the University College of London continue to be positive. The Directors regularly review the student placements to allow for adjustments to be made to improve the student experience. Formal student feedback at the end of placement and following the student examinations continues to rank the Luton and Dunstable University Hospital as one of the best placements. We have again successfully completed the final exams in March with good support from our in-house examiners.

Postgraduate

We are committed to ensuring that the quality of training for postgraduate medical and dental trainees delivers the requirements of the curriculum. During 2016/17, we hosted Health Education East of England School visits for Medicine (Department of Medicine for the Elderly, DME), Obstetrics and Gynaecology (O&G), Paediatrics and Neonates, General Practice, Ophthalmology and Anaesthetics. Any required actions were either implemented immediately or have action plans in place to sustain improvements.

After these visits, the main requirement that needed quick action was the placement of GP trainees in Trauma and Orthopaedics (T&O). This was appropriately managed with reallocation of the trainees into other clinical areas. There continues to be on-going work with the T&O team to support the changes needed to improve the training environment and thereby review the potential of re-allocating trainees to the department. For the other visits there were recommendations and requirements which are being addressed within the department with support from the DME team. The issues around Medicine and O&G have improved and work continues to be done to sustain the improvements.

Medical Revalidation

There are over 370 doctors within General Medical Council (GMC) Connect who have identified the Trust as their designated body for Revalidation. We support all doctors to prepare for their individual revalidation with the GMC which is required every 5 years. We offer access to 360° feedback at least once in every 5 years and doctors are enrolled onto a customised website which holds a portfolio of evidence in preparation for appraisal each year. This online web-based portfolio of evidence is a full record of the doctor's whole practice and provides comprehensive information towards revalidation.

We continue to focus on ensuring that doctors are made aware of their responsibilities and can confidently prepare for and successfully go through the revalidation process. Each doctor is supported by their appraiser and the Revalidation Team comprising the Responsible Officer, his two deputies and the Revalidation Support Officer. This has a positive impact on the quality of appraisal which has improved dramatically since the introduction of Medical Revalidation. We report on a quarterly and annual basis to NHS England and our performance is benchmarked against other NHS Trusts.

Pre-Registration Education for Nurses and Midwives

We currently provide placements for pre-registration nursing and midwifery students. Recently the University of Bedfordshire has commissioned a paramedic student programme and we are supporting them with placements here. We also support students from other universities with elective placements. These students come here under our honorary contract system. The quality of placement standards has continued to be monitored yearly via a qualitative and quantitative assessment through the Quality Improvement Performance Framework (QIPF). This framework is monitored quarterly against an action plan to ensure continuous improvement. All placement areas are reviewed yearly against placement audits. Our performance against this assessment is good and we strive to meet all the requirements of the regional Learning and Development Agreement.

We have continued to use student feedback on both the Higher Education Institution and the Trust placement to review the quality of placement areas. Each student, depending on year, is allocated a qualified mentor who has undertaken a recognised mentorship course. Third year students on their final sign off placement are allocated a sign off mentor who is responsible for signing them off to go on to the Nursing and Midwifery Council (NMC) register.

To monitor quality, we undertake a formal assessment of the performance of the University of Bedfordshire and the University of Hertfordshire using nursing education quality indicators as a benchmark. Annually, 160 nurses and 60 midwives are trained in partnership

with the University and the Trust. However, due to the current government changes to student bursaries from September 2017, it is unclear what impact changes in funding will have on student numbers during 2017-2018.

Collaborative Learning in Practice (CLiP) is a model of nurse training on the wards that is based on individual and group coaching led by a trained nurse coach. Following successful trials of the approach on three wards, it now being rolled out to 8 wards across the Trust. This approach to nurse development 'on-the-job' increases confidence, develops proactive learners and prepares 3rd year student nurses for their first qualified posts.

Widening Access to Training

The Foundation Degree (FD) is the qualification required of our Assistant Practitioners currently being employed in specialist areas of the Trust and more recently on general elderly care and medical wards.

From the September 2015 intake, 6 Health Care Assistants completed the Foundation Degree. 5 members of staff commenced in the September 2016 cohort, and 6 staff have submitted expressions of interest in joining the March 2017 cohort. More staff are needed to take up the FD in order to increase the number able to apply for the flexible nursing (FN), programme (1 out of the 6 applied for FN in Sep 2016). We encourage this flexible approach to provide as many opportunities to staff and to boost our the numbers of staff working with patients.

The Trust is also working across the local STP footprint to become a test site for the Nursing Associate role which is similar to the Assistant Practitioners we have in place. The Foundation Degree will be slightly adapted to ensure it covers the elements of the role as established by the recent 'Shape of Caring' review of nurse training. We have interviewed and will be offering 10 places across the organisation to successful candidates. The programme started on 3rd April 2017 at the University of Bedfordshire.

Pre-Professional Workforce

In accordance with the recommendations of the Cavendish Report, all new clinical support staff undertake the Care Certificate to ensure they have the knowledge and skills to care for our patients safely. This must be completed within 12 weeks of commencement of employment. In addition it has been agreed that if they do not currently hold a recognised Health and Social Care qualification they will complete the Apprenticeship in Health after which they have the option to consider the Foundation Degree or Nursing Associate courses. This provides a pathway into nursing for those staff who wish to progress further in their careers.

Nurse Revalidation

All nurse and midwifery registrants are now required to demonstrate they remain fit to practise to another 3rd party every three years in accordance with The Code, 'Professional standards of practice and behaviour for nurses and midwives', updated in March 2015. The start date for the process formally commenced 1st April 2016. As a Trust we had 333 registered nurses due to revalidate in 2016 and have achieved 100% compliance as of January 2017.

Streamlining Mandatory Training across the Region

Following a comprehensive review of our mandatory training provision, the Trust was able to submit a declaration of alignment to the Skills for Health Core Skills Mandatory Training Framework (CSTF) in December 2016. This has now been accepted, providing assurance that our training is sufficiently comprehensive and standardised across the East of England, and potentially paving the way for greater transference of CSTF aligned training across organisations. The next phase of the project is to review our approach to Induction for those staff already holding CSTF competencies, with a view to streamlining their pathway through commencement and out into clinical practice, whilst still maintaining high standards of training compliance and safety. This will lead to savings in time undertaking training when clinical staff move roles between NHS organisations.

Personal and Continuous Professional Development

An annual training needs analysis informs our bid for regional funds for Continuing Professional Development. This complements discussions at appraisal when individual personal development plans are developed with staff and their career aspirations discussed as part of a talent management conversation. Each year, we develop and publish our comprehensive training brochure which covers a wide range of programmes including mandatory training; health and safety, clinical skills, leadership and management development, apprenticeship qualifications, communication skills and IT training.

We have retained access to an excellent resource for leadership and management development through the Ashridge Business School. All staff can use materials

from the Ashridge website through the Intranet and we recommend it as a resource for all our management and leadership interventions. We also actively promote e-learning and continue to provide supported sessions for staff to undertake their mandatory training, where appropriate. We have increased our resources for e-learning in partnership with Library Services which benefits all staff including junior doctors who are required to complete on-line learning prior to starting their placement here.

In order for registered staff to update their clinical knowledge and skills, they attend higher education modules funded by Health Education East of England. In addition, staff are able to access specialised courses linked to their professional development at appropriate centres of excellence nationally such as Great Ormond Street Hospital.

A Special Mentoring Scheme

We successfully completed our mentoring scheme for Advanced Level students interested in a career in medicine in partnership with Luton Sixth Form College. The students were offered mentorship by consultants employed by the Trust and through this route they were introduced to what it is like to work in the hospital. The mentors also offered the students advice on the application process for medical school and how to prepare themselves for interview. Some students were successful in starting a medical degree and two others have deferred their applications to gain more work experience. All agreed that the whole experience was beneficial in building confidence and understanding of the options for a medical or scientific career.

Overseas Nurses

Since April 2014 we have recruited 155 overseas nurses of whom 102 remain in the Trust. They all have a tailor-made induction programme over 3 weeks which incorporates assessment of their prior learning and skills and time on their wards. The nurses then have the preceptorship competencies to complete which assesses their knowledge and skills in practice.

Nurses recruited from non-EU countries are supported by the Clinical Education team to prepare them for their Objective Structured Clinical Examination (OSCE) after which they are registered with the Nursing and Midwifery Council (NMC).

All EU nurses now have to provide evidence to the NMC that they meet the English language requirements they set. It is only once these are met that their registration proceeds. To ensure that all the nurses have a reasonable standard of English, they are assessed at interview as part of the screening process prior to submitting their documentation to the NMC. Prior to commencing employment our EU appointed nurses attend a residential placement and sit their International English Language Testing System IELTS) with the aim of them obtaining the required level for registration. To support English language development, we are offering English classes to prepare some of our existing staff who require professional tuition to pass their IELTS which this will enable them to proceed with their registration with the NMC.

Apprenticeships

The Trust has enrolled 77 new learners to an apprenticeship qualification since 1 April 2016 against a Health Education East of England target of 70 for this financial year. Currently the Trust has 137 staff enrolled to an apprenticeship. We are the first Trust in the East of England to offer a Chartered Management Institute Management and Leadership Level 5 Apprenticeship qualification, and building on the success of the first two cohorts, the third group will commence in May 2017.

The Trust continues to broaden the range and level of apprenticeship qualifications that we are engaged in, and to offer apprenticeship qualifications at levels 2,3,4 and 5.

The introduction of the Apprenticeship Levy in April 2017 requires the Trust to pay 0.5% of the value of its payroll into a digital account which can then be drawn down for paying apprenticeship qualification providers. In order to ensure that we get best value, we are planning to expand the number of apprenticeships that we offer internally for Trust staff as well as actively seeking the best candidates to recruit from externally. Our apprenticeship team will work closely with partners across the STP to ensure that we collaborate to facilitate qualifications for a range of clinical professionals such as theatre and blood sciences staff as well as providing qualifications in business administration for support staff.

Leadership Development

We encourage development through our talent management process which is embedded in appraisals and we continue to identify future leaders across the Trust. Staff survey results for 2016 indicate that staff appreciate the quality of appraisals that take place with line managers with a focus on staff development as well as performance.

The 'Leading Safe and Effective Quality Patient Care' programme is continuing with further groups of ward managers, clinical nurse specialists, midwives and allied health professionals. The package on offer includes the option of external coaching through a regional coaching network in Bedfordshire and Hertfordshire and completion of a 360º feedback process based on the NHS Healthcare Leadership Model.

During 2016 we established a customised programme for newly appointed consultants to support them in their new role. The programme offers provision of specialist on-line training, a New Consultants' Forum with regular sessions in a range of useful topics and the offer of a senior consultant as a mentor. This provides a supportive, developmental environment for consultants who join the Trust.

In addition we have worked with senior medical leaders to identify their development needs in senior management roles and we now offer a number of opportunities including coaching, workshops, master classes and one-to-one personal development to support doctors working in a challenging leadership role.

The NHS Healthcare Leadership Model continues to be promoted internally and we have increased the number of feedback facilitators in the Trust. Uptake of the 360º feedback model is increasing as staff see the benefit of receiving in-depth feedback on their performance as managers and leaders. This has a positive impact on the culture of the organisation.

Coaching takes place regularly for senior staff, where appropriate and helpful, and we are developing our approach to Health Coaching so that we can support patients with long-term conditions to manage their health in collaboration with their clinician. We have been running our own internal programme for clinicians and have trained a significant number of staff across specialities, particularly those clinicians dealing with patients with long-term conditions. We have just identified all the health coaches in Bedfordshire with a view to promoting this process as part of our prevention strategy within the STP.

Sustainability/Climate Change Performance

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, Luton and Dunstable University Hospital NHS Foundation Trust has the following sustainability mission statement located in our sustainable development management plan (SDMP):

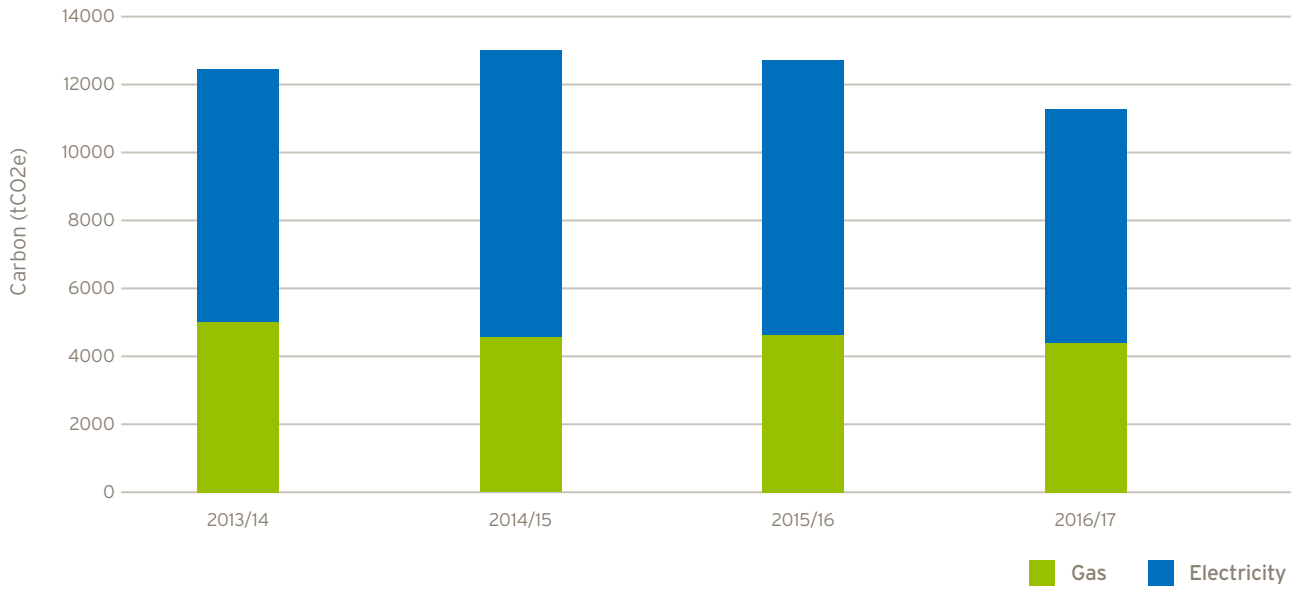
- To comply with, and exceed where practicable, all applicable legislation, codes of practice and other requirements to which the Trust subscribes
- To integrate sustainability considerations into all our business decisions
- To reduce the environmental impacts of all our activities
- To prevent pollution
- To review, annually report, and to continually strive to improve our sustainability

Performance

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year.

Energy

Carbon emissions - energy use



Power and heating is supplied to the Trust via the consumption of electricity and gas. Both are measured in kWh.

The consumption of both utilities is influenced by the seasons and has remained fairly constant over the last four years with minor reductions due to boiler improvements and the fitting of LED lighting being offset by expansion to services.

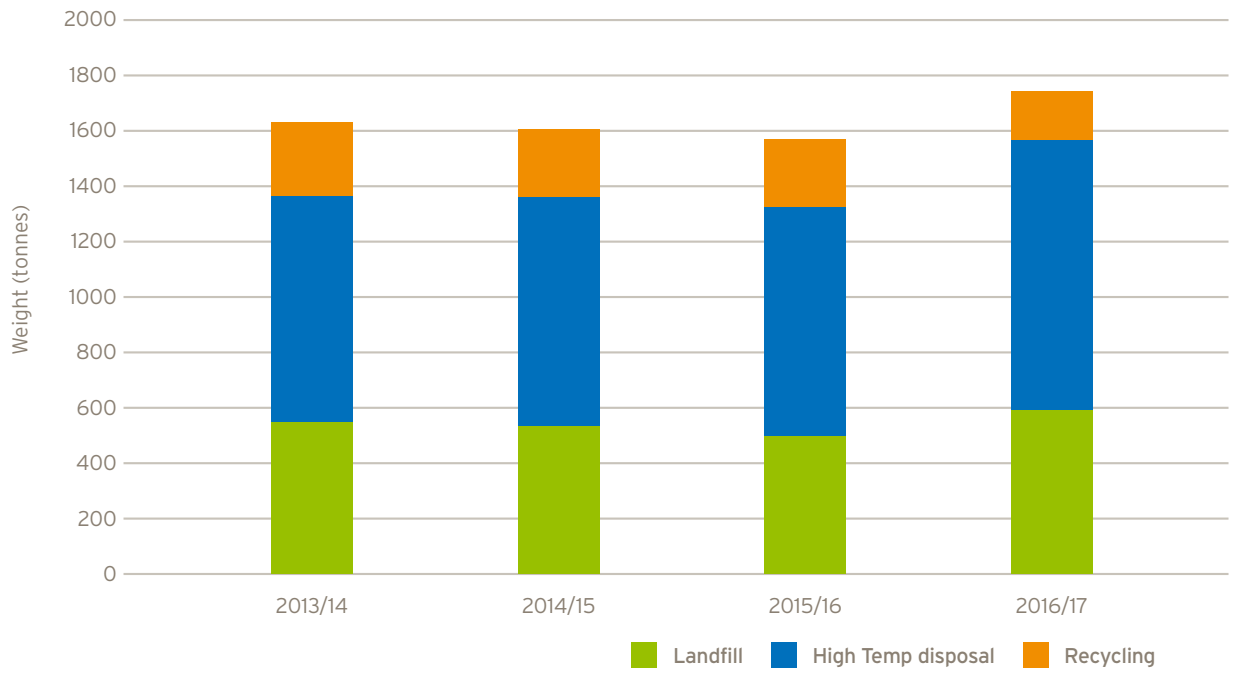
Year	2013/2014	2014/2015	2015/2016	2016/2017
Degree Days	3080	2983	2897	3029

Gross expenditure on the CRC Energy Efficiency Scheme to cover emissions generated in 2016/17 is £180,000.

Waste

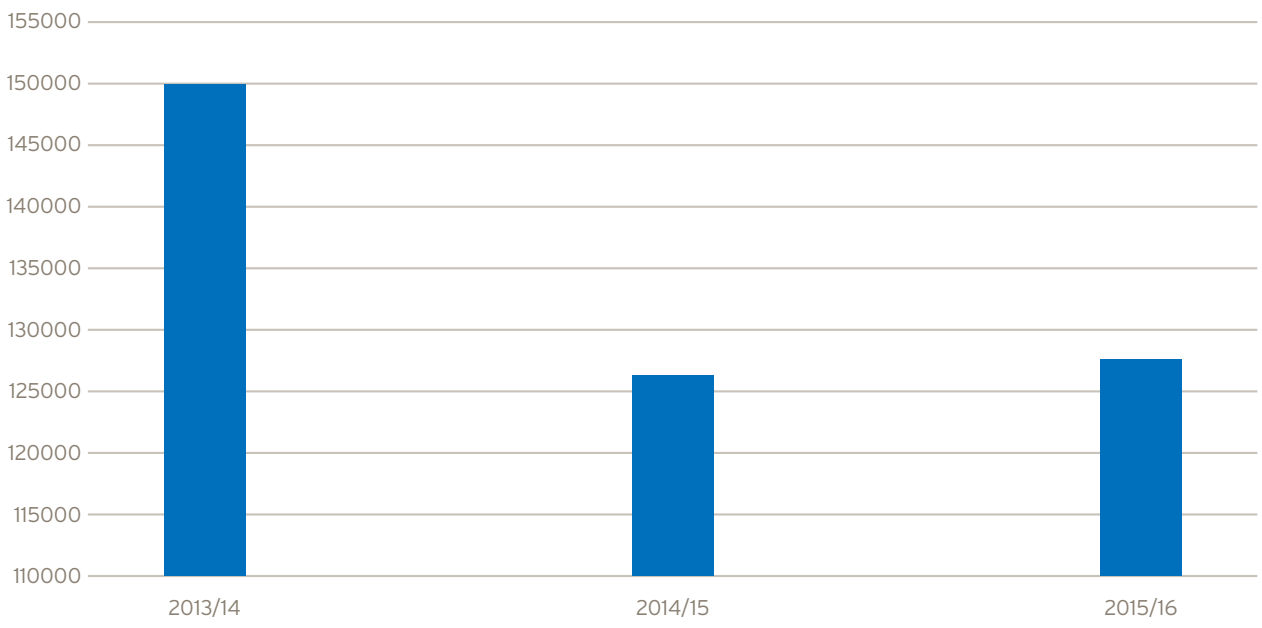
Overall waste has increased due to refurbishment, reorganisation and increased activity. Recycled volume has decreased and there has been a large increase in high temperature disposal. All waste going to high temperature disposal is incinerated in waste to energy plants so the CO_2 produced is partially offset by the energy produced.

Waste breakdown



Water

Consumption (m^3)



2014 / 2015 saw a marked reduction in water consumption due to the fixing of leaks and the installation of some water saving measures.

2015/ 2016 shows a comparable water usage

We have ended the contract with ADSM for validation and billing services. The water market began to open up in 2017 in a similar way to other utilities. We are working with Crown Commercial Services on procuring the best service going forward.

Transport

The Trust is committed to promoting sustainable transport options to all members of staff and actively encourages alternative means of transport, highlighting all public transport links within easy reach of the hospital

To free up space for patients and visitors additional parking has been provided at Skimpot road for staff, a short 10 minute walk away.

We continue to work with Arriva bus and Luton Borough Council on promoting transport options and are continuing our long standing discount bus ticket promotion with Arriva.

Recent promotions, on site 'bike doctor' and information displays have been held to encourage cycling and lift share travel scheme.

Looking Forward

Sustainability savings can be made in the forthcoming years with our redevelopment plan and other associated works.

Together with Bedford and Milton Keynes hospitals, a number of joint procurement initiatives underpinning the sustainability agenda will be completed in the coming financial year.

Energy centre
Work has progressed on strengthening our electrical infrastructure in preparation for future energy centre. The Trust has engaged with a number of interested parties with specialist expertise to complete a feasibility study for the future provision of an energy centre.

Improved controls
Planned upgrade of BMS controls to ensure that all heating and ventilation plant is controlled in the most efficient manner.

Energy efficient equipment
Continued replacement of old lighting with newer energy efficient LED is an ongoing process. In all projects we aim to ensure that wherever possible any replacement electrical / mechanical equipment is more efficient than the item it replaces.

Our patients, our staff and our partners

Our Patients

The Friends and Family Test (FFT) is an important source of feedback for the Trust. It is routinely used in Adult Inpatients, Outpatient Services and the Emergency Department. In addition to this we have continue to collect information from Maternity and Children's Services. The information is fed back on a monthly basis with overall scores and comparisons being reported through to the Clinical Outcomes, Safety and Quality Committee, where close monitoring and discussion take place to identify where there may be issues.

For example in Outpatient Services the FFT scores were below the national average at the start of the year. Issues associated with a high number of vacancies appeared to have affected patient's satisfaction. Once posts were filled, the scores for Outpatients improved and they have remained above the national average for the rest of the year. This has been fed back to the team to show the improvement their efforts have made. We have continued to use Quality Boards (figure 1) and 'You Said. We Did' so that patients and visitors are able to see how we use their feedback to make improvements.

Figure 1 Quality and Safety Information

Patient Experience Call Centre and Patient Advice and Liaison Service (PALS)

The PALS Team have continued to provide a crucial first contact point for patients and their families or carers when wishing to give feedback about their care or experience. They work to address concerns raised by individuals, which often prevents issues being escalated to formal complaints. They work closely with other departments in the hospital to resolve issues or to signpost people to the right department or team. The PALS team is also supported by a small team of volunteers who help to collect FFT feedback on the wards as well as undertake follow up phone calls to patients.

The PALS Team currently help staff to access the Interpreting Service, for use by our patients. The service is contracted from an external provider and the quality of service provided is under constant review to ensure that we are able to fully meet the needs of our patients. There has been a steady increase in the usage of the service over the last year and it is a much improved service following a change of provider in July 2016. Maternity Services is the highest user of interpreting services. The top two requested languages are Polish and Romania, which account for approximately 50% of requests.

A PALS drop in service is available from Monday to Friday from 10am to 4pm and is situated next to Reception at the Main Entrance to the hospital.

Local Involvement Networks - Healthwatch

Healthwatch Luton produced the 'Seldom Heard' Report in January 2017, which surveyed a number of service users in the Luton area from community groups that do not often get their views heard. They were asked to comment on a variety of services including discharge from hospital, and barriers for accessing general health and social care. As well as canvassing services users from mental health services, the young and homeless/living in poverty, the team from Healthwatch visited the hospital and joined carers visiting the Carer's Lounge. Whilst the feedback was positive from the carers regarding health and social care services, they raised negative points relating to transport and referral issues. There was conflicting negative and positive feedback about accessing the hospital and care and treatment in the hospital. There was also reference made to the need to upgrade the hospital facilities. This feedback will be used to underpin service developments in the coming years, particularly where facilities are concerned.

Healthwatch also produced a Provider feedback report in October 2016 (we are awaiting a further report for 2017). The overall star rating for the Trust is four out of five stars. The overall sentiment of the feedback from people surveyed was mainly positive. 46% of the reviews were positive and 29% were negative. The themes tracked demonstrated treatment and care rated highest on positive feedback and administration rated highest in negative feedback. Discharge was also rated as mainly negative.

Patient and Public Participation Group

The Patient and Public Participation Group met regularly throughout 2016/17 and the Terms of Reference were reviewed and updated. The Strategy for Patient and Carer Experience and Public Involvement was also further developed and agreed. The Group held meetings and a focus group during the year, which included the discussion and agreement of the Strategy. There were presentations from various teams in the hospital to share their services and activities. Also there were presentations about the Interpreting Services and Patient Led Assessment of the Care Environment (PLACE) Inspections. Further focus groups are planned for next year as the group goes from strength to strength.

Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. During the reporting period we received 704 Formal Complaints. A breakdown of complaints (by month, by category) is contained within the Quality Account.

All the complaints were thoroughly investigated by the General Manager for the appropriate division and a full report was sent to the complainant.

The majority of complaints were resolved at local resolution level. Some of the meetings were headed by the General Managers and some meetings were held by the Chief Nurse or the CEO. However, 8 complainants asked the Parliamentary and Health Service Ombudsman (PHSO) to review their complaints. Following this process, 6 complaints have been investigated and the PHSO have sent a final report for 3 complaints and 2 reports for two complaints, two are waiting for a decision. 4 complaints were not upheld and 2 complaints were partially upheld by the PHSO.

The data collated throughout the year highlights that there is further action that needs to be undertaken to improve consistency of achieving the timescales for responding to complaints, especially by the Surgical Division. However, the quality of the investigations being carried out and the standard of those responses remain very high.

We have made improvements to our complaints process, for example:

- If people are not happy with their response they are invited to come for a Local Resolution Meeting to discuss their concerns.
- We are sending our questionnaires with all our responses for patient feed -back.
- Patient Affairs completes a weekly update and this includes the overdue complaints for every division and this is escalated to senior managers.

Compliments

During the reporting period over approximately 4,017 compliments were received directly by the staff or service, and cascaded to the staff and/or service involved by the respective manager. This figure will rise because this does not include the figures for the last quarter.

Below are some of the compliments we received:

"The reason that I am writing to you is to bring to your attention the wonderful treatment that I recently received when I attended for a breast screening assessment. I had a recall for a mammogram. This was obviously a very anxious time for me waiting for my second assessment. I arrived early for my assessment and was seen very promptly. The nurse was delightful and so very reassuring. An assessment was carried out by the doctor who was absolutely wonderful, making me feel calm and relaxed. It was a real pleasure to meet such a professional and caring team of people. Thankfully my results were all clear."

"Please pass on my thanks for the excellent treatment I have received. I've a possible prostate issue. From first appointment to follow up appointment I've had very respectful treatment. I also like the fact that I had a 19.00 hours appointment. This was very convenient for me as it meant no time off work. Thank you."

"I just wanted to say a huge thank you to everyone who was involved in my 11 year old's care last night and this morning. He had to have emergency surgery in the early hours of this morning and my husband said everyone involved was fantastic, caring and informative - so thank you, you all do such an amazing job and we are very lucky to have you all and the NHS!"

"I was admitted through A&E and wanted to say how excellent the care and treatment I received was. I could not have asked for more. I was seen immediately, and had lots of tests but every step was explained to me, the nursing staff hardly left me but if they did someone was always checking I was ok. I want to say thank you. In this difficult time for the NHS I could not have asked for more and wanted to pass on my thanks."

National Cancer Patient Experience Survey

National Cancer Patient Survey response rate for the Trust across all tumour sites was 64% and a total of 302 patients. The Trust achieved excellent results, meeting the expected level for all questions with 5 questions exceeding the expected score. No results were below the expected level. The report highlights the excellent standard of clinical and supportive care that is provided for our cancer patients and their families, not only by the clinical cancer teams and multidisciplinary teams but all staff who come into contact with cancer patients throughout their pathway, both clinical and administrative, across the Trust.

The Chaplaincy Service

This has been another successful year for the Chaplaincy Service. We have continued to grow with many new volunteers joining the team. This has given us the opportunity to develop the care and support we are able to offer patients, visitors and staff whilst they are in the L&D, this past year supporting over 27,000 patients and staff.

We have further developed both the care we offer to patients, and their families, and the partnership of care between the Chaplaincy and the communities and faith communities as we have established Hindu and Muslim visiting teams alongside our general ward visiting.

We are working closely with the Palliative Care Team to ensure that all patients and those close to them receive the appropriate spiritual care as people come to the end of their lives.

Another focus of our work has, with the support of the L&D's Charitable Fund, been the refurbishment of the Chapel of St Barnabas. This has enabled us to create a Faith Centre that welcomes everyone from the communities we serve. We have enhanced the environment and there are better facilities for people of all faiths and none who use the Chapel as a place for prayer, worship or quiet reflection.

Safeguarding Children and Adults

Luton & Dunstable University Hospital NHS Foundation Trust is committed to safeguarding and promoting the welfare of children and young people and safeguarding our adult population..

All staff have a duty to be aware of safeguarding of patients of all ages while in our care.

The Chief Executive of Luton & Dunstable Hospital NHS Foundation Trust has Board level responsibility for safeguarding children and adults. Our Director of Nursing and Midwifery acts on their behalf to ensure that the Board of Directors is satisfied that all measures are taken to safeguard children and young people in our care.

Actions taken and measures in place are as follows:

- Reports are presented to the Clinical Outcome, Safety and Quality Committee annually on safeguarding children and young people and there is a clear reporting structure in place to raise issues throughout the year.
- Audits and reviews are carried out to check and satisfy us that our systems and processes are effective.
- Clear procedures are in place in the Emergency Department (A&E) and staff receive regular update training on safeguarding.
- Clear procedures are in place to ensure that the Trust is working with other organisations to safeguard children and adults.
- Disclosure and Disbarring (DBS) checks are made on all new staff adhering to the NHS Employer guidelines and the Trust is compliant with safeguarding guidelines.
- Training in safeguarding children and young people and adults is one of the key components of the corporate induction programme for all new starters and is included in the annual mandatory refresher training which is being made available as e-learning.

- All training arrangements have been reviewed.
- A Named Nurse, Named Midwife and Named Doctor have specific responsibility for safeguarding children and young people across all parts of our hospital – they are clear about their roles and are given sufficient time to enable them to fulfil their responsibilities.
- A Named Nurse and Named Doctor have specific responsibility for safeguarding adults.

Our Staff

Our success is delivered through our people and as such our staff continue to be our most valuable asset when it comes to delivering clinical excellence, quality and safety to our patients. We strive to achieve this through many different routes, including delivery of learning and development; good leadership and good communication. This journey starts from the point that an individual applies for a post with us and continues through their employment with the Trust.

Recruitment and Resourcing

Assistant Practitioners

As a Trust we recognise that there are national challenges in recruiting to band 5 Registered Nurse positions. As per Carter (2016) recommendations, we are trying to make best use of resources and develop new ways of working to address this. One initiative that we have firmly embedded is the use of band 4 Assistant Nurse Practitioners (ANP). Currently we have 31 WTE ANPs employed in the Trust. They can be seen working in areas such as Medicine, Surgery and Paediatrics. These staff are vital in supporting our registered nursing staff to deliver safe, quality patient care. Following our success with this, we will be the 'fast followers' for the NMC band 4 implementation programme. It is envisaged that these staff will be supported to move through the registered nurse training pathway. As such this will help us 'grow our own' and go some way towards reducing our vacancies. This is a great opportunity for us to support our local community members who wish to become nurses, but may not be able to do so as a result of the removal of the nurse training bursary.

Role of the Workforce Nurse

In April 2016 we introduced a corporate nursing role; Nurse Lead for Workforce. This role has been active in helping the Recruitment team deliver the vision of the right staff, in the right place, with the right skills at the right time. The role has seen changes to the on boarding process of clinical staff, competency monitoring, revalidation compliance and robust management of the temporary workforce. The role has been pivotal in ensuring communication between the Recruitment and Resourcing, E-Rostering and Corporate Nursing teams.

Registered Nurse Recruitment

We continue to face a challenge when recruiting to band 5 registered nurse posts in particular. This is due to national shortages and changes in service requirements in order to deliver safe care in our hospital.

Numerous approaches are being undertaken to try and address this situation. These include the use of local and national advertising, social media, overseas recruitment and the promotion of nursing careers at local career fairs at schools, colleges and universities.

Proactive recruitment activity, continues with both targeted and expedient campaigns running monthly. The Trusts overseas recruitment programme saw events held in Italy, Singapore, Spain and Portugal. However, the high International English Languages Test (IELTs) and Objective Structured Clinical Examination (OSCE) requirements remain a challenge. Subsequently the length of time for these nurses to commence in post remains protracted due to the amount of time it takes for all the stages to be completed and for the Nursing and Midwifery Council to process the applications for registration.

New starter questionnaires

In order to understand new staff members' experiences better and to assist the Trust to improve staff experience a new starter questionnaire was introduced. All new staff are asked to complete a questionnaire commenting on their findings of both the recruitment process as well as their experiences during their first weeks at the Trust. This information is then reviewed to consider what improvements could be made to the recruitment/ induction process.

Health Care Assistants (HCAs)

The Trust has continued with bi-monthly Healthcare Assistant campaigns. These have been very successful and have resulted in the majority of vacancies being filled. At present we are continuing these campaigns to allow for people who leave and changes in services.

In order to support the Trust's vision to meet the apprenticeship requirements, and to deliver an alternative route for staff into nursing, we have introduced a literacy and numeracy assessment for all potential HCA candidates. The shortlisting criteria have been revised and we have implemented strength-based interviewing which has resulted in an increase in the calibre of HCAs recruited.

Agency Collaboration

Since the implementation of the national NHS Improvement (NHSI) agency rules the Trust has been working collaboratively with trusts across Bedfordshire on joint tendering and common processes to ensure best value without risks to patient safety. Since inception this project has delivered savings of £2m to the trust and was recognised with a highly commended award in the 'collaboration' category at the Healthcare Supply Association Awards in November 2016.

Consultant Job Planning

The Trust recognises the importance of ensuring alignment between meeting patient demand and the availability of senior medical staff. Following a refresh of the Trust's Job Planning Principles and Guidance, the Trust has embarked on a project to ensure all consultant job plans are up-to-date and representative of service needs 7 day a week, 365 day a year. Dedicated project support has been procured to ensure due focus on completion of the project. To provide a clean baseline for future timetable adjustments, and to ensure clinical leaders and general managers are fully equipped to manage the on-going job planning process, and to make best use of the Health Medics / Allocate job planning software. The Trust's Job Planning Assurance Group meets monthly to provide oversight and scrutiny of all job plans and a final approval process which has been designed to ensure a fair and consistent approach across the Trust.

Junior Doctor Contract

During 2016 the roll out of the new Junior Doctors Contract commenced and this will continue during 2017, with phased transition for all trainees in line with NHS Employer's timeline. The Trust appointed a Guardian of Safe Working and also established a Junior Doctors Implementation group that includes the Guardian of Safe Working, Director of Medical Education , Junior Doctors, General Managers, Finance and HR. The focus of the group is to ensure a smooth transition to the new contract by engaging with and listening to our Junior Doctors. The group also ensure that all actions are communicated to relevant staff who may be directly impacted by new contract. The Medical Workforce team regularly attend the Regional Medical Personnel Specialist group meetings to ensure there is parity and shared practice with other local Trusts.

Junior Doctor's Strike

During 2016, there were two junior doctors' strikes. The Trust put plans in place ahead of both of the strikes and the impact on the patients was minimal.

Managing Absence

In October 2016, the Trust reduced the Bradford Score trigger point from 200 to 150 as a way of managing employee attendance more effectively through providing earlier formal support and continuing to deliver against the Trust's operational requirements.

Since the introduction of the sickness absence project the Trust has seen a reduction in staff with a Bradford Score of over 200 from approx. 540 (in 2013) to a figure of between 325 and 350 cases. The focus on managing absence has also led to a considerable change in mind-sets and behaviours; an increase in the number of stage 2 formal sickness absence meetings has increased from 27% in 2013 to approx. 70% meetings being held in 2016 and an improved use of return to work interviews. With the recent reduction in the Bradford score trigger point, it is anticipated that the continued benefits of this will include:

- Suitable support mechanisms and appropriate, reasonable adjustments implemented at an earlier stage, allowing employees to achieve and maintain maximum attendance;
- A reduced absence rate resulting in alleviating staffing pressures on wards and departments;
- A reduction in costs associated with sickness absence and subsequent bank and agency usage, with this money being reinvested back into patient care;
- Earlier intervention in sickness absence cases with less progressing to a formal hearing stage.

As a result of this focus, the Trust continues to have one of the lowest sickness absence rates of any acute Trust in the East of England and one of the leading Acute Trusts across NHS England when it comes to sickness absence rates.

Staff Engagement and Consultation

The L&D takes pride in having a healthy and productive relationship with staff and this is reflected in the staff engagement scores in the Staff Opinion Survey, where this year score were again higher than the national average, with our overall staff engagement scores placing us in the top 20% of Trusts.

The feedback for recognition and value of staff by managers and the organisation, Staff motivation at work and the organisation and management interest in and action on health and wellbeing also placed the L&D in the top 20% of Trusts.

Partnership working is demonstrated in many varied ways for example:

Staff Involvement Group

This focus of this group is on developing a culture of staff involvement, open communication and partnership working with factors that have a real impact on staff such as reward and recognition, security, health and wellbeing. The membership of the group is diverse and members are active in taking forward themes from the

staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.
Staff and Volunteers Recognition

There have been a number of opportunities over the year to thank staff and volunteers for their contributions. In particular:

- In recognition of their long service, staff are invited to an awards event at Luton Hoo Hotel bi-annually with the next event scheduled for April 2017. This is the Trust Board's way of thanking staff who made a significant contribution to the Trust over the last 25 or 40 years. The event continues to be supported by the L&D Charitable Fund.

- During National Volunteers week held in June 2016, we arranged a picnic in the park for our volunteers, which was a very enjoyable day. A further event was held in in January 2016 where 80 volunteers enjoyed an afternoon at the Pantomime at a local theatre.

Communicating and engaging with our staff

The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2016 Staff Survey showed that the Trust scored above average for its overall staff engagement score. Similarly, we scored above average for the percentage of staff reporting good communication between senior management and staff.

Having a committed and engaged workforce contributes directly to the quality of the care we provide to our patients. Messages are delivered in a variety of ways both within individual teams and departments and across the Trust as a whole.

Examples of staff communications and engagement include:

- Regular face-to-face staff briefings are led by our Executive Team, where we share information on key operational issues
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets quarterly with our Council of Governors, which includes nine elected staff governors
- Quarterly public Trust Board meetings
- Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust
- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.
- Staff Involvement Group
- The focus of this group is on developing a culture of staff involvement, open communication and partnership working with factors that have a real impact on staff such as reward and recognition, security, health and wellbeing. The membership of the group is diverse and members are active in taking forward themes from the staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.

Staff Involvement Group Newsletter

The newsletter is produced every two months and is full of news and stories for staff, by staff and about staff. The aim is for staff to be involved in something that is purely for them, and is a method for individuals to share their stories such personal achievements, smoking cessation, weight loss, hobbies/interests or a new fitness regime that could inspire others to take action to live healthier lifestyles.

Engagement events 2016

Our third 'Good, Better, Best'' staff engagement event was a great success. More than 80% of our staff participated during the week of 11 July 2016. The focus of the event was Patient Safety and Patient Experience. We worked with a specialist training provider who used theatre to 'bring training to life' with professional actors simulating a patient safety situation. The event enabled us to brief on the forthcoming comprehensive patient safety review which will be led by the Institute for Healthcare Improvement (IHI).

During the week we were also able to thank our staff for the tremendous work for the year. The finale to the event was a Keynote Address given by Sir Bruce Keogh attended by staff. The event was funded from L&D Charitable Fund and commercial sponsorship.

The fourth Good, Better, Best Christmas staff engagement event was held in the week of 12 December with more than 2000 members of staff attending the sessions. Themes this Christmas included presentations on Patient Safety, the L&D's
new Freedom to Speak Up Guardian, and an update on the Bedford, Luton and Milton Keynes Sustainability and Transformation Plan (STP).

Our Volunteers

We currently have 264 volunteers working closely with our staff in a variety of different roles within the Trust. Our volunteers are a vital part of our organisation and provide an invaluable helping hand to complement our workforce. Alongside our own volunteers, Carers in Bedfordshire and Hospital Radio provide important services not only for patients and visitors, but also staff. The Royal Volunteer Service has a shop in the Maternity Unit and a Ward Trolley Service and each year they donate several thousand pounds to the Trust. The League of Friends raises funds for new medical equipment and extra facilities and comforts for those using our hospital.

All volunteer recruitment is aligned to that of a paid member of staff and external organisations working with us sign up to an agreement to ensure consistency. All new volunteers attend a comprehensive induction and undertake training to be able to carry out their roles safely and effectively.

The highest percentage of our Trust volunteer base fall within the 66-79 age category, with the remainder as follows:

Age (years)	% of volunteers
80 and over	5.88
66 - 79	47.35
50 - 65	21.59
25 – 49	17.61
18 - 24	7.58

Generally, those in the 18 – 24 age category use their volunteering experience to help them gain an insight into healthcare which in turn support their applications for health related courses.

25.37% per cent are from a BME background, which is slightly under representative of our local community. Plans are in place to work with our local Imam to discuss how we can encourage out local Muslim population to engage with the hospital.

During 2016/2017:

- Our Trust volunteers gave us a total of over 22,500 hours, which is the equivalent to 11.5 full time band 2 staff.
- 87 new volunteers were recruited and there were a total of 85 Leavers. Of the volunteers who left during this period, 4 returned as University of Bedfordshire Nursing and Midwifery students.
- 3 former volunteers have secured permanent or bank employment within the Trust.

National Volunteers Week is held during the first week of June each year. The Grove Theatre in Dunstable hosted the 'Cheering Volunteering Awards' which were organised by Central Bedfordshire Council. David McDonald one of our own Main Reception volunteers, was the proud recipient of an 'Outstanding Contribution' award for his professionalism and for the average 375 hours he gives us each year.

In November we worked with Nationwide Building Society who provided their support as part of their Employee Community Volunteering Programme. They transformed the garden area of our NICU parents bungalow and the balcony outside the Chemotherapy Unit. Their visit was a huge success and provided an excellent opportunity for positive publicity, they will be returning once again in May this year.

New roles this year include assisting Medical Education with the Junior Doctors mock OSCE exams by acting as patients and volunteers are now assisting with PLACE assessments. We have also extended volunteer cover to include weekend Pharmacy TTA deliveries.

We held our annual Long Service awards event in December which was attended by 100 Volunteers .The awards were presented by the Trust Chairman and included a special award presented by the Trust's very first Voluntary Services Manager, Rhona Harvey to Jill Wills who had dedicated over 50 years Voluntary Service to the Hospital.

Health and Wellbeing / Occupational Health

We offer a full range of Occupational Health and Wellbeing Services which contribute to increasing the effectiveness of the organisation, by enhancing staff performance and morale through reducing ill-health, absence and accidents.

During 2016/17 the Trust has continued with and also introduced new initiatives, to promote opportunities for staff to adopt a healthier lifestyle either on site or by promoting external facilities that are conducive to good health.

We had a company visit to provide free eye testing to staff, and 574 member of staff were seen over a five week period

The Occupational Health and wellbeing Service has focussed on providing information on health promotion topics and activities, by acting as a signpost for staff to obtain information and advice on a variety of health and fitness related initiatives. This has been achieved through the continued development of a health and wellbeing section on the staff intranet, various electronic communications, newsletters, and awareness raising events.

In June 2016, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place, which proved to be very popular. Awareness raising stands and activities included: smoking cessation, Livewell Luton promoted personal health plans, smoothie bikes, Heights/weights and Body Mass Index, healthy eating, a nutritionist performing health snacks demonstrations, Active Luton conducted chair exercise classes and Team beds and Luton workplace challenge promoted table tennis and a skipping challenge, among other initiatives. There was also a stand raising awareness around prevention of bullying and harassing with staff being encouraged to make pledges in support of good behavior at work. A similar event is currently being planned for 2017.

Team Beds and Luton activities such as paddle boarding and Dodge ball, took place with those staff taking part reporting back via the Staff involvement group newsletter.

This year, 71.4% of our frontline staff were vaccinated against flu, which was a higher uptake than the national average amongst other NHS Acute Trusts.

The Wednesday walking activity (30 minutes of a brisk walk) that first started in 2009 continued, and was stepped up with the help of Active Luton, offering incentives to regular walkers.

The Occupational Health team were successful in retaining their accreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the Faculty of Occupational Medicine. SEQOHS accreditation is the formal recognition that an Occupational Health Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

The Trust continues to employ the services of an Employee Assistance Programme, which is available to all staff. This provides access to an independent, free and confidential telephone advice service, staffed by highly experienced counsellors who can provide practical and emotional support with work or personal issues. Advice is available 24 hours a day, 365 days of the year. The provision of this support during the past four years has proved to be valued greatly by staff with an excellent utilisation rate. Monthly help/awareness raising sheets are also provided, which not only remind our staff of the availability of this important support but also give information about health/life issues.

Health Checks for staff

The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. Live Well Luton is a company commissioned by Luton Borough Council and they provide free health checks to those over the age of 40 and up to the age of 74. Whilst this is national scheme we have been able to continue to secure dates for this service to be brought on site to our staff. Since October 2013 sessions have been available on a monthly basis with over 470 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary referrals made.

Fruit and Vegetable Market Stall

Following on from a staff suggestion, a fruit and vegetable vendor was asked to set up a stall in an effort to promote healthy eating primarily to staff, this has also been welcomed by patients and visitors to the Trust alike.

Since September 2015, the stall has been on site one day a week. In April 2016 we introduced a new activity entitled 'Apples and Pears to take the stairs', this was in order to encourage staff to use the stairs more, increase levels of fitness and also to raise awareness of the fruit and veg stall.

Staff Health and Wellbeing questionnaire

During the 2016 Christmas Good, Better, Best staff engagement event, we took the opportunity to ask staff what health and wellbeing activities they had accessed, and what they would like to see more of.
From the 29 listed activities, the top five were:

- Occupational Health Department services
- Health and wellbeing emails
- Free on site eye tests
- Fruit and Veg Stall
- NHS Discounts

Staff asked for Health checks for those who did not qualify for the over 40 health checks, and these were introduced in February 2017.

2016 NATIONAL STAFF SURVEY SUMMARY OF RESULTS AND ACTION PLAN

1. Introduction

The thirteenth National Staff Survey was undertaken between September and December 2016. All Trusts are required to participate in the survey using a random sample of staff and the data from which is used by the CQC for the Benchmark reports across all NHS Acute Trusts.

The feedback reports produced for each organisation focus on 32 key areas (known as key findings)

The key findings are presented in the feedback reports under the following nine themes:

- Appraisals & support for development
- Equality and diversity
- Errors and Incidents
- Health and wellbeing
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying
- Working patterns

This year the Trust opted to survey a sample survey of 1250 staff. Questionnaires were distributed in paper format only.

Completed questionnaires were sent directly to the Trust's independent survey contractor, Quality Health, for analysis by age, staff groups and work and demographic profile.

This report gives a high level overview of the survey findings. A summary report of the complete results is available on the Trust intranet.

The survey report provides vital feedback from staff about working in the Trust.
As in previous years, there are two types of key finding:

- Percentage scores, i.e., percentage of staff giving a particular response to one, or a series of survey questions.
- Scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these summary scores, the minimum score is always 1 (Strongly disagree) and the maximum score is 5 (Strongly agree)

2. Response Rates

2016 National NHS Staff Survey		2015 National NHS Staff Survey		Trust Deterioration
Trust	National Average*	Trust	National Average*	
43%	43%	49%	41%	6%

* Acute Trusts

The official sample size for our Trust was 1250, and we had 516 members of staff take part.

3. Staff Engagement

The survey measures overall Staff Engagement and the Trust scores are detailed as follows:

	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
Overall Staff Engagement	3.90	3.81	3.84	3.79	No significant change	Highest (best) 20%
KF 1 Staff recommendation of the Trust as a place to work or receive treatment	3.88	3.76	3.81	3.76	No significant change	Above (better than) average
KF 4 Staff motivation at work	4.01	3.94	3.94	3.94	No significant change	Highest (best) 20%
KF 7 Staff ability to contribute towards improvements at work	75%	70%	73%	69%	No significant change	Highest (best) 20%

4. Key Findings

A summary of the key findings from the 2016 National NHS Staff Survey are outlined in the following sections:

4.1 Top Ranking Scores

Top 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 7 % of staff able to contribute towards improvements at work	75%	70%	73%	69%	No significant change	Highest (best) 20%
KF9 Effective Team working	3.84	3.75	3.79	3.73	No significant change	Highest (best) 20%
KF 12 Quality of appraisals	3.40	3.11	3.31	3.05	No significant change	Highest (best) 20%
KF 19 Organisation and management interest in and action on health and wellbeing	3.75	3.61	3.56	3.57	Increase (better than)	Highest (best) 20%
KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	54%	45%	***36%***	***37%***	Increase (better than)	Highest (best) 20%

Other Key Findings that scored above or below (better than) average

- KF1 --Staff recommendation of the Trust as a place to work or receive treatment
- KF2 - Staff satisfaction with the quality of work and care they are able to deliver
- KF3 - % agreeing that their role makes a difference to patients/service users

- KF4 - Staff motivation at work - highest (best) 20%
- KF5 - Recognition and value of staff by managers and the organisation - highest (best) 20%
- KF6 - % reporting good communication between senior management and staff
- KF8 - Staff satisfaction with the overall responsibility and involvement –highest (best) 20%
- KF10 - Support from immediate managers
- KF13 - Quality of non-mandatory training, learning or development
- KF14 - Staff satisfaction with resourcing and support
- KF24 - % reporting most recent experience of violence - highest (best) 20%

4.2 Bottom Ranking Scores

Bottom 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 16 % of staff working extra hours***	79%	72%	75%	72%	No significant change	Highest (worst) 20%
KF 20 % of staff experiencing discrimination at work in the last 12 months	15%	11%	12%	10%	No significant change	Highest (worst) 20%
KF 22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	15%	15%	14%	No significant change	Highest (worst) 20%
KF 25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%	27%	30%	28%	No significant change	Highest (worst) 20%
KF 32 Effective use of patient/service user feedback	3.62	3.72	3.65	3.70	No significant change	Lowest (worst) 20%

*** While KF 16 is an amalgamation of both paid and unpaid hours, a further breakdown indicates the following:-

	2016 National NHS Staff Survey		2015 National NHS Staff Survey	
	Trust	National Average	Trust	National Average
% working additional paid hours	48%	35%	43%	35%
% working additional unpaid hours	63%	57%	63%	58%

Other Key Findings that scored above or below (worse than) average

- KF11 - % appraised in the last 12 months – lowest (worst) 20%
- KF18 - % attending work in the last 3 months despite feeling unwell because they felt pressure
- KF21 - % believing the organisation provides equal opportunities for career progression/promotion
- KF23 - % experiencing physical violence from staff in last 12 months
- KF26 - % experiencing harassment, bullying or abuse from staff in last 12 months
-

4.3 Where Staff Experience has improved (largest local changes since 2015)

Improvements	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 5 Recognition and value of staff by managers and the organisation	3.55	3.45	3.41	3.42	Increase (better than)	Highest (best) 20%
KF10 Support from immediate managers	3.79	3.65	3.65	3.69	Increase (better than)	Highest (best) 20%
KF19 Organisation and management interest in and action on health and wellbeing	3.75	3.61	3.56	3.57	Increase (better than)	Highest (best) 20%
KF27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	54%	45%	36%	37%	Increase (better than)	Highest (best) 20%

Of the total 32 reported key findings, all 32 can be compared to 2015 and these are as follows:

- No real statistical change = 28
- Improvements = 4
- Deteriorated = 0

Equality and Diversity

During 2016/17 one umbrella document was created to bring together the Equality Objectives, Five Year Plan and Equality, Diversity and Human Rights (EDHR) Strategy. The reviewed approach has made the documentation simpler and more engaging, reflecting the most recent developments within the field of EDHR practice. The Trust published reports for Workforce Equality; Patient Equality and the Workforce Race Equality Scheme on the website at the end of July 2016 in accordance with our Public Sector Equality Duty.

The EDHR work plan was updated to include improvement actions that were identified through the gap analysis that was completed as part of the work on these three reports that was completed between April-August 2016.

Examples of Trust identified objectives include:

1. Addressing areas of low declaration from staff / patients that prevent an accurate picture of performance / addressing of needs e.g. Disability, Belief, Sexual orientation.

2. Delivering the WRES action Plan - The WRES measures data for any gap in the treatment of White and BME staff, so that any less favourable experience of BME staff can be addressed. For all Trusts, the first WRES report in 2015 culminated in a National WRES Report 2015. A summary report of the Trust's position in this benchmarking was shared.

3. Preparing for the Workforce Disability Equality Standard WDES. NHS England plans a WDES standard from April 2017 to address disability areas. The Trust has been undertaking initiatives to attain an improved level of declaration from staff / patients. This will enable better application of fairer treatment and meeting of adjustment needs.

4. Transgender – Workforce, services and society has seen an increased presentation of the transgender community - several patients identified as "other". Actions included the delivery of briefings for key staff; the provision of advice and supporting documents and the development of a policy and guidance for patients and staff including conduct, and confidential handling. Further progress needs to be made in respect of increasing declaration of sensitive information.

5. Gender Pay Gap Monitoring April 2017– Preparation for the Trust's requirement to meet new mandatory pay reporting requirements.

6. Review of Equality Analysis Policy, Process and Guidance - The process of using Equality data to analyse the impact of a proposed service or workforce change, or policy on equality areas has undergone a review. This key tool for informed decisions needs to be more user-friendly, relevant, embedded and business as usual in use.

As data is newly scoped, consideration is being given to the value and rationale in what has been and will be collected in the future, how often and how it is used.

The Trust has in place policies and procedures to support Equality and Diversity including:

- Equalities and Human Rights Policy – supporting positive action for equal access
- Equality Analysis Guidelines – ensuring that policies, guidelines and service changes are assessed for equality issues
- Recruitment, Advertising and Selection Policy – supporting fair recruitment
- Flexible Working Policies – supporting working arrangements
- Workplace risk assessment for new and expectant mothers
- Reasonable Adjustment Policy – supporting positive changes to the workplace to allow continued employment

Accessible Information Standard (AIS)

A new complex mandatory requirement for service providers across the NHS and adult social care system. It involves the co-operation and response of all stakeholder organisations in the Trust's services in achieving a consistent approach to meeting information and communication support needs of patients, service users, carers and parents, in relation to disability, impairment or sensory loss. Successful implementation means consistently identifying, recording, flagging, sharing and meeting these needs.

A working group was established to implement the accessible information standard and has included:

- Raised engagement and participation from Luton CCG with GP participation initiatives
- Making this part of the Communications and Strategic Transformation Planning
- Assessing current Electronic Information Systems Internally
- An AIS Patient Form to identify needs and consent
- Consideration of Information Governance aspects
- Arrangements for enhanced provision in appointment Letters and in translation and foreign languages provision

- Arrangements to enhance Website Accessibility alongside new NHS branding and Identity guidelines 2016 and meeting Web Accessibility Standards
- Scoping Training and awareness needs – Communications Plan

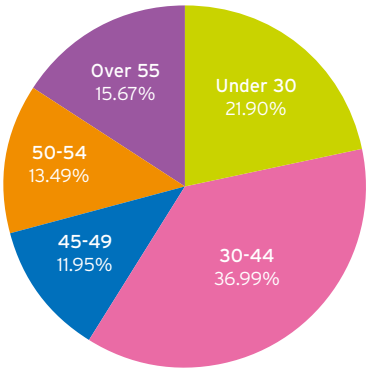
Momentum and engagement need to be maintained to ensure delivery is conclusive and fully implemented such as ensuring training, awareness and communications plans (internally and externally) are progressed, more formally implementing the working manual systems, ensuring continued stakeholder relationships and that AIS is a prime consideration in the STP and new IT system planning. Also that there are changes to policy, procedure, practice and electronic systems as applicable.

Since EDHR strategy and Equality Objectives must be reviewed every 4 years and be relevant to the Trust, the EDHR review dates are now in line with corporate reporting and review for simultaneous consideration and embedding in all the Trust does, along with corporate vision, values and objectives.

Equality and Diversity Graphs – using employee data as at 31st March 2017.

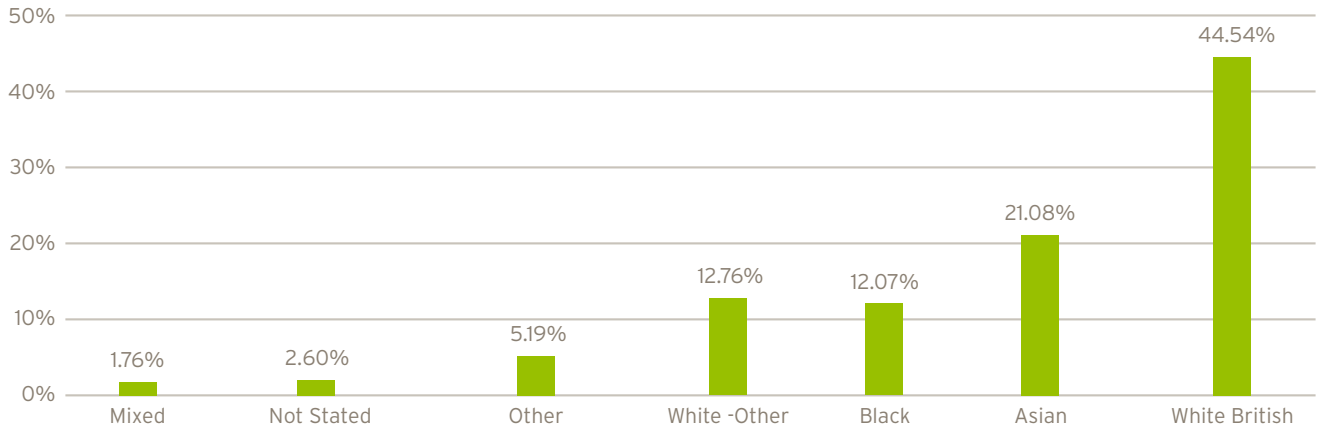
There is very little change in the age profile of the workforce from 2015/16 with the majority of staff falling between 30 and 54 years old. The challenge for the Trust remains the significant proportion of staff in the over 55 age range who may opt for retirement.

Workforce by age band



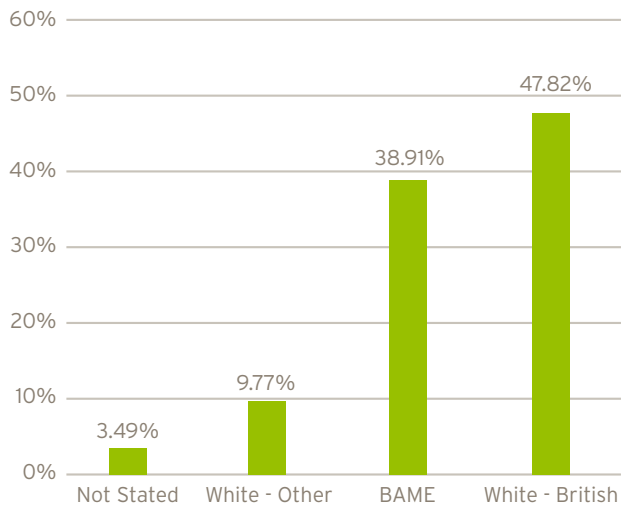
Over 40% of the nursing and midwifery workforce and the workforce as a whole declare themselves as 'other than white' which is reflective of the local community.

Nursing & midwifery ethnicity



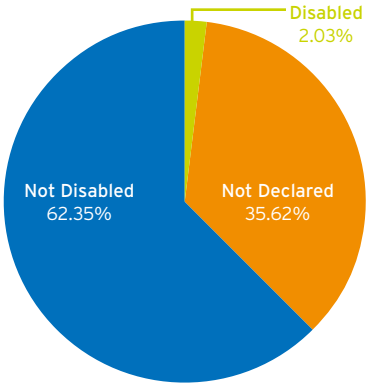
There has been a slight increase in the number of people who have declared their ethnicity since 2015/16. This reflects the fact that people are generally more prepared to declare both ethnicity and age.

Workforce by ethnicity



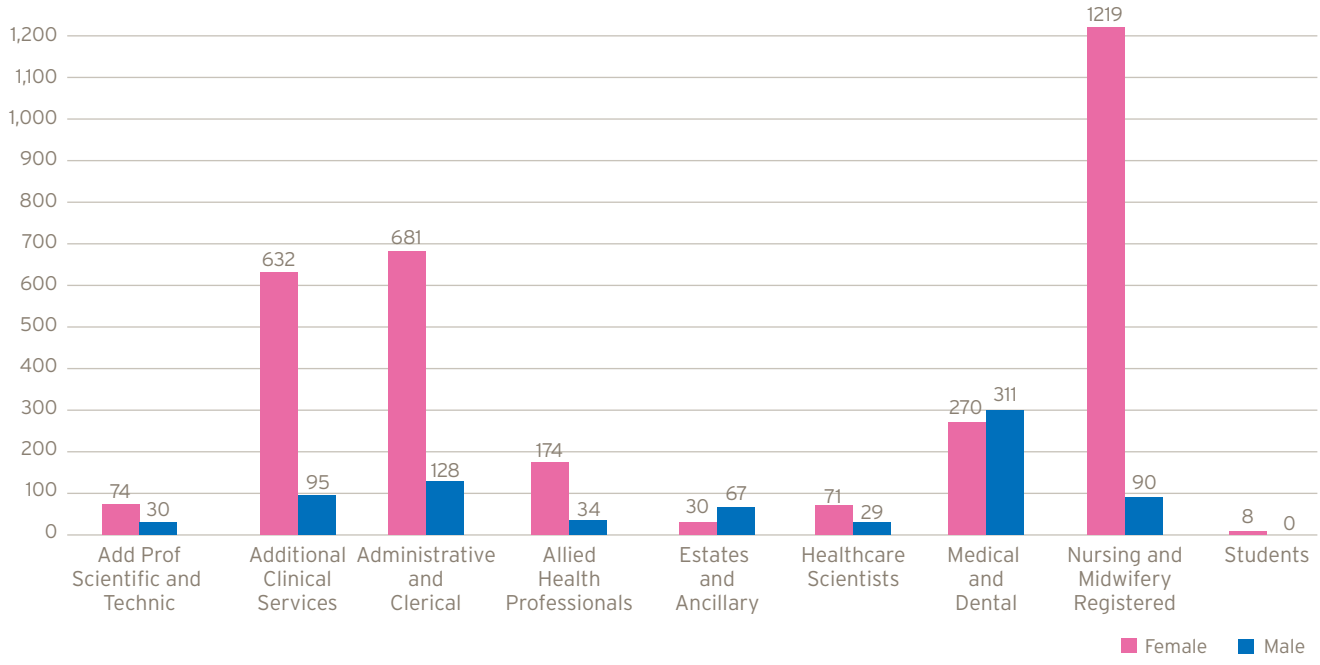
Disability Declaration is low across the service and workforce but on a par with NHS declaration level nationally e.g. in 2016 under 50% of staff had declared if they had a disability or not making the 1.6% staff declared disability level inaccurate. In reality the level expected would be closer to the 10-17% of general national declaration.

Disability

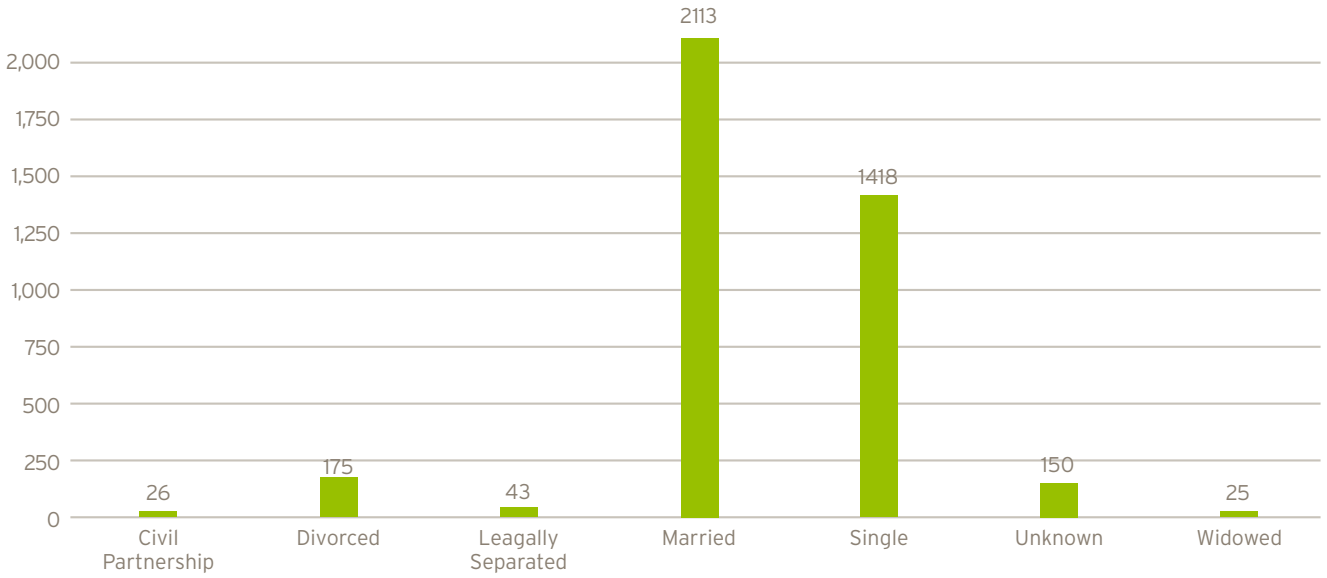


The gender profile remains broadly similar to 2015 – 2016 with the majority of staff being female with the exception of Estates and Facilities and Medical and Dental staff.

Gender by staff group



Workforce by Marital Status

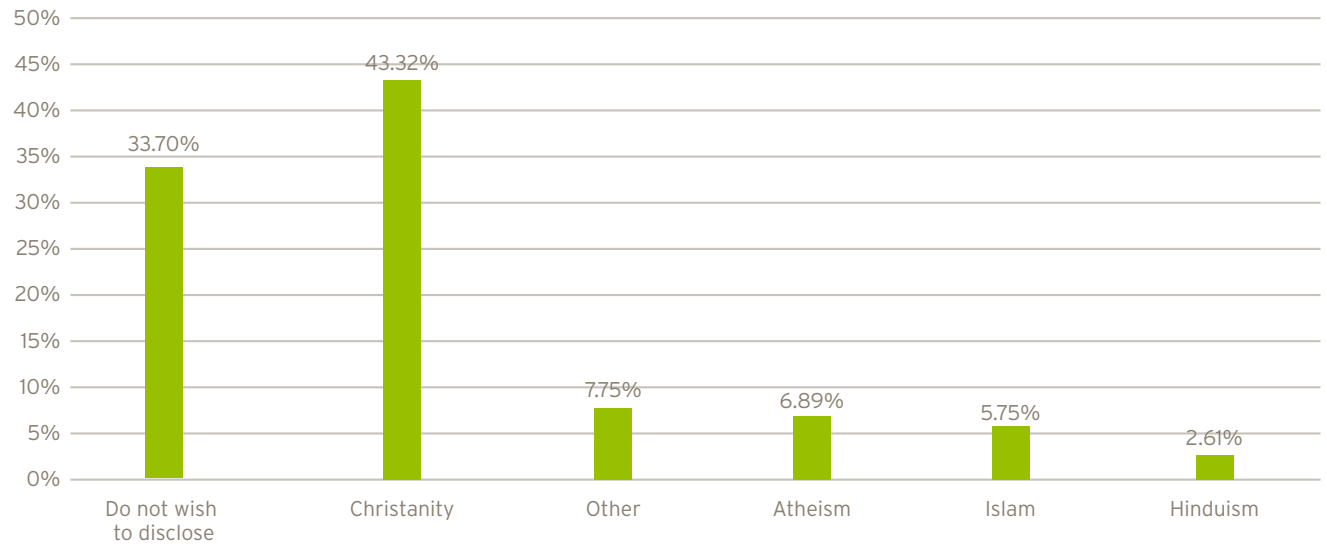


In relation to Belief and Sexual Orientation Declaration across the service and workforce there is low declaration in these areas. This is particularly the case in Belief for staff where non declaration in 2016 was 37.06%. Belief covers a broad range of religions (50 plus) including non-belief and atheism. There is more confidence in declaring ethnicity which can be linked to Belief, but both Belief and Sexual Orientation are more personal.

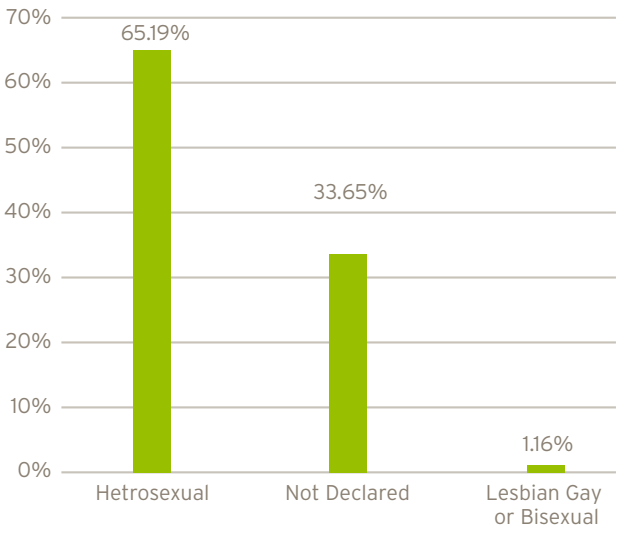
For sexual orientation in staff, non-declaration was 36.95% in March 2016 with Heterosexual 61.97% and a very low LGBT declaration at 1.08%. Initiatives to encourage declaration need to cover the reasons collected and used, removing misconceptions e.g. making clear that it is about general sexual orientation data and ensuring LGBT do not encounter different treatment not about an individual's sexual activity or preference.

Transgender, in terms of "LGBT", where transgender has been linked to Sexual Orientation initiatives, both the workforce and patient services have seen an increase in the number of Transexual / transgender people presenting. Several patients have identified as "other" rather than male or female. There needs to be a review of how this data is collected and the sensitive handling of the information once gathered.

Workforce by religion or belief



Workforce by Sexual Orientation



Leavers by Division 1/4/2016 to 31/3/2017	Total
Corporate	73
Diagnostics, Therapeutics and Outpatients	133
Medicine	253
Surgery	205
Womens & Children's	125
Grand Total	**789**

Top Ten Reasons for Leaving 1/4/2016 to 31/3/2017	% of all Leavers
Voluntary Resignation - Other/Not Known	23.57%
End of Fixed Term Contract	21.17%
Voluntary Resignation - Relocation	14.58%
Voluntary Resignation - Work Life Balance	8.24%
Retirement Age	6.84%
Voluntary Resignation - Promotion	6.72%
Voluntary Resignation - Child Dependants	2.53%
End of Fixed Term Contract - Other	2.41%
Voluntary Resignation - Better Reward Package	1.90%
Voluntary Resignation - Health	1.52%

Gender Pay Gap

There are more female than male staff represented across middle to senior grades. However, the proportion is more evenly spread between male and female staff at Band 8c and above.

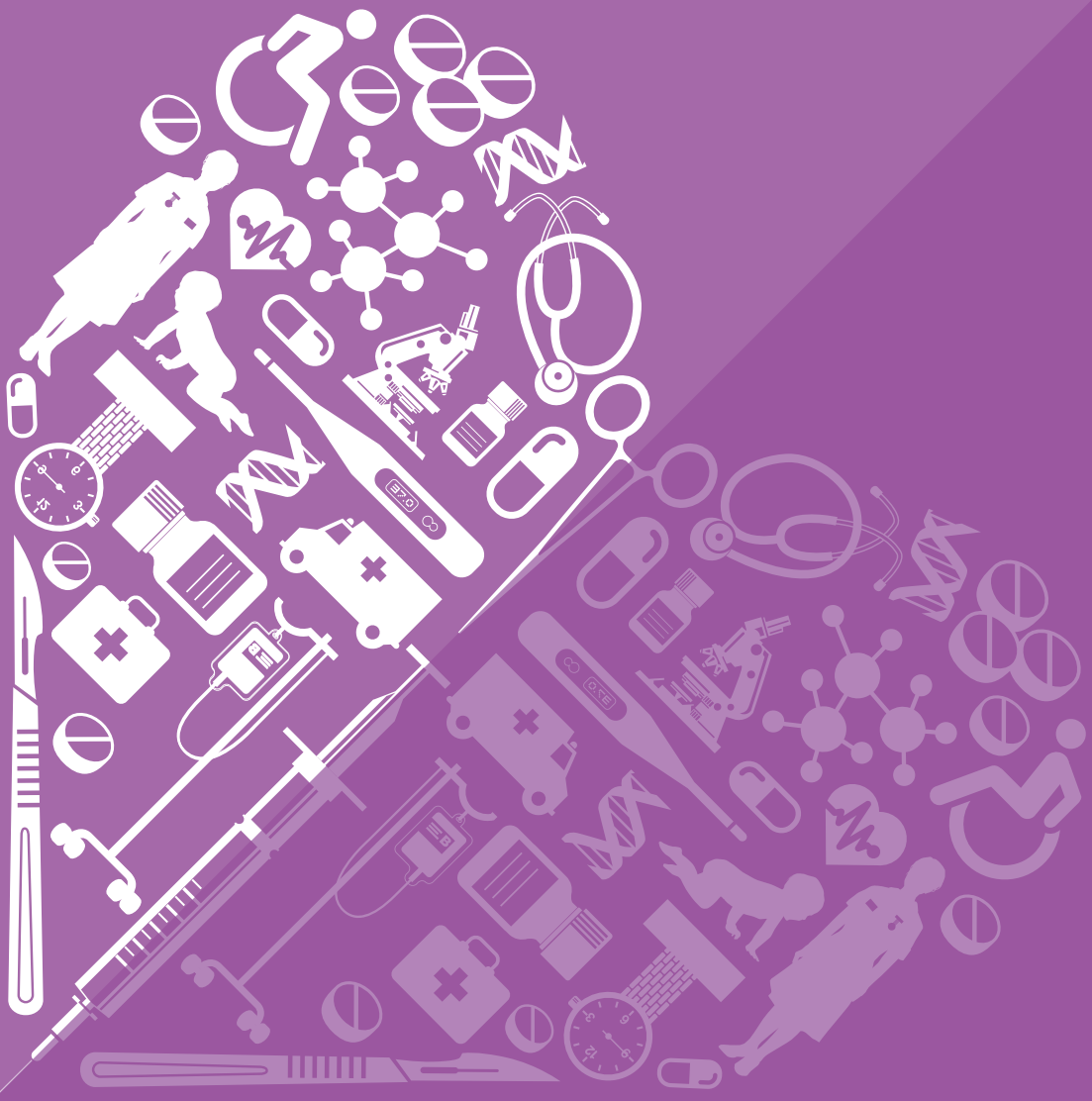
AFC Band	Female	Male	Total	% of females
Band 7	330	46	376	87.77%
Band 8a	81	15	96	84.38%
Band 8b	30	9	39	76.92%
Band 8c	11	8	19	57.89%
Band 8d	8	4	12	66.67%
Band 9	3	3	6	50.00%
Grand Total	**463**	**85**	**548**	**84.49%**

Working with our Partners

The Trust contributes to nationally recognised and statutory partnerships through:

- Cross system networks to support high quality care and Choosing Health priorities such as cardiac network, diabetes network, mental health partnership arrangements and prevention of teenage pregnancy in maternity services.
- Local strategic partnerships such as System Resilience Groups and Bedfordshire and Luton Local Resilience Forum.
- Local Safeguarding Children's Boards (LSCB) – Luton LSCB and Bedfordshire LSCB.
- Local Safeguarding Vulnerable Adult Boards for Luton and Bedfordshire.
- East of England meetings and events.
- Regular CEO meetings with Clinical Commissioning Groups (CCG) Chief Officers, Directors of Social Care and the Chief Officer of the Local Area Team.
- Better Care Boards with Local Authority and CCGs.
- A&E Delivery Board chaired by the L&D Managing Director/Deputy Chief Executive
- Ongoing work improving communication across Luton and Bedfordshire with all stakeholders involved in the management of those patients on an end of life care pathway. The collaborative approach of sharing information through SystmOne (Primary Care Information system) will ensure care is timely and patients achieve their preferred place of death by enabling Trust staff access to the advanced care plans.

Governance Report



Board of Directors

The affairs of the Foundation Trust are conducted by the Board of Directors in accordance with the NHS Constitution and the Foundation Trust's Authorisation.

The Board manages the business of the hospital and is the legally responsible body for making decisions relating to the strategic direction, performance and overall running of the Foundation Trust. The Board has in place a schedule of decisions reserved for the Board and a delegation of powers document, setting out nominated officers to undertake functions for which the Chief Executive retains accountability to the Board.

The Board delegates its duties for the day to day operational activities of the hospital to the Executive Board which includes finance, activity, performance, safety, clinical quality and patient care. The Board comprises seven executive and seven non-executive directors and meetings are in a public setting every two months. In addition the Non-Executive and Executive Directors meet bi-monthly in a seminar session and attend monthly Council of Governors meetings or seminars.

As far as the Directors are aware there is no relevant audit information of which the auditors are unaware and the Directors have taken all the necessary steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Independent Professional Advice

The Board has access to independent professional advice, where it is judged that it is necessary to discharge their responsibilities as Directors.

The Role of the Chairman of the NHS Foundation Trust

The Chairman is pivotal in creating the conditions for cohesion between Board members and the executive roles of the directors. Specifically it is the responsibility of the Chair to ensure the effectiveness of the Board of Directors and to:

- Run the Board, taking account of the issues and concerns of Board members, be forward looking, and concentrate on strategic matters.
- Ensure that members of the Board receive accurate, timely and clear information to enable them to take sound decisions, monitor effectively and provide advice to promote the success of the Trust.
- Preside over formal meetings of the Council of Governors, and ensure effective communication between Governors and the Board of Directors and with staff, patients, members and the public.
- Arrange regular evaluation of the performance of the Board of Directors, its committees and individual Directors.

The Role of Non-Executive Directors (NEDs)

Our NEDs work alongside the Chairman and Executive Directors as equal members of the Board of Directors. The distinct roles of a Non-Executive Director are to:

- Bring independence, external skills and perspectives, and challenge to strategy development and Trust performance.
- Hold the Executive to account for the delivery of strategy; offer purposeful, constructive scrutiny and challenge; and chair or participate as member of key committees that support accountability.
- Actively support and promote a positive culture for the organisation and reflect this in their own behaviour; provide a safe point of access to the Board for whistleblowers.
- Satisfy themselves of the integrity of financial and quality intelligence and that the system of risk management and governance are robust and implemented.
- Ensure the Board acts in the best interests of the public; a Senior Independent Director (SID) is available to members and governors if there are unresolved concerns.
- NEDs including the Chair appoint the Chief Executive.
- As members of the Remuneration and Nomination Committee, determine appropriate levels of remuneration for Executive Directors; support the Chair in appointing and, where necessary removing executive directors, and in succession planning.
- Meet annually with the Chair to review the Chair's performance. The Senior Independent Director takes soundings from Governors.
- Consult with the Council of Governors to understand the views of governors and members and accounts to the Council of Governors in terms of the Statutory and NHS Foundation Trust Code of Governance requirements.

Information regarding the appointment and removal of Non-Executive Directors can be found in the Council of Governors section.

Remuneration and Interests

The remuneration of individual Directors can be found in note 4.5 to the accounts.

Board of Directors 2016/17

Name	Post Held	Year Appointed	Term of Appointment	Status
Mrs Pauline Philip	Chief Executive	2010	Permanent	
Mr Andrew Harwood	Director of Finance	2000	Permanent	
Mr David Carter	Managing Director	2011	Permanent	
Mrs Pat Reid	Chief Nurse	2012	Permanent	Left January 2017
Mrs Sheran Oke	Acting Director of Nursing and Midwifery	2017*	Interim voting	From February 2017
Dr Danielle Freedman	Chief Medical Advisor	2015**	Interim voting	
Ms Angela Doak	Director of Human Resources	2010	Permanent	
Ms Marion Collict	Director of Operations and Risk	2017***	Permanent	From January 2017
Mr Mark England	Director of Re-Engineering and Informatics	2014	Permanent	
Mr Simon Linnett	Chairman	2014	3 Yr Fixed Term	To September 2017
Ms Alison Clarke	Non-Executive Director	2006+	Annual	To July 2017
Mr John Garner	Non-Executive Director	2012**	3 Yr Fixed Term	To May 2018
Dr Vimal Tiwari	Non-Executive Director	2012**	3 Yr Fixed Term	To May 2018
Mr Mark Versallion	Non-Executive Director	2014	3 Yr Fixed Term	To October 2017
Mr David Hendry	Non-Executive Director	2014	3 Yr Fixed Term	To October 2017
Mrs Jill Robinson	Non-Executive Director	2014	3 Yr Fixed Term	To October 2017
Mr Cliff Bygrave	Non-Executive Director	2017	Interim voting 2 years	To March 2019

* Appointed as Deputy Chief Nurse in July 2013 and seconded into Director of Nursing and Midwifery
** Appointed as Chief Medical Advisor (at the L&D since 1987)
*** Appointed in October 2011 and became a voting Director in February 2017
\+ Reflects appointment to Board of Foundation Trust

A declaration of interest register is available for viewing in the Trust Offices

Compliance with the NHS Foundation Trust Code of Governance

It is considered that the Luton and Dunstable University Hospital NHS Foundation Trust complies with the main and supporting principles of the Code of Governance. This includes the issues of whether or not all of the Non-Executive Directors are independent in accordance with code provision B.1.1. The Board has determined that all of the NEDs are independent in character and judgement.

In relation to the more detailed provisions of the Code of Governance, the Trust are compliant with the provision with the exception of section B.1.2 in that the Board does not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

Independent Evaluation of Board Performance both Collectively and Individually

The Board continuously analyses its performance, duties and role on an ongoing basis and employs a Board Secretary to observe the board activity and report findings into the Board of Directors. The Board analyses its own performance at the end of each Board meeting and also requests feedback from Governor Observers at each meeting that is subsequently reported to the Council of Governors.

HM Treasury

The FT has complied with cost allocation and charging guidance issued by HM Treasury.

Board Evaluation

Monitor's Code of Governance suggests that Trusts conduct an external Board Evaluation every three years.

The Trust understands and accepts that a periodic and rigorous board evaluation process represents best-practice and should be considered as part of any governance review. The last review took place in 2013. An evaluation would, therefore, have been due in 2016.

However, a decision was taken to not undertake a separate review, given the fact that the Trust underwent a significant level of scrutiny during its CQC inspection in January 2016. Part of this process was to look at how the organisation is managed and we were assured that acceptable processes were in place by the fact that we received a score of Outstanding in the Well Led domain of the CQC assessment.

The Board of Directors continued to hold a number of seminars throughout the year and to assess the strategic direction of the Trust and ensured that PricewaterhouseCoopers (PwC - internal audit) provided independent review of progress within the clinical divisions.

Trust Directors: Expertise and Experience

Executive Directors

Mrs Pauline Philip
Chief Executive

Pauline joined the L&D as Chief Executive on 1st July 2010. With a strong clinical background, together with a number of highly successful Chief Executive positions, she brings a unique combination of skills and experience to the Trust.

Her vision is to create an organisation that puts patients first every time and that constantly strives to ensure that every patient receives safe care and the best clinical outcomes available in the NHS.

Pauline has an enviable track record in healthcare having spent over eight years in key Chief Executive positions at NHS Trusts in London, followed by her appointment as Director of Mental Health for the London Region of the Department of Health.

In 2002, she was seconded to the World Health Organisation (WHO) to establish a department dedicated to global patient safety. Pauline's appointment at the L&D follows her success at WHO and her proven expertise in leading and driving positive change through complex organisations.

In December 2015, Pauline was appointed to the position of National Director for Urgent and Emergency Care on a part-time secondment from the Trust. David Carter, Managing Director acts up to cover her duties when she is not in the Trust and NHS England have provided financial compensation to provide for other necessary support.

(Membership of Committees – CF, FIP, COSQ, HRD)

Mr David Carter
Managing Director

David Carter has twenty years' experience as a Board Director for various NHS organisations including mental health, community and primary care trusts and in the acute sector at Barnet and Chase Farm Hospitals NHS Trust. David's background is in finance and prior to joining the NHS he spent seven years at KPMG in London working in audit and consultancy where he qualified as an accountant.

David has overall responsibility for operational and estates, performance and contracting.

David acts as Deputy CEO in Pauline's absence.

(Membership of Committees – CF, FIP, COSQ, HRD)

Mr Andrew Harwood
Director of Finance

Andrew has been the Director of Finance since February 2000, with overall responsibility for the Trust's finances.

Andrew's robust approach to financial management has helped to ensure that the L&D has successfully balanced its books in each of the last 18 years. With over 30 year's finance experience in the NHS, gained in health authorities and individual Trusts, he co-ordinated the Trust's financial strategy for our application for NHS Foundation Trust.

(Membership of Committees – CF, FIP, HRD)

Dr Danielle Freedman
Chief Medical Advisor*

Danielle is a Consultant Chemical Pathologist and Associate Physician in Clinical Endocrinology and Director of Pathology. In addition, she was the hospital Medical Director from October 2005 until December 2010.

She trained in medicine at the Royal Free Hospital School of Medicine, London University and then went

on for further training in Clinical Biochemistry and Endocrinology both at the Royal Free Hospital and the Middlesex Hospital, London University.

Nationally, in the UK, she was an elected Vice President of Royal College of Pathologists (2008 – 2011) and sat on RCPath Executive and Council (2005 – 11). She was Chair of the RCPath Speciality Advisory Committee for Clinical Biochemistry (2005 – 11).She is a Member of the UK NEQAS Clinical Chemistry Advisory Group for Interpretative Comments (2010 -) and also Member of ACB Council (2011-2015). She is now the Chair of Lab Tests Online Board UK (2012).

Her main interests include clinical endocrinology, point of care testing and, importantly, the role of the laboratory/ clinician interface with regard to patient safety and patient outcome. She has over 100 publications in peer review journals including Lancet, New England Journal of Medicine, JAMA and Annals of Clinical Biochemistry in her areas of interest.

She is a frequently invited speaker both nationally and internationally on the above topics. She won the 'Outstanding Speaker' award in 2009 from the American Association of Clinical Chemistry (AACC) and was a Member of the AACC Annual Meeting Organising Committee (AMOC) for 2011(Atlanta) and also Member of AMOC for 2014.(Chicago). She was also on the Scientific Committee for EUROLAB FOCUS 2014 (Liverpool, UK).

* Medical Directors David Kirby, James Ramsay, Robin White & Nisha Nathwani

(Membership of Committees – CF, COSQ, HRD)

Ms Angela Doak
Director of Human Resources

In November 2010 Angela took up post as the Director of Human Resources in an acting capacity, after initially joining the Trust in July 2010 as Associate Director of Human Resources.

Angela has over 20 year's experience in human resources and organisational development in acute NHS trusts. Just prior to joining the Trust Angela held the post of Director of HR in a Foundation Trust. She has a strong track record in providing high quality HR services and her particular areas of interest and expertise include dealing with major organisational change, complex employee relations cases and also employment matters concerning medical staff.

(Membership of Committees – COSQ, CF, FIP, HRD)

Mrs Patricia Reid
Chief Nurse – left January 2017

Pat was previously the Deputy Chief Nurse at Cambridge University Hospitals NHS Foundation Trust. Pat trained as a nurse at University College Hospital London and had numerous senior nurse posts before moving into publishing as Editor of the Nursing Times. She was also the very first nurse on the board of the BMJ.

Pat has a broad experience in the NHS having also undertaken General Management and service redesign roles.

(Membership of Committees – COSQ, CF, HRD, FIP)

Mrs Sheran Oke
Acting Director of Nursing and Midwifery – from February 2017

Sheran has over 30 years experience of working in the NHS at a senior nursing and general management level, working in a number of different NHS Trusts including single specialty, DGH and an Academic Health Science Centre, most latterly she was Deputy Chief Nurse at the L&D. Sheran also has held the post of a Registered Nurse on the Governing Body of a CCG for a number of years where she chaired their Quality and Performance Board

In the past Sheran has worked internationally establishing health related community development programmes and has been a senior advisor and Board member to a large UK youth organisation as well as chairing the European Committee and has been an elected member to the Board of the World Associatoion of Girl Guides and Girl Scouts

(Membership of Committees – COSQ, CF, HRD, FIP)

Mr Mark England
Director of Re-Engineering and Informatics

Mark joined the Trust in 2008 from the London Borough of Croydon where he had been a Chief Information Officer for Children's Services for four years. There he delivered high-quality, commercially competitive technology services to almost 150 schools, while leading multiple high profile eGovernment projects. Many of these were Pan-London, including leading the technical delivery of the award winning shared eAdmission portal used by 100,000s of parents each year. By enabling electronic channels of payment Croydon was also the first authority to take cash transactions out of all schools, releasing considerable financial and quality benefits.

His first exposure to the NHS was working to develop an early Children's Index with local NHS providers in South London.

Prior to that he spent five years working as a Project Manager on the development, and global implementation, of a web-based multilingual Enterprise Resource Planning (ERP) system. This was focussed on supporting the delivery of Reproductive Health services in the developing world, and was implemented in 140 countries in four languages. Qualified as a software engineer, specialising in multi-lingual application design, he worked across multiple sectors on commercial internet based applications for many years.

(Membership of Committees – CF, FIP, HRD)

Ms Marion Collict
Director of Operations and Risk – from January 2017

Marion is a nurse and midwife by background and moved from Scotland to England in 1998. She has worked at local and regional level in the East of England before coming to the L&D in 2011. Marion has held a number of positions in the Trust including Interim Chief Nurse and Director of Transformation before taking over Operations Risk & Governance. Marion lives locally and is keen to ensure the L&D Hospital goes from strength to strength.

(Membership of Committees – CF, COSQ)

Non-Executive Directors

Mr Simon Linnett
Chairman

Simon Linnett is an Executive Vice Chairman at Rothschild in London. He has devoted a large part of his professional life to working within the public/private interface both nationally and internationally and is responsible for the bank's relationship with the UK government. He has had a long association with the health dialogue including the health reform process and the health debate generally and has engaged with various government bodies and other health institutions on this subject. Simon has previously headed Rothschild's global transport group and remains closely involved with its initiatives. He has a strong personal interest in the "green" debate, seeking to influence discussion on auctioning emissions and chairing Rothschild's Environment Committee. Simon graduated from Oxford in Mathematics in 1975 and joined N. M. Rothschild & Sons Ltd where he has been ever since. Simon's external roles include: on the Council and Treasurer of Queen Mary University London; Trustee of the Science Museum Group; a Patron of the Independent Transport Commission; and Trustee of Exbury Garden Trust (a Rothschild family garden). He is a Trustee of NESTA.

(Membership of Committees – CF, RNC, FIP, HRD)

Ms Alison Clarke
Non Executive Director, Vice Chair and Senior Independent Director

Prior to being appointed as Non-Executive Director in 2002 Alison held Chief Officer and Assistant Director posts in several London local authorities. Her special areas of interest and expertise are performance management, quality management and human resources. She was awarded an MBA in 2000. In view of her experience in July 2015 the L&D Board appointed Alsion as L&D's Senior Independent Director and Vice Chair.

(Membership of Committees – COSQ, CF, RNC, AC)

Mr John Garner OBE
Non Executive Director

John began life in HM Forces serving overseas and then coming out to become a Police Officer, Teacher and Education Officer HMP Preston. From this point he entered local government to become a Chief Officer in a number of authorities in the North Department Community Services (Environmental Health, Leisure and Housing).

After a career in local government he became the Chief Executive of the National Union of Students and progressed from there to become Controller for Sport and Entertainment at Wembley Stadium Ltd.

John has been the Chair of integrated governance, Deputy Chair of the Audit Committee, NED with South Beds PCT and Chair of Beds Shared Services Board. He has also been the Chair of Beds Children's Safeguarding Board. He was NED and Chair of Audit, Chair Information Governance, Chair Risk Committee Milton Keynes Community Health Services. In addition to this John has been a NED and Audit Committee member for the Football Licensing Authority DCMS and Chair of Audit for the Government Office NW and Member Dept Communities and local Government Dept Audit and Risk Management Committee.
John was also awarded an OBE for his services to children with special needs.

(Membership of Committees – AC, CF, RNC, FIP, HRD)

Dr Vimal Tiwari
Non Executive Director

Dr Vimal Tiwari was educated at Aberdeen University Medical School and St Mary's Hospital London, and also has a Master's Degree in Medical Education from the University of Bedfordshire. She has worked as a GP in Hertfordshire for over 30 years and as a Named Safeguarding GP for 8 years, with parallel careers over the years in Mental Health, Community Paediatrics, Medical Education and more recently Clinical Commissioning. She maintains a strong interest in Child Health, while being committed to securing the best quality compassionate, modern and comprehensive health care for all ages.

She was elected to Fellowship of the Royal College of General Practitioners in May 2016 for services to the College as Clinical Lead in Child Health and Child Safeguarding and contributions to educational resources including editing the 2014 edition of the RCGP/NSPCC Safeguarding Children Toolkit.

(Membership of Committees – AC, CF, RNC, COSQ)

Mr Mark Versallion
Non Executive Director

Mark was appointed to the board in 2013 having served on the board of NW London NHS Hospitals Trust from 2008-13. As well as experience in the public sector he brings many years' experience from the commercial sector, with companies such as BAE Systems plc, Capgemini plc, and ten years as Managing Director of the London marketing agency VML. He worked for a U.S. Senator and a U.K. Government Minister in the 1990s and has held a number of national and local political posts and non-executive directorships.

He was a Royal Navy officer for fourteen years in the reserves and was a Councillor in London for nine years. He has been a Bedfordshire Councillor since 2011, holding senior positions and specialising in children's social services and education.

Mark is married with four children and lives in Heath and Reach, Bedfordshire.

(Membership of Committees – AC, FIP, CF, RNC)

Mr David Hendry
Non Executive Director

David was born in Luton and qualified as a Chartered Accountant with Whittaker &Co in Castle Street before gaining further professional experience with KPMG. Following eight years in the profession he moved into the retail sector, firstly with BHS plc, where he went through a series of promotions ultimately heading the Finance Directorate and contributing to the company's significant turnaround. He was then recruited by TK Maxx as the US retailer's European Finance Director, helping them adapt and profitably grow the concept from four UK stores to 212 operating in three countries over the 11 years he was there.

Wanting to gain experience in the public sector, he then spent six years with Transport for London as Surface Transport Finance Director, the division which facilitates 80% of all journeys through the capital's streets and rivers, contributing to significant improvements in service and efficiency over this period.

In 2014 David decided to pursue a portfolio career, giving him more personal flexibility and opportunity to utilise his skills. He sees the Non-Executive role at L&D as a significant opportunity helping support the right to health and treatment for all, and to do so in an area that has been home to him throughout his life.

(Membership of Committees – AC, CF, HRD, COSQ, RNC, Attends FIP)

Mrs Jill Robinson
Non Executive Director

Jill has a background in Financial Services and qualified as a certified accountant with Prudential plc. Having gained extensive financial, management and project accounting experience Jill moved into operational roles to use her accountancy skills and progressed to become Operations Director of Prudential Europe and then Operations Transformation Director for Prudential UK. Jill moved to Equitable Life Assurance Society as Operations Director where she was responsible for delivering two regulated projects allowing release of reserves of £540m, restoring stability to the servicing through the elimination of backlogs and resolving complaints within two days. From there she moved to Mercer as Partner, Head of Customer Service Delivery. Jill was responsible for the development of a new operational model, resulting in cost reduction of 30% and improvement of service level standards to 98%. Jill is currently Outsourcing and Finance Director for Marine & General Mutual, setting strategy and effecting the sale of the company. Jill is passionate about enthusing teams to deliver improved services, at reduced cost, for the benefit of customers and considers it a privilege to be able to use her skills in the NHS for the benefit of patients and staff alike.

(Membership of Committees – AC, CF, FIP, RNC)

Mr Clifford Bygrave
Non-Executive Director
From January 2017

Clifford Bygrave is a Fellow of the Institute of Chartered Accountants in England and Wales, a Chartered Tax Adviser and a Member of the Society of Trust and Estate Practitioners. Clifford has been a Non-Executive Director at the L&D since 2001. He also served as Non-Executive Director of Bedfordshire Health Authority until its merger with the East of England Strategic Health Authority and was Chairman of the L&D's Audit and Risk Committee.

Following his retirement as a partner at Ernst & Young, Clifford is now the National Finance Director of the Boys' Brigade. He has served on the Council of the Institute of Chartered Accountants in England and Wales for 23 years. He also represented the UK Accounting bodies on the International Federation of Accountants Ethics Committee for five years. In addition he represented his Institute in Brussels for a number of years. In view of his seniority on the L&D Board and his extensive governance experience Clifford was appointed as L&D's Senior Independent Director with effect from July 2007 until he retired in July 2015. In February 2017, Cliff was asked to return as an interim Non-Executive Director for a maximum of two years.

Cliff is the Chair of the Charitable Funds Committee.

(Membership of Committees – AC, CF, FIP)

Key to committees:

COSQ – Clinical Outcomes, Safety and Quality Committee
CF – Charitable Funds Committee
RNC – Remuneration & Nomination Committee
AC – Audit and Risk Committee
FIP – Finance, Investment and Performance Committee
HRD – Hospital Re-Development Programme Board

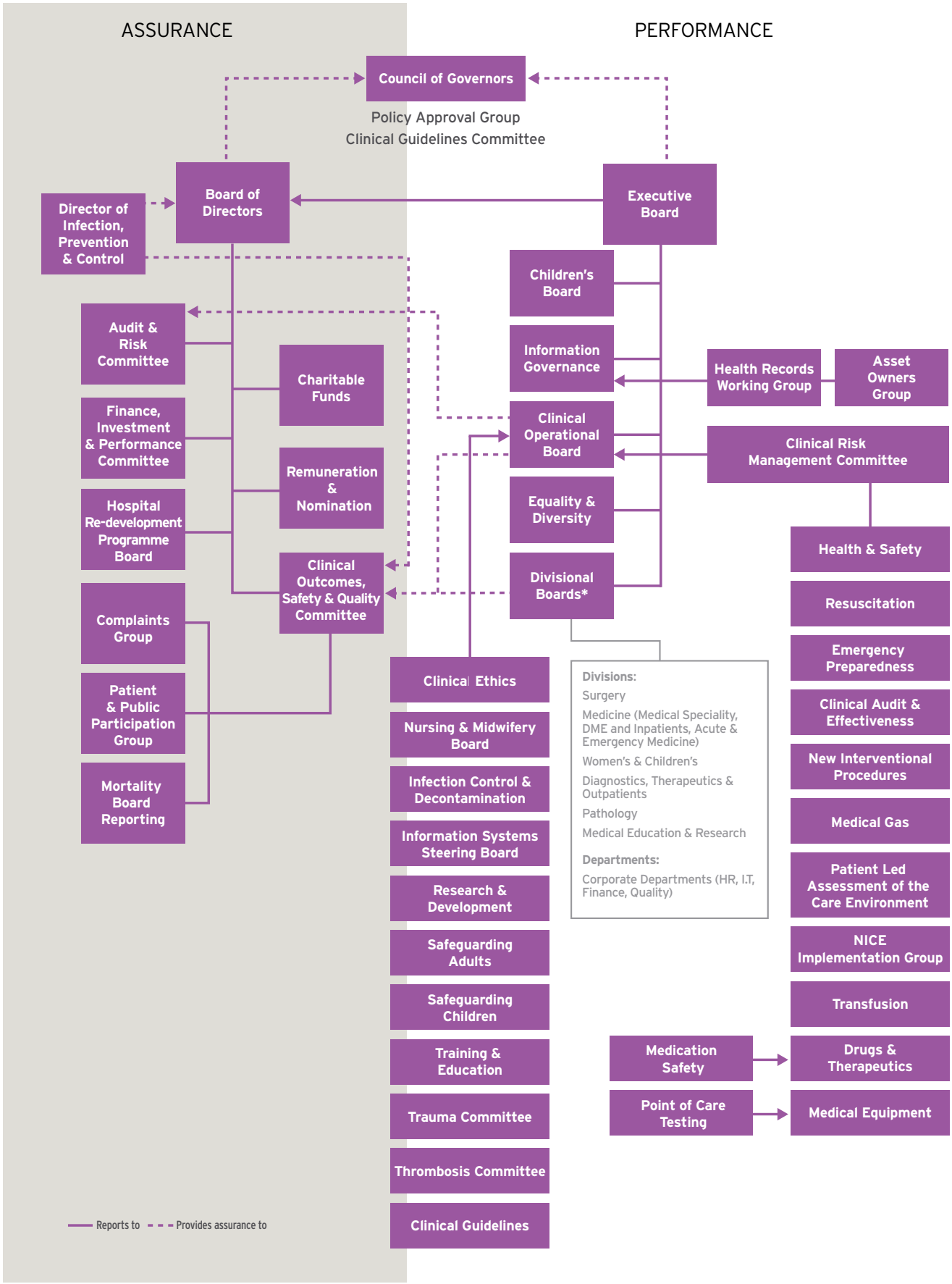
Record of committee membership and attendance

Total Meetings	Public Board Meetings	Private Board Meetings	Audit & Risk	Remuneration and Nomination	Charitable Funds	COSQ	HRD	FIP
Pauline Philip	3/4	7/9			1/4	5/10	1/5	8/9
Simon Linnett	4/4	9/9		3/3	4/4		5/5	8/9
Andrew Harwood	4/4	9/9			4/4		4/5	9/9
David Carter	4/4	8/9			1/4	7/10	5/5	9/9
Pat Reid to January 2017	3/3	7/7			3/4	6/9*	1/5	3/6
Sheran Oke from February 2017	1/1	2/2			0/0	1/1	0/0	2/2
Angela Doak	4/4	8/9			4/4	8/10**		7/9**
Mark England	4/4	8/9			4/4		5/5	7/9
Marion Collict from February 2017	0/0	2/2			0/0	1/1		
Medical Directors	4/4	8/9			1/4	10/10		8/9
Alison Clarke	4/4	8/9	4/4	3/3	4/4	9/10		
John Garner	4/4	9/9	3/4	3/3	4/4		5/5	9/9
Vimal Tiwari	4/4	8/9	4/4	3/3	3/4	8/10		
Mark Versallion	4/4	9/9	4/4	3/3	4/4			9/9
David Hendry	4/4	7/9	4/4	3/3	4/4	10/10	4/5	8/9
Jill Robinson	3/4	7/9	4/4	3/3	3/4			9/9
Clifford Bygrave from February 2017	1/1	2/2	1/1	1/1	0/0			1/2

* S Oke deputised
** Denotes that J Machon deputised for FIP and S Gitkin deputised for COSQ
\+ at the beginning of 2016/17 the Hospital Re-Development programme was paused for review due to the STP plans. Meetings were still held but had a different focus.

Committees of the Board of Directors

Luton and Dunstable Hospital Governance and Committee Structure



* Divisional Board meeting include standard agenda items of Risk Management, Risk Registers, Incidents, Complaints and claims and information related to each of the relevant sub-committees of the Clinical Operational Board

Audit and Risk Committee

The function of the Audit Committee has been to ensure an adequate and effective operation of the Trust's internal control system. The committee focuses on the establishment and maintenance of controls designed to give reasonable assurance that assets are safeguarded, waste and inefficiency avoided, reliable information produced and that value for money is continuously sought.

Key responsibilities delegated by the Board to the Audit and Risk Committee are to:

- Ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.
- Monitor and review compliance with Standing Orders, Standing Financial Instructions and Scheme of Delegation.
- Review the annual financial statements and Annual Report for compliance with accounting standards and legal requirements before submission to the Board of Directors.
- Review the annual Counter Fraud programme and ensure the Trust is adequately resourced to meet the requirements of the Directorate of Counter Fraud;
- Ensure cost-effective external audit.
- Appoint, monitor and review Internal Audit service.
- Report to the Council of Governors on any matters that require immediate action and make recommendations on steps to be taken.
- Obtain assurance from the other committees, COSQ, FIP, RNC, HRD and Executive.

Membership of the Audit and Risk Committee:

The Audit Committee membership has been drawn from the Non-Executive Directors and is chaired by Mr David Hendry (NED).

Audit and Risk Committee Report

The Audit and Risk Committee reviewed financial and operating performance and compliance against national and regulatory standards. A comprehensive work plan is agreed each year which ensures oversight and monitoring of risks, mitigations and issues relating to the financial statements, internal controls and compliance with regulatory, statutory responsibilities and internal policies and procedures which in turn enables action to be escalated as appropriate, i.e. officer attendance to explain critical risk or failure to implement internal audit recommendations and escalation to the Board where appropriate. An annual report of the Committee's activities and how the Committee has fulfilled its role is reported by the Chair of the Audit & Risk Committee to the Board and the Council of Governors. The Committee has had close oversight throughout the year of the Board Assurance Framework and principal risks on efficiency planning and sustainability. In depth reviews of operational risks on the register, including Income from Activities, Agency and Locum Staff CIPs, Cash Flow Forecasting and Cash Management, HR Recruitment and Retention, Financial Governance and Medical Devices have further supported the Committee's understanding and review of the key issues facing the Trust. In relation to CQC compliance with care standards, the Committee reviews regular reports from the Clinical Outcome Safety and Quality Committee and was sighted on the CQC Report received in June 2016 that rated the Trust as 'Good'.

Internal Audit

The Audit and Risk Committee has been assured by the Head of Internal Audit Opinion on the Trust's internal control environment and positive approach to identifying, assessing and mitigation planning to risks.

External Audit

The Audit and Risk Committee engages regularly with the external auditor throughout the financial year, including holding private sessions with Non-Executive Directors.

The Audit and Risk Committee considers the external audit plan, technical updates, any matters arising from the audit of the financial statements and the Quality Account and any recommendations raised by the external auditor.

The External Audit programme is scheduled to focus on key areas of risk and for 2016/17 the areas of audit risk were:

- The valuation of land and buildings
- The valuation and existence of NHS and non-NHS receivables and completeness, existence and accuracy of NHS and non-NHS income
- The fraud risk from revenue recognition
- The fraud risk from management override of controls and the focus on any areas of management judgement or transactions outside of routine business

The ISA260 report presented on the 24 May identified that there were no material concerns or control weakness identified during the year.

The appointment of the auditor was made in 2012 as a result of a competitive process under a procurement compliant framework. The appointment was extended in 2014 and 2016 on the same terms. Each appointment is subject to Council of Governors agreement. Reports from External Audit are received and reviewed at each Audit and Risk Committee to assess the effectiveness of the external audit programme. External Audit confirmed they were able to complete the required testing against the controls in the fee agreed with the Trust.

The organisation's going concern status has been specifically discussed with the External Auditors in relation to the financially challenging environment the Trust faces. Assurance on the accounts review of the "going concern" opinion is based on risk to service continuity and that the Trust is able to confirm service continuity and therefore going concern status over the medium term.

KPMG LLP have also provided tax advice on an ad hoc basis during 2016/17 totalling £22,231 (excluding VAT). Each assignment was subject to an individual engagement letter and undertaken by a separate division within the organisation thereby avoiding any objectivity or independence issues.

Remuneration and Nominations Committee

This Committee reports to the Board of Directors and acts as defined in the Standing Financial Instructions, Standing Orders and Code of Governance documents.

The Committee has delegated responsibility from the Trust Board for the appropriate remuneration for the Chief Executive, other Executive Directors employed by the Trust and other senior employees on locally agreed pay arrangements, including:

- All aspects of salary.
- Provisions for other benefits, including pensions and cars.
- Arrangements for termination of employment and other contractual terms;
- Review the composition of the Board of Directors and make recommendations as to the appropriate make-up of the Board.
- Make recommendations to the Nomination Committee of the Council of Governors in respect of Non-Executive Director positions.

Membership of the Remuneration and Nominations Committee:

The Remunerations and Nominations Committee has been drawn from the Board members and is chaired by Mark Versallion (NED).

Charitable Funds Committee

The L&D is a Corporate Trustee. The Charitable Funds Committee, on behalf of the Corporate Trustee, agrees proper use of charitable funds and approves fundraising schemes.

Key responsibilities are to:

- Keep proper accounting records and prepare accounts in accordance with applicable law.
- Safeguard the assets of the charity.
- Take reasonable steps for the prevention and detection of any fraud and other irregularities.
- Determine operating procedures for the administration of charitable funds.
- Appoint investment advisors.
- Appoint independent auditors.

Membership of the Charitable Funds Committee:

The Charitable Funds Committee membership has been drawn from Board members. In September 2015, the Board of Directors agreed an independent chair of this committee and Mr Clifford Bygrave was appointed.

Clinical Outcome, Safety and Quality Committee

The Clinical Outcome, Safety and Quality Committee provide assurance to the Board of Directors that the Trust is compliant with legislation and guidance on clinical, patient safety and quality issues.

The Clinical Outcome, Safety and Quality Committee monitors the implementation of strategic priorities and the organisations performance in relation to clinical outcome and research and development. It ensures compliance with regulatory requirements and best practice within the patient safety and quality improvement agenda.

Membership of the Clinical Outcome, Safety and Quality Committee:

The Clinical Outcome, Safety and Quality Committee membership includes Board members, and is chaired by Alison Clarke (NED and SID).

Finance, Investment and Performance Committee

The purpose of the Finance, Investment and Performance Committee has been to lead the strategic direction of the Trust's finance work, approving capital bids and plans and monitoring performance.

Membership of the Finance, Investment and Performance Committee:

The Finance Investment and Performance Committee membership included Board members, senior managers and clinicians and is chaired by Mrs Jill Robinson (NED).

Hospital Re-Development Programme Board

The purpose of the Hospital Re-Development Programme Board has been to lead the progression of the Outline Business Case following approval of the Strategic Business Case at the Board of Directors on the 1 October 2014 progressing to the full business case and enabling works.

The progress towards a full business case is currently on hold pending proposals being developed regarding service delivery across BLMK STP are developed; meanwhile the board oversees development of enabling works not dependent on the likely proposals.

Membership of the Hospital Re-Development Programme Board:

The Hospital Re-Development Programme Board membership included Board members, senior managers and clinicians and is chaired by Mr Simon Linnett.

Council of Governors

Council of Governors

The constitution defines how we will operate from a governance perspective and it is approved by the Board and the Council of Governors. The basic governance structure of all NHS Foundation Trusts includes:

1. The Membership;
2. The Council of Governors; and
3. The Board of Directors

In addition to this basic structure, Board and Council of Governor committees and working groups, comprising both Governors and Directors, are used as a practical way of dealing with specific issues.

The specific statutory powers and duties of the Council of Governors are:

- Appoint and, if appropriate remove the Chair.
- Appoint and, if appropriate remove the other Non-Executive Directors.
- Decide the remuneration and allowances and the other terms and conditions of office of the Chair and the other Non-Executive Directors.
- Approve the appointment of the Chief Executive.
- Appoint and, if appropriate remove the NHS Foundation Trust's auditor.
- Receive the NHS Foundation Trust's annual accounts, any report of the auditor on them and the annual report.
- Hold the Non-Executive Directors to account for the performance of the Board
- Approve significant transactions as defined in the Trust's Constitution.

In addition:

- In preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

The Monitor Code of Governance determines that every NHS Foundation Trust will have a Board of Governors which is responsible for representing the interests of NHS Foundation Trust members and partner organisations in the local health economy in the governance of the NHS Foundation Trust. Governors must act in the best interests of the NHS Foundation Trust and should adhere to its values and code of conduct. The Board of Governors should hold the Non-Executive Directors to account for the performance of the Trust, including ensuring the Board of Directors acts so that the Foundation Trust does not breach the terms of its authorisation. Governors are responsible for regularly feeding back information about the NHS Foundation Trust, its vision and its performance to the constituencies and stakeholder organisations that either elected them or appointed them. The Code of Governance states that one of the independent Non-Executive Directors should be appointed by the Board of directors as the "Senior Independent Director", or SID, in consultation with the Board of Governors. The SID should act as a point of contact if governors have concerns which contact through normal channels has failed to resolve or for which such contact is inappropriate. Mrs Alison Clarke acts as the SID.

The constitution provides that the Board of Directors appoint a vice chairman from one of our Non-Executive Directors. The vice chairman should deputise for the chair as and when appropriate. Mrs Alison Clarke acts as the Vice Chair.

It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS Foundation Trust.

The Council of Governors was chaired by Mr Simon Linnett. Council of Governor meetings are held at least three times in each financial year and are open to the public and representatives of the press. Since September 2009 these meetings have been held every two months. In February 2016, the Council of Governors agreed to meet formally quarterly.

In October 2015 the Council of Governors re-elected Mr Roger Turner as Deputy Chair/Lead Governor of the Council of Governors for a term of two years. The Deputy Chairman or Lead Governor of the Council of Governors presides as chair of any meeting of the Council of Governors where the Chairman presiding at that meeting in terms of a conflict of interest (section 12.29 of the Constitution). The Lead Governor is also the nominated person that NHS Improvement would contact in the event that it is not possible to go through the Chair or the Trust's Secretary.

The Council of Governors met seven times during 2016/17 and the attendance is recorded.

Register of Interests of the Council of Governors' Members

A declaration of interest register is available for viewing in the Trust Offices.

Elections

Our annual elections to the Council of Governors were held during May – August 2016. Electoral Reform Services (ERS) were our independent scrutiniser to oversee the elections, which were held in accordance with the election rules as stated in our constitution.

The following constituency seats were filled by uncontested candidates

- Staff: Administration, Clerical and Management
- Staff: Ancillary and Maintenance

The following constituency seats were filled by election

- Public: Luton
- Public: Bedfordshire
- Staff: Nursing and Midwifery

Analysis of Annual Election Turnout:

Date of election	Constituencies involved	Number of members in Constituency	Number of seats contested	Number of Candidates	Election turnout %
August 2016	Public: Luton	6,890	6	11	15%
August 2016	Public: Bedfordshire	2,957	1	6	20%
August 2016	Staff: Nursing and Midwifery (including HCAs)	2,071	1	2	18%

The Trust annual elections to the Council of Governors are held during May – July and the elected candidates initiate their terms from September. The average turnout is around 20%. For each election the Trust requests a voter profiling report to identify whether there are any issues with diversity. During 2016/17, the Trust added five languages to the letter and envelope and members could request translated packs. However, there were no requests for these packs and voter turnout in the minority groups in Luton remained low. During 2017/18, we will engage with the Trust's Equality and Diversity Lead to identify any other positive action that can be taken to increase voting from minority groups.

Governors in post – April 2016 to March 2017

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Appointed Governors					
Luton CCG	Carole Hill	Appointed to 2016	Resigned June 2016	3 years	1/1
	Colin Thompson	Appointed from June 2016	Start of 1st term	3 years	
Bedfordshire CCG	Vacant				
Hertfordshire CCG	Vacant				
Central Bedfordshire Council	Cllr Maurice Jones	Appointed to 2019	Resigned Feb 2017	3 years	3/3
Luton Borough Council	Cllr Ayub Hussain	Appointed to 2018		3 years	3/4
University College London	Prof Brian Davidson	Appointed to 2016	Term Ended	3 years	0/2
	Prof Ann Blandford	Appointed to 2020	Appointed March 2017	3 years	0/0

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Public Governors					
Hertfordshire	Mr Donald Atkinson	Elected to 2018		3 years	4/4
	Mr John Harris	Elected to 2017		3 years	3/4
	Ms Helen Lucas	Elected to 2018		3 years	2/4
Bedfordshire	Mrs Sandra Bowden	Elected to Sept 2017		3 years	2/4
	Miss Dorothy Ferguson	Elected to 2018		3 years	3/4
	Ms Jennifer Galluci	Elected to 2018		3 years	4/4
	Mr Ray Gunning	Elected to 2018		3 years	4/4
	Mr Bob Shelley	Elected to 2016	End of term	3 years	2/2
	Mrs Sue Steffens	Elected to 2019			2/2
	Mr Jim Thakoordin	Elected to 2018		3 years	3/4
	Mr Roger Turner	Elected to 2017		3 years	4/4
Luton	Mr Keith Barter	End of term		3 years	2/2
	Mr John Barclay	Resigned	Sept 2016	3 years	1/2
	Mrs Pam Brown	Elected to 2019	Start of 1st term	3 years	2/2
	Ms Marie-France Capon	Elected to 2018		3 years	3/4
	Mrs Susan Doherty	Elected to Sept 2017		3 years	2/4
	Mr Sean Driscoll	Elected to 2019	Start of 1st term	3 years	2/2
	Mr Amer Hussain	End of term		3 years	0/2
	Mrs Judi Kingham	Elected to Sept 2017		3 years	3/4
	Mr Anthony Scroxton	Elected to 2019	Start of 3rd term	3 years	4/4
	Mr Tariq Shah	End of term		3 years	0/2
	Mr Derek Brian Smith	Elected to 2018		3 years	4/4
	Mrs Geraldine Tassell	Resigned	June 2016	3 years	0/1
	Ms Shamim Ulzaman	End of term		3 years	1/2
	Mr Jack Wright	Elected to 2019	Start of 1st term	3 years	2/2
	Mr Mohammed Yasin	Elected to 2019	Start of 1st term	3 years	2/2
	Mr Shaobo Zhou	Elected to 2018		3 years	3/4
Staff Governors					
Admin, Clerical and Management	Mr Jim Machon	Elected to 2018	Start of 3rd term	3 years	3/4
	Mrs Ros Bailey	Elected to 2019	Start of 3rd term	3 years	4/4
Nursing and Midwifery (including Health Care Assistants)	Mrs Belinda Chik	Elected to 2018		3 years	4/4
	Mrs Ann Williams	Elected to 2018		3 years	2/4
	Mrs Marva Desir	Elected to 2019	Start of 1st term	3 years	0/2
Volunteers	Mrs Janet Graham	Elected to 2018		3 years	3/4
Medical and Dental	Dr Ritwik Banerjee	Elected to 2017		3 years	2/4
Ancillary and Maintenance	Mr Gerald Tomlinson	Elected to 2019	Start of 2nd term	3 years	1/4
Professional and Technical	Ms Cathy O'Mahony	Elected to 2018		3 years	4/4

Anyone wishing to contact Governors can write to the Governors' email address governors@ldh.nhs.uk or to the Board Secretary. The Members' Newsletter can be found on the L&D's website.

Council of Governors Sub Committees

There are three sub-committees of the Council of Governors

Remuneration and Nomination Committee
The Remuneration and Nomination Committee assists the Council of Governors in carrying out the following of its functions:

- To appoint and if appropriate remove the Chair.
- To appoint and, if appropriate remove the other Non-Executive directors.
- To appoint and, if appropriate remove the Vice-Chairman of the Board of Directors.
- To decide the remuneration and allowances and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.
- To approve the appointment of the Chief Executive.
- To agree the outcome of the annual appraisals of the Non-Executive Directors by the Chair.
- To agree the outcome of the annual appraisal of the Chair by the Senior Independent Director.

During 2016/17 the committee met twice and has completed the following activities:

- Approved the remuneration and allowances for the Non-Executive Directors.
- Agreed the outcomes of the Non-Executive Directors appraisals.
- Completed the process to be able to recommend to the Council of Governors the extension of three Non-Executive Directors and the Chairman.

Membership and Communication Committee
The Membership and Communications Committee assists the Council of Governors in carrying out the following of its functions:

- To implement the Trust Membership Strategy.
- To be a contact for the Trust to encourage membership.
- To represent the Council of Governors and visit locations around the Trust's constituencies to encourage membership.
- To support the publication of the Ambassador newsletter to members.
- To support the Annual Member's meeting.
- To ensure the Trust's Membership Strategy is reviewed yearly and remains fit for purpose.

During 2016/17 the committee met four times and has completed the following activities:

- Issued two Ambassador newsletters.
- Reviewed the Membership Strategy.
- Supported the two Medical Lectures on Critical Care and Stroke Services.
- Supported the Annual Member's Meeting.
- Visited locations across the catchment to increase membership.

Constitutional Working Group
The Constitutional Working Group assists the Council of Governors in carrying out the following of its functions:

- To ensure that the Constitution is up to date with new developments.
- To review the Constitution at least annually.
- Recommend amendments to the constitution to the Council of Governors;
- Liaise with Monitor and legal representatives when required.
- Report to the Annual Members Meeting to approve any Constitutional amendments.
- During 2016/17 the committee met twice and agreed a number of improvements to the current constitution that were agreed by the Council of Governors in January and February 2017 and the Board of Directors in February 2017 and May 2017. None of the amendments affected the powers of the governors.

Foundation Trust Membership

The Trust's Governors and Members continue to play a vital role in our Constitution as a Foundation Trust. There are two broad categories of membership constituency namely public and staff (including volunteers). The public constituency is further divided into three:

i. Luton
ii. Bedfordshire
iii. Hertfordshire

The Trust currently has 16,508 members (12,073 public and 4435 staff). The FT public membership numbers increase around 3% each year and the Governors set a target of 600 new members annually. The Governors agree a Membership Strategy through the Council of Governors and follows six key objectives:

1) To increase the membership - The strategy outlines more focussed work on recruiting members in Bedfordshire with an engagement approach to the Luton and Hertfordshire membership.

2) To ensure membership diversity - A review of the diversity of the membership identified that an increase the number of younger members was required. The Trust has made links with the Youth Parliament and Apprenticeship schemes.

3) To develop the membership database - In order to increase communication, the aim is to maintain the number of recorded e-mails at 30%. The Trust has also continued to use an email use group where appropriate to expedite communications.

4) To provide learning and development opportunities to the membership - Two medical lectures were held for 2016/17 (Critical Care and Stroke) and two more are planned for 2017/18. Engagement events are also supported across the catchment area for the public and membership that provide opportunity to learn about the L&D services and speak to medical teams.

5) To communicate with the membership and encourage them to stand in elections - This has been part of the strategy for over two years following an uncontested election of the Luton constituency. The Governors are key to ensuring that when members are recruited, they are also informed about being a Governor. At each of the L&D events, there is an information stand to encourage members to stand for election and the Ambassador magazine includes communication from governors to also provide clarity on the role and how they can be involved. This year, we also offered information packs for election in the top five languages for the area.

Strategy for 2016/17

The strategy will be reviewed in May 2017 by the Membership and Communication Sub-Committee to identify the plans for 2017/18. The committee will consider the objectives to include:

- Forecast an increase of the membership to 12,910 for period ending 31 March 2017.
- Further increase the membership and hold engagement events in Bedfordshire.
- Target key membership groups to discuss becoming Governors.
- Encourage members to vote for their preferred candidates in the elections.

In 2017/18, there are seven vacancies; 6 Public Governors (3 Luton, 2 Bedfordshire and 1 for Hertfordshire) and 1 Staff Governor (Medical and Dental). The Trust, in conjunction with the Council of Governors and the Board of Directors, is reviewing the Constitution in light of the STP.

Table 1: Membership size and movement:

Public constituency	2016/17 (Plan)	2016/17 (Actual)	2017/18 (Plan)
At year start (April 1)	12,051	12,051	12,510
New members	600	657	600
Members leaving	200	198	200
At year end (March 31)	12451	12,510	12,910
Staff constituency *			
At year start (April 1)	4450	4450	4519
New members	1040	938	888
Members leaving	958	869	736
At year end (March 31)	4532	4519	4671
Total Members	**16983**	**17029**	**17581**
Patient constituency			
Not applicable			

* The Staff Constituency in line with the Trust Constitution and includes volunteers and bank staff that are not part of the Trust headcount.

Table 2: Analysis of current membership:

Public Constituency	Number of members	Eligible membership+
Age (years):		
0-16	2	364482
17-21	68	92286
22+	9061	1213055
Unknown	3379	
Ethnicity:		
White	6378	1327296
Mixed	87	40567
Asian or Asian British	1693	139935
Black or Black British	518	54924
Other	315	10922
Unknown	3,519	
Socio-economic groupings: *		
AB	2841	132796
C1	5842	154585
C2	-	94527
DE	3815	94885
Unknown	12	
Gender analysis		
Male	4879	822872
Female	7600	846951
Unknown	31	
Patient Constituency		
	Not applicable	

Analysis excludes: 3,379 members with no date of birth, 31 with no stated gender, 3519 with no stated ethnicity, and 12 with no stated socio-economic grouping.

* Socio-economic data should be completed using profiling techniques (eg: post codes) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this information.

Notes:

TOTAL - Eligible members:

AGE:	1,669,823
Ethnicity:	1,573,644 **
Socio-economic:	476,793 ***
Gender:	1,669,823

The figures for Ethnicity and Socio-economic do not add up to1,669,823.
The reasons provided by **Membership Engagement Services** are listed below:

The overall Ethnicity figure for **Eligible members is often lower than the other figures purely because it is based on a projection from the 2001 Census data so unable to provide a perfectly accurate representation.

***The overall **Socio-economic** figure for **Eligible members** is lower due to the fact that it only takes into account those between the ages of 16-64 leaving out those outside of that range.

Governor Training, Membership Recruitment and Engagement

The Trust continues to have in place a number of engagement activities to facilitate engagement between Governors, Members and the Public:

- Medical Lectures – the Trust held two lectures on key topics identified by the Governors – Critical Care and Stroke. Trust clinical staff presented to 150 or more members at each session.
- Engagement Events – engagement events were held across the Trust to support the Governors and Trust staff to engage with the public.
- Annual Members Meeting – the Trust had over 150 people at the Annual Members Meeting in September and it is considered an excellent event by those that attend.
- Membership recruitment – all Governors are involved with recruiting members. This ranges from visiting GP practices, attending events such as at the Chamber of Commerce and linking with local groups like the Women's Institute. A sub-committee of the Governors oversee this programme to ensure there is diversity of approach and this year we achieved our target of 600 new members.
- Ambassador Magazine – The Trust issued two 20 page magazines – August 2016 and February 2017 and provides the opportunity for the Governors to report back to the members about Trust progress, Governor involvement and how the Governors are holding the Non-Executive Directors to account.
- Being a Governor awareness sessions – The Trust offers awareness sessions for those interested in becoming a governor. These are held twice a year in April and October and also on a one to one basis as required.
- Governor training – Training is accessible to all Governor through NHS Providers GovernWell programmes. Additionally, joint training sessions with Milton Keynes Governors are taking place. This was an opportunity for the L&D Governors to network and share ideas. The Trust plans to continue this programme for 2017/18 especially in line with the STP activities.

Contact Details

The L&D Foundation Trust's Membership
Department can be contacted on:
01582 718333 or by email:
foundationtrustmembership@ldh.nhs.uk

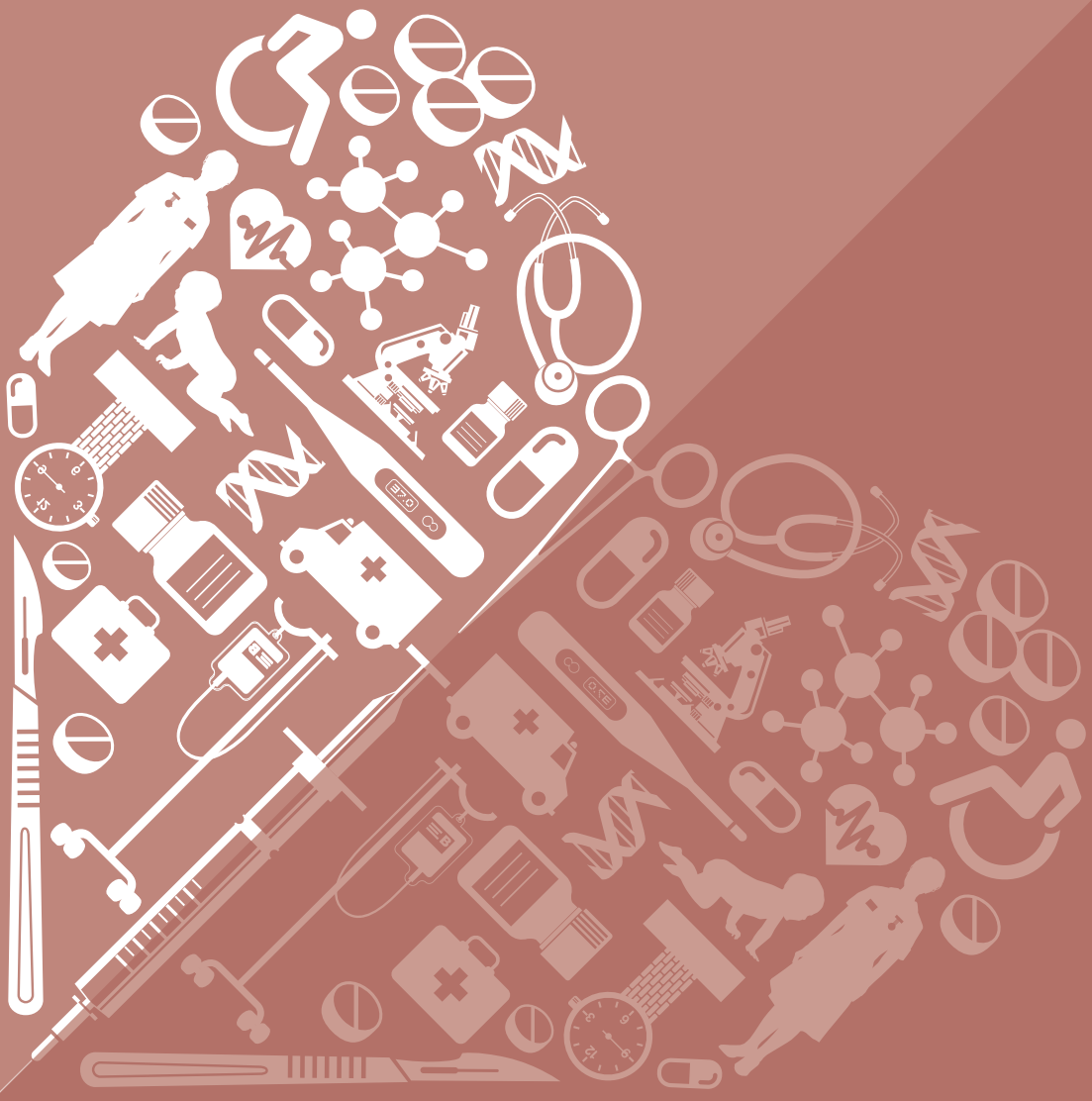
or by writing to:
Membership Department
Luton & Dunstable Hospital NHS Foundation Trust
Lewsey Road
Luton
LU4 0DZ

The L&D Foundation Trust's Governors
can be contacted by email:
governors@ldh.nhs.uk
(please indicate which Governor you wish to contact)

or by writing to:
(Name of Governor)* c/o Board Secretary
Luton & Dunstable Hospital NHS Foundation Trust
Lewsey Road
Luton
LU4 0DZ

*Full list of Governors available on:
www.ldh.nhs.uk

Financial Performance Report



Review of Financial Performance

A financial surplus for the 18th successive year was achieved with a 2016/17 surplus of £12.9m. Whilst our surplus is in line with our Annual Plan delivering it relied on non-recurrent items to offset the additional costs of temporary staffing that are very much part of the challenging environment in which the Trust operates. It should be noted that the £12.9m surplus includes a £10.1m performance bonus (known as Sustainability & Transformation Funding) which recognised the achievement of agreed performance and financial targets.

Our staff successfully handled a range of financial pressures and challenges throughout the year. This included delivering savings to accommodate efficiency targets inherent within the national tariff system, meeting the costs of pay reform from Agenda for Change, costs of additional activity above plan and costs of achieving the four hour emergency care target and the 18 week elective care targets.

Furthermore the hospital was put under a substantial amount of pressure during the winter driven by record emergency attendances, a lack of community bed provision and increased demand for services.

The table below illustrates our income and expenditure (I&E) performance since 2006/07.

Fig £m	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Turnover	153.2	169.1	189.3	204.9	211.6	220.8	230.6	244.3	259.2	271.2	308.8
Surplus	2.0	2.9	4.3	3.1	2.6	2.5	0.9	0.4	0.1	0.1	12.9
Cash	18.8	35.4	45.4	43.7	50.9	47.6	37.5	24.8	11.7	9.1	28.2

All figures £m

Cash balances continued to be monitored closely, with the FT ending 2016/17 financial year with a balance of £28.2m. This was more than expected and arose as a result of both an increased surplus (arising from bonus Sustainability and Transformation monies received for delivering the Control Total) and some slippage on our capital expenditure programme. The increased cash balance will enable the FT to address a range of site backlog issues (currently totalling £50m).

The FT has spent nearly £10m on capital in 2016/17 to deliver modern NHS services. The FT drew down the remainder of a loan from DH that was used to finance key schemes focussed on increasing capacity and mitigating winter pressures. These notable developments include two new wards within the St Mary's building, a Haematology/Oncology Unit, & two new Theatres.

As the new Trust strategy emerges it will be underpinned by an updated, flexible and transparent 5 year business plan. This will link to the outcome of strategic work undertaken with our BLMK STP partners.

This plan will reflect the changing ways in which the FT will be working. It will acknowledge influences and expectations such as the Better Care Fund, improved funding for Social Care, 7 day working and the delivery of truly integrated care as well as further integration with STP partners. It will also be responsive to the means that will be adopted in rising to the associated financial challenges, abiding by the principles of economy, efficiency and effectiveness – all with the intention of protecting the resources that are available to ensure that the L&D continues to be able to deliver the highest possible level of quality healthcare in the most appropriate environment.

Going Concern

In 2017/18 the FT is facing, along with all other providers, a challenging financial environment. Despite this the FT has submitted a surplus plan for 2017/18 to NHS Improvement, albeit one that contains substantial risk and requires collaboration with NHS leadership organisations to deliver it. After due consideration, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

Key Variances from the Plan in 2016/17

In 2016/17 the Trust was disadvantaged by the twin impact of reduced income (as a result of the minimal tariff changes) and unavoidable inflationary cost pressures. These two factors working in tandem required the Trust to improve efficiency by nearly 4% per annum (£10m).

During 2016/17 the Board became aware that anticipated demand management initiatives identified by commissioners were not materialising as expected. This meant that the Trust was required to increase staffing to accommodate patient need. This led to a substantial unplanned agency pay bill which was only partly mitigated by some agency price reductions. These price reductions were achieved as a result of a national initiative to focus on agency pay arrangements.

This mismatch between CCG anticipated patient numbers and actual growth in patient activity in 2016/17 has given rise to substantial over-performance within the contract, and substantial Trust costs. The impact of contract over-performance forced our main commissioners into challenging a variety of billed items in an attempt to mitigate their unplanned financial cost.

The Board of Directors continued to review the position of the hospital site developments in 2016/17 in order to achieve increased value for money, operational efficiency and effectiveness. It was determined that a more considered approach to major investment was required – particularly in light of the challenges facing the NHS locally and nationally. Accordingly the Board will receive a final business case that dovetails in with any strategic changes that emerge from the work on the BLMK STP.

Principal Risks and Uncertainties facing the Trust

Looking forward our main commissioners have benefitted from both growth per capita and overall growth on their CCG allocations for 2017/18. Nevertheless our commissioners, when compared to their peers, remain behind a 'fair share' funding position. This position is compounded by an expectation that our two main commissioners repay historic debts.

Notwithstanding the ultimate benefit of 'fair shares' funding, our CCGs will, it is believed, continue to seek downward pressure on providers as they seek to redress short term funding issues and contribute to the Better Care Fund.

A plan designed to deliver our financial strategy has been developed. This contains more risk than has been evident in previous years and places emphasis on the abilities of the Trust's Management Team to deliver improved financial performance whilst maintaining operational targets and requires assistance from partner organisations to achieve some of the financial improvement initiatives.

The belief that appropriate clinical outcomes, patient experience and safety remain the highest priorities has continued to be maintained, as well as the recognition that this must be balanced with the requirement to achieve year-on-year efficiency savings.

Another risk for the Trust is the lack of community provision of nursing, intermediate care and rehabilitation beds, and how this impacts on our ability to safely discharge patients from hospital to appropriate facilities. The Trust is working with STP partners to resolve these issues as soon as possible.

Commissioning aspirations for the provision of care closer to home provides us with challenges and opportunities but also uncertainty with regards to the potential tendering of services.

Remuneration report

The Remuneration Committee is a Standing Committee of the Board of Directors which is appointed in accordance with the constitution of the Trust to determine the remuneration and any other associated payments or terms of service of the Executive Directors. This also includes reimbursement of travelling and other expenses incurred by Directors. The Committee meets, as a minimum, twice yearly.

The membership of the Committee includes the Trust Chairman and all Non-Executive Directors. The Chief Executive and the Director of Human Resources are also in attendance. The Director of Human Resources, is present to provide advice and services to the Committee that materially assist them in the consideration of the matters before them, other than consideration of their own remuneration or performance.

Strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and an ongoing appraisal process.

The remuneration of individual Directors can be found in note 4.9 to the accounts.

There were no pay inflation increases for 2016/17.

Assurance on Very Senior Managers (VSM) Pay

The Trust has processes in place to provide assurance on VSM.

During 2016/17 the Committee sought assurance by:

- Participating in the annual benchmarking exercise through NHS Providers, the results of which showed are salaries to be in line with other similar Trusts.
- An external Hay review was completed and reported back to the Remuneration and Nomination Committee Reporting to the Board of Directors.

The Remuneration Committee does not determine the terms and conditions of office of the Chairman and Non-Executive Directors. These are decided by the Council of Governors at a separate Remuneration Committee.

Pauline Philip
Chief Executive
Date: 24th May 2017

Fundraising and Charitable Donations

During the 2016/17 financial year the Luton and Dunstable Hospital Charitable Fund received £1.1m from 1245 donations from grant-giving trusts, companies, individuals, community groups and legacies.

Of the £1.1m income, 46% of income was from Charitable Trusts, 32% was from individuals, 16% from legacy donations, 3% was from community groups and 3% was from companies. The charitable trust figures are higher than usual, as £500k was received from The County Air Ambulance Trust, as part of their £1.5m pledge towards the new Helipad appeal.

Legacy donations received totalled £93,005 from four separate legacies gifted to benefit the hospital's general fund and also the Cancer Unit. Legacies play a key part in shaping the Hospital for future generations.
We are planning to host our first legacy event in the next financial year.

The Friends of the Hospital have continued their kind support towards the hospital and donated £75,389. This has been used to buy medical equipment for various wards and departments.

The NICU (Neonatal Intensive Care Unit) still has a lot of support from the local community, current and past patients. It has received 633 donations during 2016/2017 totalling £121,307. All of the 2016 Christmas campaigns fundraising income was allocated to the on-going costs of the Parents Facilities. Light up a Life raised £4,385 in 2016 which is up on the previous year.

This year, we were able to help support many projects across the hospital site, a few are included below:

- An Eyesi cataract training simulator device. This device is incredibly life like and allows the registrars and consultants to simulate difficult situations and practice eye surgery in a safe environment.

- A new maternity pool and telemetry equipment for the consultant led delivery suite, enabling high risk maternity patients better birthing options.

- Blue Light Cystoscopy device, assisting accurate diagnosis and effective removal of bladder cancer tumours.

- Sensory guru magic carpet device. This has proven useful for children with multiple disabilities, children with food and drink aversions to calm, distract and enable treatment. Also as a physiotherapy and education tool.

- Chapel redesign, to update the area and allow multi faith and multifunction worship space.

- Disabled changing space and refreshed staff rooms in outpatients.

We ran the Give a Gift campaign where people donate presents for patients through our online wish lists. Over 800 gifts were bought in total and a number of companies also came in with additional presents for patients. This year we were able to provide a present for every inpatient in on Christmas day, some of the Governors and Non-Executive Directors helped to distribute these to the wards.

Going forward we are just about to launch a new appeal for an onsite helipad. The County Air Ambulance charity has offered to contribute £2m towards this project and we will be looking to secure a further £1.7m from charitable trusts, corporates and community fundraising approaches.

On behalf of all the staff, patients and their families the Trust would like to say a huge thank you to everyone who has supported the hospital by making a donation, giving gifts or volunteering their time. Your support makes a real difference to our patients and their families and helps make a difficult time more comfortable and less distressing.

For more details about how to get involved with fundraising or to find out more about specific projects and what donations are spent on please contact the Fundraising Team on 01582 718 043 or email fundraising@ldh.nhs.uk

The Luton and Dunstable Hospital Charitable Fund is a registered charity in England and Wales number: 1058704

Property Plant and Equipment and Fair Value

As stated in note 1.5 to the accounts, Property Plant and Equipment are stated at Fair Value which is defined as the lower level of replacement cost and recoverable amount. A review is carried out each year for any potential impairment, with a formal revaluation every five years. A full property valuation as at 31 March 2015, was undertaken by Gerald Eve LLP. Since the last valuation there had been significant works to the St Mary's block and so a valuation was obtained for this specific asset as at 31 March 2017 and is reflected in the financial statements. The Directors' opinion is that there are no fixed assets where the value is significantly different from the value included in the financial statements.

External Auditor

KPMG LLP (UK) is our external auditor. The appointment was made and approved following a presentation by the Chair of the Audit Committee to the Council of Governors.

KPMG LLP (UK) may, from time to time, be asked to carry out non-audit work. The cost of these other services is shown in note 5.5 to the accounts. It is important to ensure that any additional services provided by the external auditors do not impact on their ability to be independent of management, and that conflicts with objectivity do not arise. We will develop a protocol through the Audit and Risk Committee to address this. This protocol will need to be approved by the Council of Governors.

Private Finance Initiatives (PFI Schemes)

We have two capital schemes arranged under the PFI:

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 13 years remaining.

2. The electronic patient record scheme is a 10 year scheme that has now completed.

There were no new PFI schemes in the year and any future schemes are unlikely as they would be funded either through internally generated resources or external financing using the additional freedoms granted to Foundation Trusts.

Better Payment Practice Code

We are continuing to maintain cash balances within the needs of our suppliers, settling 85% of non-NHS invoices within 30 days of receipt of a valid invoice.

2016/17	Number of invoices	Value £000s
Total Non-NHS trade Invoices paid in the year	90324	£121,495
Total Non-NHS trade Invoices paid within target	77181	£100,719
Percentage of Non-NHS trade Invoices paid within target	85%	83%

Off Payroll Engagements

NHS Foundation Trusts are required to disclose the information in the tables below about off-payroll engagements. There is a nil return for 2016/17.

Table 1: For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2017	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	0
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	0
Number for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	17

Counter Fraud

The Trust has a counter fraud policy for dealing with suspected fraud and corruption and other illegal acts involving dishonesty or damage to property. Nominated staff whom Trust staff can contact confidentially are the Director of Finance and the Local Counter Fraud Specialist (LCFS). The LCFS provides reports quarterly to our Audit and Risk Committee.

Data Loss

All Health, Public Health, Adult Social Care services and commissioned NHS service providers are required to use the Information Governance Incident Reporting Tool for reporting a level 2 IG Serious Incident. This tool is part of the online Information Governance (IG) Toolkit system. The level of an IG incident is determined by sensitivity factors.

As part of this reporting requirement all organisations are also required to complete and publish the tables below with information in relation to level 1 and level 2 IG incidents.

Level 1 = Confirmed IG Serious Incident but no need to report using the IG Toolkit.

Summary of other personal data related incidents in 2016-17

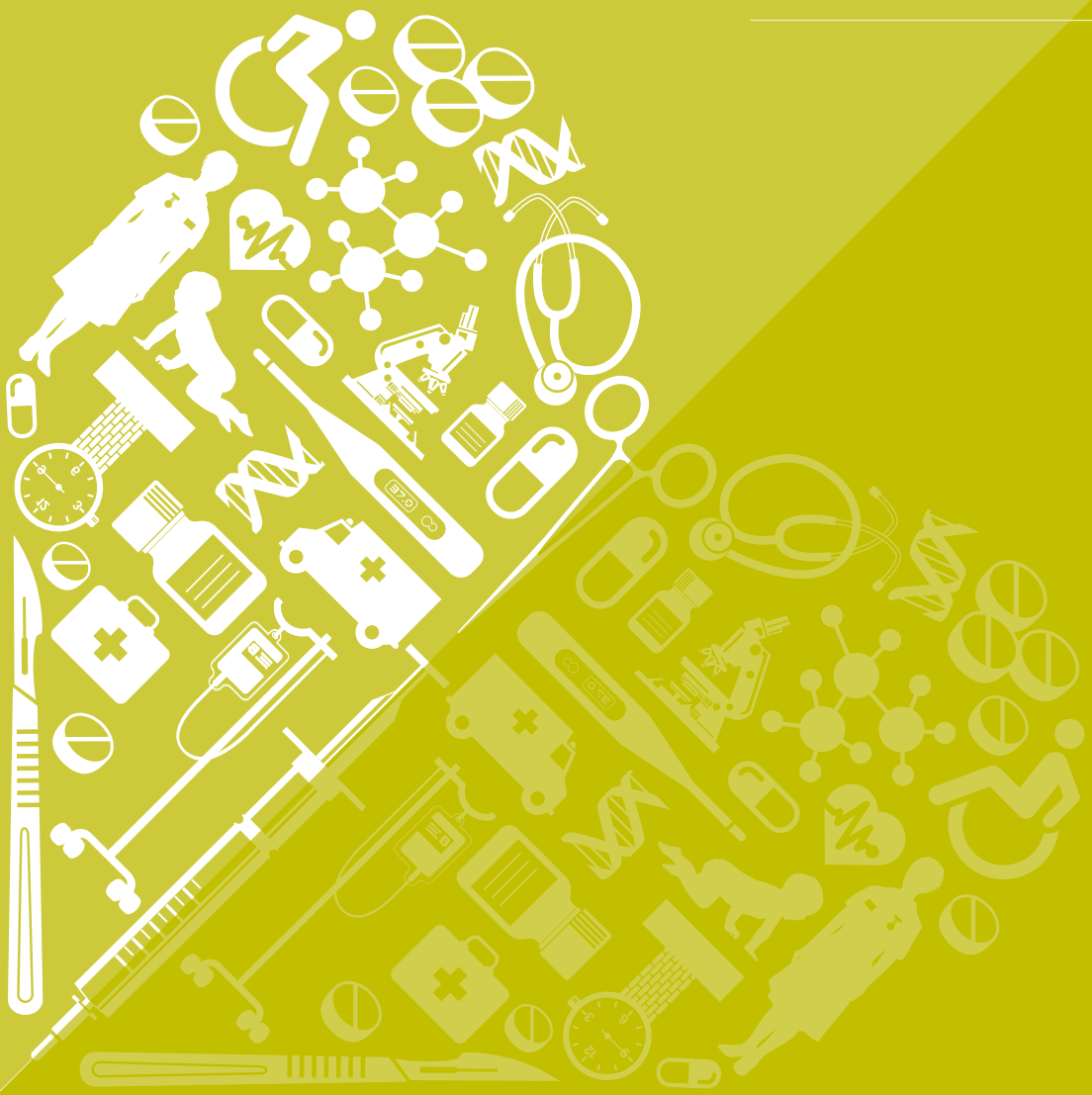
Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	6
C	Lost in Transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	1
J	Unauthorised access/disclosure	1
K	Other	0

Level 2 = Confirmed IG Serious Incident that must be reported to ICO, DH and other central bodies by reporting it on the IG Toolkit. A level 2 IG SIRI can be defined as a personal data breach (as defined in the Data Protection Act), so reportable to the ICO, or high risk of reputational damage.

Summary of incident requiring investigations involving personal data as reported to the information commissioner' office in 2016/17

Date of Incident (Month)	Nature of Incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
July 2016	Theft of staff members car whilst working in the community	Demographics	Approx. 275	Reported as a level 2 incident

Annual Governance Statement and Accounts



Statement of the Chief Executive's Responsibilities
as the Accounting Officer of Luton and Dunstable University Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation ***Trust Accounting Officer Memorandum*** issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Luton and Dunstable University Hospital NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of directed Luton and Dunstable University Hospital NHS foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the ***Department of Health Group Accounting Manual*** and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Helath Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the ***NHS Foundation Trust Accounting Officer Memorandum.***

Signed

Pauline Philip
Chief Executive
Date: 24th May 2017

Annual Governance Statement 2016/17

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Luton and Dunstable University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is accountable for managing risk and leads the Executive Board, attends each of the Sub-Committees of the Board and the Clinical Operational Board to ensure that the Trust has robust processes in place to manage risk.

The Board leads for Risk Management are the Chief Medical Advisor and the Chief Nurse. The Managing Director is the Board lead for non-clinical (including Health and Safety) risk management. The Chief Medical Advisor leads on clinical risk management and chairs the Clinical Risk Management Committee where all aspects of clinical risk management are discussed. A report is provided to the Clinical Operational Board and assurance is then provided to the Clinical Outcome, Safety and Quality Committee and the Audit and Risk Committee. The Clinical Operational Board includes a high level Executive membership and includes the clinical medical consultant leadership though the Clinical Chairs and Divisional Directors. The Clinical Chairs and Divisional Directors are accountable for ensuring risk is embedded within their Divisional Boards.

All risks are reviewed by the Executive that demonstrates top level leadership to risks by considering and approving all new risks to the risk register.

At induction, new joiners to the organisation undergo basic training in risk management (clinical and non-clinical).

Risk management training sessions are provided to staff as required.

Liaison with Clinical Chairs and Divisional Directors ensures that when practice is changed as a result of integrated learning from the risk management process, this is cascaded to Divisions. This takes place through the Clinical Operational Board and the Divisional Board meetings.

The Trust Risk Register is developed from risks identified at the Board of Directors and its sub committees and at divisional and department level plus from those identified from other sources e.g. external reports. The Board ensures action is taken to mitigate any risks to quality. Risks and benefits to quality and safety are assessed for all reviews of efficiency related initiatives. The Board receives the Board Assurance Framework every three months and reviews a summary of the risk register every three months in order to be able to maintain understanding of the current and future risks. The Board has participated in seminars which help in the identification of future external risks to quality such as new national guidance, new technologies and business continuity.

The risk and control framework

Risk continues to be managed at all levels of the Trust and is co-ordinated through an integrated governance framework consisting of performance and assurance processes. The Executive Board and the Clinical Operational Board lead the review of risk through the Clinical Risk Management, Divisional Boards, Information Governance and Equality and Diversity sub Boards. The Board of Directors lead the review of board level strategic risk seeking assurance from the Audit and Risk, Clinical Outcome, Safety and Quality, Finance, Investment and Performance Committees and the Hospital Re-Development Board.

The Risk Management Strategy continues to provide an integrated framework for the identification and management of risks of all kinds, whether clinical, organisational or financial and whether the impact is internal or external. This is supported by a Board Assurance Framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management.

There is a Risk Review process under the leadership of the Executive Directors, who are consulted to approve any new risks that have been identified through the Divisions, Corporate Services or Committees and reported through the central risk register database (Datix). The relevant Executive Director agrees whether the risk is a Strategic Board Level Risk that has implication to the achievement of the Trust Objectives, review the assessment score and also allocate the risk to the relevant Sub-Committee for assurance and operational board for performance monitoring. The closed risks are also monitored to ensure the Executive Team is aware of risk amendments. The Trust has in place a weekly Senior Staff Committee that overseas operational risk.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the Risk Management Framework across a range of domains; the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. The Trust risk tolerance is set by considering all risks through the Risk Review by the relevant Executive Director and identifying those risks that have implications to the achievement of the Trust Objectives. Any of these Board Level Risks that are rated as a high risk are reported to the Board of Directors every two months. Actions and timescale for resolution are agreed by the risk leads and monitored by the Board of Directors and relevant sub-committee. Through this process, the Board are informed of any risks that would require acceptance as being within the Trust's risk tolerance.

The organisations major risks are detailed on the Trust Risk Register and Assurance Framework. Through the annual planning, the risks are formulated into five elements and the risks linked to those and their mitigating actions are documented below. The Risk Register is reviewed by the Board of Directors, Audit and Risk Committee, Clinical Outcome, Safety and Quality Committee, FIP, and Executive Board, it contains in year and future risks.

L&D Top 5 Risks (Summary)

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Clinical Operational	1. Workforce Pressures 2. Increased emergency pressures 3. Implementation of integrated care 4. The need for robust and whole system working	High	High	Workforce plans in place Board approved action plans with Trust partners where appropriate Re-engineering programme managed by an Executive Director	Weekly Senior Team and Executive meetings Monthly Clinical Outcomes, Safety & Quality Committee
Finance	Delivering the financial challenge in 2016/17 including Commissioner plans, agency spend, CQUIN and Re-engineering programmes	High	High	Monthly review of key income, expenditure, capex, cash, balance sheet and quality performance metrics Monthly performance review meeting with Divisions led by Executive Directors Monthly Re-engineering Boards	Monthly reports of cumulative financial performance incorporating clear forecasting and an alert mechanism to identify issues that allow corrective action Monthly Finance, Investment & Performance committee review

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
				Enhanced process for business case preparation and evaluation	Executive oversight group to monitor re-engineering milestones
Present Hospital Campus	Trust site may not be consistent for optimum patient care Sustainability and Transformation Plan(STP) may impact on the Trust plans Backlog Maintenance	High	High	Robust management and governance arrangements in place to manage ongoing risks and hospital re-development project Leading role in STP governance Finance, Investment and Performance Committee (FIP) oversight of backlog maintenance plans and strategy	Board review of Full Business Case and approval of actions arising from STP process Finance, Investment & Performance committee review
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legalisation	High	Moderate	Board approved action plans in place	Regular monitoring / Assurance from Board Sub-Committees
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event	High	Low	Ensure that the Emergency and Business Continuity plans are frequently reviewed, communicated and understood by key staff	Ongoing review and testing of Business Continuity plan relevant adaptation of plans Oversight by Board Sub group

Incident reporting is actively promoted and encouraged across all directorates as part of the culture of the organisation. The Trust actively promotes a culture of 'fair blame' or 'just blame', to encourage staff to report incidents. Incidents that have a significant impact on the Trust, its business or an individual are immediately and thoroughly investigated and the lessons learnt are shared across the Divisions.

Risks to data security are managed through a security risk register and through incident reporting. Mitigating actions are reviewed through the Information Governance Steering Group and reports to the Executive Board. Duty of Candour is also complied with for all incidents and above that result in moderate or severe harm.

Risk Management is an embedded activity of the organisation and can be demonstrated through a number of examples:

- Each Divisional Board reviews reported incidents and are required to report to the Clinical Operational Board and reflect on the issues raised, develop any further controls to manage the principal risks and to minimise, as far as reasonably practical, the incident occurring again. If there is a persistent risk issue identified from the incident, the issue is evaluated through the Risk Register and also subjected to independent scrutiny (for example: internal audit, external accreditation)

- Risk management is integrated into core Trust business in relation to equality impact assessments. All policies and procedures when created or reviewed have to include an Equality Analysis Form. If there are any negative impacts on a particular group of people/ equality group following the completion of this form, the Trust will record any changes to the service and/ or policy. Any actions will be integrated into existing service planning and performance management frameworks along with monitoring and review processes.

- Business cases include a risk analysis both financially and clinically.

During the coming year the Trust will continue to embed a culture of external review and engagement of independent expertise to facilitate greater objectivity and learning;

- During the year in addition to using the services of internal and external audit, a number of specific reviews were commissioned.
- The Trust received an external CQC visit and the report received in June 2016 identified the Trust as 'good' with the Well-Led element of the assessment as 'Outstanding'.

The Luton and Dunstable NHS Foundation Trust is fully registered with the CQC and its current registration is **Registration without Conditions**.

No enforcement action has been taken against the Trust during the reporting period April 1st 2016 and 31st March 2017 and we have not participated in special reviews or investigations by the CQC during the reporting period.

The CQC monitor, inspect and regulate care services to ensure patients receive safe, effective, compassionate, high quality care. To really measure the patient's experience of care, they have identified five key questions based on the things that matter to patients. The CQC will ask these questions of every service.

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?

- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?

- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.

- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.

- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016.

A programme of communication to all staff was undertaken and action plans put in place across the domains. The action plans are monitored by the Clinical Outcome, Safety and Quality Committee on a quarterly basis.

We have in place a CQC self assessment programme for all wards and clinical areas. This involves a three month cycle of self assessment, peer assessment and external peer assessment to support the delivery of performance and the implementation of corrective action in a timely manner. We have reviewed our CQC assessment programme to reflect the revised CQC inspections and these assessments are reported to each Board of Directors meeting.

Non-Executive Assessments (3x3)
The assessment process is further enhanced by Executive and Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.

Transforming Quality Leadership 'Buddy' System
We re-launched a wider more focussed programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete a cycle of visits every two months against one of the CQC domains. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team. The results are reported to each Board of Directors meeting.

The Trust promotes the involvement of patient representatives to ensure the quality of performance data and to triangulate feedback and reviews in many aspects of its activities. Patients and Governors are represented on the following committees:

- Equality and Diversity Committee
- Clinical Audit and Effectiveness Committee

- Patient and Public Participation Group
- PLACE (Patient Led Assessment of the Care Environment)
- Ethics Committee
- Transforming Outpatients
- Hospital Re-Development Board
- Car Parking Working Group
- Re-Engineering Group
- Safeguarding Adults
- Carbon Management

Healthwatch monitor the services provided by the Trust and report directly to the Chief Executive and issues are then referred to appropriate Directorate for consideration and action. Representatives from Luton Healthwatch are members of the Trusts Patient and Public Participation Group. The National Patient Survey action plan is also progressed and monitored through this group. Healthwatch have been involved in the development and assurance of the Quality Accounts.

Since becoming a Foundation Trust the organisation has extended the involvement of staff and the public by creating a Council of Governors. The Council of Governors is responsible for a wide range of duties including, but not exclusively, being consulted on health service changes, meeting with members in their constituency, appointing and holding to account the Chair and Non-Executive Directors and attending Council of Governors' meetings. The Governors include representatives from other key stakeholders such as the CCGs, Local Government Councils and Universities.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments in accordance with emergency preparedness and civil contingency requirements, to ensure that the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Delivery of the Carbon Management Plan is ongoing: the Trust reports on progress with carbon reduction within the Operational Performance section of this report.

Review of economy, efficiency and effectiveness of the use of resources

In addition to the financial review of resources within the quarterly monitoring returns to NHS Improvement and the monthly financial information provided to all budget holders, the processes that have been applied to ensure resources are used economically, efficiently and effectively include Clinical Audit and Effectiveness, Medical Equipment and Medicines Management. The Trust has governance arrangements for the Finance, Investment and Performance Committee with Divisions presenting directly to the committee on a range of financial and operational matters.

A Clinical Audit and Effectiveness Department is also maintained to:

- Oversee the implementation of National Institute of Clinical Effectiveness (NICE) guidance.
- Monitor the introduction of new techniques ensuring clinical and cost effectiveness of new treatments, as well as the appropriate training of clinicians.
- Support clinical audit work within the Trust, ensuring clinicians work in the most effective way, adopting good practice uniformly across the Trust through protocols and guidelines.

The use of management groups charged with monitoring efficiency and effectiveness as part of their terms of reference:

- The Medical Equipment Group advises on the replacement and purchase of new medical equipment.
- The Medicines Management Group oversees the maintenance and development of the drug formulary to ensure clinically appropriate and cost effective use of medicines.

The Trust's efficiency is quantified annually through the national reference costs exercise. The latest published index for the Trust is 89 (based on 2015-16 accounts and activity) compared to a national average index of 100.

The Trust is also engaging in a range of benchmarking exercises to determine best practice and assess the means of implementing it at the L&D.

Information Governance

The Trust has had no serious information governance incidents in relation to a confidentiality breach.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 in the NHS Foundation Trust Annual Reporting Manual.

The Quality Account is the responsibility of the Director of Nursing and Midwifery supported by all of the Executive Team and is written following guidance issued by NHS Improvement. Processes put in place via the Information Governance Toolkit, led by the Director of Information Technology, as Senior Information Risk Owner (SIRO), provides assurance that the Trust's Data Quality is reviewed and monitored.

For 2016/17 the Chief Executive and Chief Nurse (at the date where this was agreed) engaged with Trust staff and Trust Governors to review the indicators and priorities that the Trust should focus on and develop indicators on into next year.

Through the Information Governance Toolkit, the Trust has a number of key information policies in place including data quality that sets out the roles and responsibilities.

The Trust has three reports that feed data into the Board of Directors; the Quality and Performance Report, Finance Report and Workforce Report. Each of these contains data that is tracked over months and years to identify variances.

The Trust monitors Dr Foster alerts through the Mortality Board, Clinical Operational Board and Clinical Audit and Effectiveness Committee. Clinical Audit forward plans detail the work undertaken to review the data quality of these alerts. Annually the Trust has an external audit of clinical coding that demonstrated excellent practice and an external peer review of Information Governance that demonstrates assurance against the Information Governance Toolkit that includes Data Quality.

The Trust reviews directorate dashboards e.g. maternity to collect data at source and monitors the effectiveness of central data through the SUS (Secondary Uses Service) reports. The Trust monitors key performance indicators in relation to data quality that demonstrates improving practice across the Trust.

18 week data is generated by the Information Department on a weekly and monthly basis and then actively used by key departments to manage the patients' pathways so that patients receive treatment within 18 weeks of referral. Although initial checks are made by the Information Department, this data is further validated by our separate 18 week team who interrogate the files and physically track the patients pathway on our current IT systems and record comments regarding the progress of the pathway. Inputting of the 18 week data is restricted to a core team to reduce the risk of inaccurate data entry and the further weekly validation allows for any errors to be rectified immediately. Weekly graphs are produced which are cascaded to a wider senior team both specifically around waiting list demand and 18 week performance, both which are able to highlight data discrepancies should they arise. A fortnightly meeting also interrogates the Flash report which details the 18 week patients at specialty level.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Clinical Outcome, Safety and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control during 2016/17 was monitored by the following:

- The Board of Directors – The Board places reliance upon the Audit and Risk Committee for assurances that the system of internal control is sound.

- The Audit and Risk Committee – The function of the Audit and Risk Committee is to ensure an adequate and effective operation of the Trust's internal control system. The committee focuses on the establishment and maintenance of controls designed to give reasonable assurance that assets are safeguarded,

waste and inefficiency avoided, reliable information produced and that value for money is continuously sought.

- The structure of the Board of Directors meetings allows the appropriate time to ensure matters regarding Performance and Quality would be managed through the whole Board

- The Clinical Outcome, Safety and Quality Committee focus on assurance issues relating to clinical and corporate governance, risk management and assurance framework and report monthly to the Board. This committee is supported by the Clinical Operational Board that ensures divisional clinical leadership. The COSQ committee also receive assurance against the Care Quality Commission Quality Outcomes on a monthly basis.

- The Clinical Audit and Effectiveness Committee reports to the Clinical Operational Board. The committee ensures clinical leadership through the divisions, monitors the implementation of NICE guidance and reviews the Dr Foster benchmarking data sets to review trends. This process is reported to the Executive Board and assurance provided to the Clinical Outcome, Safety and Quality Committee.

- The Finance, Investment and Performance Committee takes an overview of operational activity and performance against national and local targets.

- Internal Audit – Internal Audit review the system of internal control during the course of the financial year and report accordingly to the Audit and Risk Committee.

- A Provider Licence Assurance Framework was reviewed by the Audit and Risk Committee. The Trust has reviewed Governance arrangements through the assessment of the Healthy Board 2013 and the Monitor Code of Governance. These assessments have been cross referenced against the Licence requirements laid out in condition 4 of the FT Governance.

Compliance with the NHS Foundation Trust Code of Governance

It is considered that the Luton and Dunstable University Hospital NHS Foundation Trust complies with the main and supporting principles of the Code of Governance. This includes the issues of whether or not all of the Non Executive Directors are independent in accordance with code provision B.1.1. The Board has determined that all of the NEDs are independent in character and judgement.

In relation to the more detailed provisions of the Code of Governance, the Trust are compliant with the provision with the exception of section B.1.2 in that the Board does not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

My review is also informed by:

Internal Audit which has completed reviews of Recording of Activity, controls covering Agency and Locum Staff, Cash Flow Forecasting and Cash Management, HR Recruitment and Retention, Financial Governance and Medical Devices in 2016/17. This work has supported the Audit and Risk Committee's understanding and review of the key issues facing the Trust. Internal Audit reviews are conducted using a risk-based approach covering areas agreed as being the priority for review based on a risk assessment agreed between the Audit and Risk Committee, Management and the auditors.

The Head of Internal Audit reports that they have completed the programme of internal audit work for the year ended 31 March 2017 with the exception of work to assist management in relation to discharge planning, which is in progress. Their work identified low, moderate and high rated findings but there were no critical risk rated reports in 2016/17, nor any individual findings rated critical. Based on the work that internal audit have completed, the Head of Internal Audit has concluded that governance, risk management and control in relation to business critical areas is generally satisfactory; however there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk

The key factors that contributed to this opinion are that whilst the majority of reports did not highlight any high risk findings, the following matters were reported:

- The Scheme of Delegation includes a caveat to the delegation of certain authorities to Divisions based on the Finance Investment and Performance Committee's monitoring of divisional financial performance and forecasting, but the practical requirements and expectations need to be clarified;
- The required controls for the recruitment of agency and locum staff should be formally reviewed and confirmed;
- An assessment of the funding requirement for replacement of medical devices that extends beyond the annual budget setting process should be undertaken. In addition, there is a need to improve evidenced compliance with the Trust's policy for staff training on medical devices.

All recommendations arising from Internal Audit's work are considered by managers and an action plan agreed. The report, action plan and subsequent progress in implementing those actions are reviewed and monitored by the Audit and Risk Committee, and where relevant also by the Clinical Outcome, Safety and Quality Committee and the Finance Investment and Performance Committee, this process of follow-up of Internal Audit actions through the sub-committee structure having been commenced during 2016/17.

The Trust has taken action throughout the year to address the issues raised through the Internal Audit process. This included:

- Enhanced the data capture and reporting of HR indicators.
- Initiated a review of processes for agency and bank to further improve the adequacy of controls.
- Commenced an appraisal of the medical device provision to include lifecycle management and training records.

Conclusion

The generally sound system of internal control is supported by a robust governance structure that reviewed any identified weaknesses regularly. Some areas for action were identified during the year and immediate action taken to mitigate and resolve the concerns.

Pauline Philip
Chief Executive
Date: 24th May 2017

Independent auditor's report

to the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust only

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the group financial statements of Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2017 set out on pages C14 to C55. In our opinion:

— the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2017 and of the Group and the Trust's income and expenditure for the year then ended; and

— The Group and the Trust's financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

Overview		
Materiality: Group financial statements as a whole	£5.5m (2015/16:£5.2m) 2% (2015/16: 2%) of total income from activities	
Risks of material misstatement 2015/16		**vs**
Recurring risks	Valuation of land and buildings	◀▶
	Valuation and existence of NHS and non-NHS receivables and completeness, existence and accuracy of NHS and non-NHS income	◀▶

2. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows (unchanged from 2015/16):

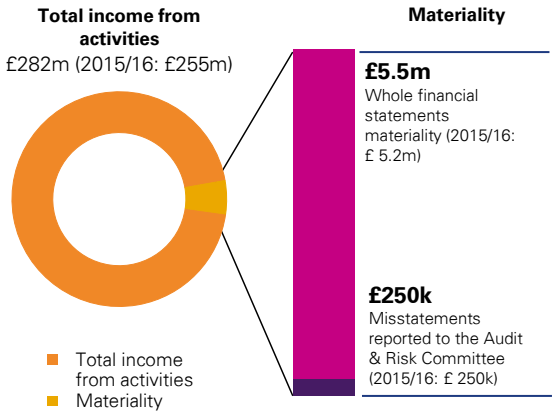
	The risk	Our response
Valuation of land and buildings £86.2 million; 2015-16: £87.5 million *Refer to page 102 (Audit & Risk Committee Report), pages C19 to C22 (accounting policy) and pages C39 to C41 (financial disclosures).*	**Valuation of land and buildings excluding dwellings** Land and buildings are required to be held at fair value. Initially, land and buildings are recognised at cost, but subsequently are recognised at current value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. A review is carried out each year for any potential impairment, with a full valuation every five years. Further, DRC is decreased if VAT on replacement costs is deemed to be recoverable. Both of these assumptions can have potentially significant effects on the valuation. The Group operates from one site near Luton and holds land assets with a value of £10.6 million and buildings (excluding dwellings) with a value of £75.6 million as at 31 March 2017. A full property valuation took place at 31 March 2015, carried out by the Trust's valuers Gerald Eve LLP. Full valuations are completed every five years, with an assessment of impairment undertaken by Trust management annually. No impairment to land and buildings has been recognised in the 2016/17 financial year. Due to the investment in one of the Trust's building assets over the last two years, an external valuation was obtained from Gerald Eve for this individual asset as at 31 March 2017. The asset was revalued downward to £10.879m, a movement of £3.205m reflected in the financial statements.	Our procedures included: — **Review of asset records:** We tested to confirm the completeness, existence and ownership of material items of land and buildings. We drew on the Trust's asset register and verification exercise and conducted our own testing of asset existence (during on site visits) and of asset ownership (through examination of title deeds and contracts); — **Assessing disclosures:** We considered the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities with reference to the Department of Health's Group Accounting Manual 2016/17; — **Impairment review:** We considered how management had assessed the need for an impairment across its asset base either due to loss of value or reduction in future benefits that would be achieved; — **Assessment of experience:** We assessed the scope, qualifications and experience of Management to determine whether they are appropriately experienced and qualified to undertake the annual impairment review; — **Additions to assets**: For a sample of assets added during the year we tested that an appropriate valuation basis had been adopted and it was appropriate to capitalise them; and — **Assets under construction:** For a sample of the assets recorded in the accounts as under construction we tested the status to assess the appropriateness of the impairment and write off applied to its value.
Recognition of income and receivables NHS receivables £7.5 million, 2015-16: £6.8 million. Non-NHS receivables £18.1 million, 2015-16: £15.3 million. NHS income £283 million, 2015-16: £248 million. Non-NHS income £26 million, 2015-16: £23 million. *Refer to page 102 (Audit & Risk Committee Report), pages C18 to C19 and pages C24 to C26 (accounting policy) and pages C30 to C31 and pages C43 to C44 (financial disclosures).*	**Valuation and existence of NHS and non-NHS receivables and completeness, existence and accuracy of NHS and non-NHS income** The main source of income for the Group is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 92.7% of income from activities (2015/16: 95.2%). The Group participates in the Agreement of Balances exercise, which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated when the consolidation exercise takes place to report to the Department's Consolidated Resource Account.	Our procedures included: — **Contract agreement:** We agreed a sample of the NHS income recorded in the financial statements to the signed contracts in place with key commissioners; — **Income billing:** We agreed invoices had been issued in line with the contracts signed with five of the Trust's key commissioners, comprising 77% of the total income billed; — **Agreement of balances exercise:** We obtained third party confirmations from commissioners, through the Agreement of Balances exercise and compared the values they are disclosing within their financial statements to the value of income and receivables captured in these financial statements; **(continued on next page)**

	The risk	Our response
Recognition of income and receivables (continued) NHS receivables £7.5 million, 2015-16: £6.8 million. Non-NHS receivables £18.1 million, 2015-16: £15.3 million. NHS income £283 million, 2015-16: £248 million. Non-NHS income £26 million, 2015-16: £23 million. *Refer to page 102 (Audit & Risk Committee Report), pages C18 to C19 and pages C24 to C26 (accounting policy) and pages C30 to C31 and pages C43 to C44 (financial disclosures).*	The AoB exercise identifies mismatches between income and expenditure, and receivable and payable balances recognised by the Group and its counter parties at 31 March 2017. Mis-matches can occur for a number of reasons, but the most significant arise where the Group and commissioners have not concluded the reconciliations of healthcare spells completed within the last quarter of the financial year, which have not yet been invoiced, or there is not final agreement over proposed contract penalties as activity data for the period has not been finally validated. In 2016/17 the Department of Health introduced the Sustainability and Transformation Fund (STF), enabling Trusts to secure additional funding upon achievement of specified financial and operational targets. In 2016/17, the Trust secured £10.1m of STF funding, representing achievement of all four quarterly targets and a bonus element. In addition to this patient care income the Group reported total income of £26 million (2015/16: £23 million) from non-NHS bodies. Much of this income is generated by contracts with Local Authorities and from overseas or private patients. Consequently there is a risk that income will be recognised on a cash rather than an accruals basis. We do not consider NHS and non-NHS income to be at high risk of significant misstatement, or to be subject to a significant judgement. However, due to its materiality in the context of the financial statements as a whole, NHS and non-NHS income is considered to be one of the areas that had the greatest effect on our overall audit strategy and allocations of resources in planning and completing our audit.	— **Agreement of activity**: We tested the levels of over and under performance reported agreed to the records held on the Group and Trust's activity system; — **Non-NHS income testing:** We sample tested non-NHS income by agreeing to invoices and subsequent receipt of funds; — **NHS receivables review:** We agreed receivables to post year-end cash receipts, supporting invoices and other documentation. This included testing the assumptions made by the Group in respect of income due that was based on meeting agreed performance targets with commissioners known as CQUIN targets and ensuring that any fines or deductions have been taken into account; — **Non-NHS receivables review:** For a sample of local authority or other non-NHS income we formed an expectation of the value of the year end receivable to be recorded in the financial statements, based on agreed contracts and cash receipts and investigated any differences; — **Impairment of receivables review:** We challenged the approach to impairing receivables and confirmed that they are in line with the Trust's accounting policies, and that the Group's judgement for the level of provision is appropriate; — **Transformation funding:** We tested the Trust's calculation of performance against the financial and operational targets used in determining receipt of transformation funding to determine the amount the Trust qualified to receive. We agreed the amounts recorded in the Group accounts to our calculation; and — **Credit note provision:** We tested the recording of credit note provisions to ensure they were accounted for against NHS organisations for the Department of Health consolidated accounts.

3. Our application of materiality and an overview of the scope of our audit

The materiality for the Group financial statements was set at £5.5 million (2015/16: £5.2 million), determined with reference to a benchmark of income from activities (of which it represents approximately 2%). We consider income from activities to be more stable than a surplus-related benchmark. We report to the Audit & Risk Committee any corrected and uncorrected identified misstatements exceeding £250k (2015/16: £250k), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group financial statements comprise the parent, Luton and Dunstable University Hospital NHS Foundation Trust and its subsidiary, Luton & Dunstable Hospital NHS Foundation Trust Charitable Fund. The Group team performed the audit of the Group as if it was a single aggregated set of financial information. The audit was performed using the materiality levels set out above and covered 100% of total Group income from operations, Group surplus and Group assets.



4. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5. We have nothing to report in respect of the matters on which we are required to report by exception

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or
- the Audit & Risk Committee's commentary on page 102 of the Annual Report does not appropriately address matters communicated by us to the Audit & Risk Committee.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

6. We have completed our audit

We certify that we have completed the audit of the accounts of Luton and Dunstable University Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

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Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities on page 125 the accounting officer is responsible for the preparation of financial statements that give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

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This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body, for our audit work, for this report or for the opinions we have formed.

Fleur Nieboer for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
15 Canada Square, Canary Wharf, London, E14 5GL

26 May 2017

KPMG

Foreword to the Accounts

These accounts for the year ended 31 March 2017 have been prepared by the Luton and Dunstable University Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Pauline Philip
Chief Executive
Date: 24th May 2017

Statement of comprehensive income

		Parent (L&D NHSFT)		Group (L&D NHSFT & NHS Charitable Funds)''	
		2016/17	Restated[1] 2015/16	2016/17	Restated[1] 2015/16
	note	£000	£000	£000	£000
Operating Income from continuing operations	2.5	**308,790**	271,170	**309,588**	271,300
Operating Expenses of continuing operations	3	**(291,656)**	(267,322)	**(292,246)**	(268,060)
OPERATING SURPLUS		**17,134**	**3,848**	**17,342**	**3,240**
Finance Costs					
Finance income	6.1	**25**	44	**116**	135
Finance expense - financial liabilities	6.2	**(967)**	(811)	**(967)**	(811)
Finance expense - unwinding of discount on provisions		**(2)**	(11)	**(2)**	(11)
PDC Dividends payable		**(3,264)**	(2,960)	**(3,264)**	(2,960)
NET FINANCE COSTS		**(4,208)**	**(3,738)**	**(4,117)**	**(3,647)**
Gains/(losses) of disposal of assets		**(7)**	(57)	**(7)**	(57)
Movement in fair value of investment property and other investments	11	**0**	0	**407**	(164)
Surplus / (deficit) from continuing operations		**12,919**	53	**13,625**	(628)
SURPLUS / (DEFICIT) FOR THE YEAR		**12,919**	**53**	**13,625**	**(628)**
SURPLUS/ (DEFICIT) FOR THE YEAR		**12,919**	53	**13,625**	(628)
Other comprehensive income					
Revaluation Impact	23	**(3,205)**	0	**(3,205)**	0
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**9,714**	**53**	**10,420**	**(628)**

Note: Allocation of profits for the period: This surplus is wholly attributable to the owner of the parent.

[1] Restatement relates to presentational change for gains/ losses on disposal of assets in line with requirements of the Department of Health Group Accounting Manual. (Previously shown within Operating Income and Expenditure now reported specifically on Statement of Comprehensive Income.)

Statement of financial position

	note	Group 31 March 2017 £000	Group 31 March 2016 £000	Parent 31 March 2017 £000	Parent 31 March 2016 £000
Non-current assets					
Intangible assets	7	**194**	264	**194**	264
Property, plant and equipment	8	**113,538**	115,444	**113,538**	115,444
Other investments	11	**0**	0	**3,075**	3,072
Trade and other receivables	14	**1,917**	1,492	**1,917**	1,492
Other assets	15	**2,574**	2,712	**2,574**	2,712
Total non-current assets		**118,223**	**119,912**	**121,298**	**122,984**
Current assets					
Inventories	13	**3,291**	3,210	**3,291**	3,210
Trade and other receivables	14	**23,665**	20,518	**23,614**	20,503
Cash and cash equivalents	25	**28,176**	9,146	**28,986**	9,403
Total current assets		**55,132**	**32,874**	**55,891**	**33,116**
Current liabilities					
Trade and other payables	16	**(24,134)**	(22,923)	**(24,253)**	(23,070)
Borrowings	18	**(1,423)**	(617)	**(1,423)**	(617)
Provisions	22	**(521)**	(408)	**(830)**	(792)
Other liabilities	17	**(1,650)**	(1,823)	**(1,650)**	(1,823)
Total current liabilities		**(27,728)**	**(25,771)**	**(28,156)**	**(26,302)**
Total assets less current liabilities		**145,627**	**127,015**	**149,033**	**129,798**
Non-current liabilities					
Borrowings	18	**(29,611)**	(20,682)	**(29,611)**	(20,682)
Provisions	22	**(619)**	(650)	**(641)**	(755)
Total non-current liabilities		**(30,230)**	**(21,332)**	**(30,252)**	**(21,437)**
Total assets employed		**115,397**	**105,683**	**118,781**	**108,361**
Financed by					
Taxpayers Equity					
Public Dividend Capital		**61,512**	61,512	**61,512**	61,512
Revaluation reserve	23	**8,317**	11,522	**8,317**	11,522
Income and expenditure reserve		**45,568**	32,649	**45,568**	32,649
Others' Equity					
Charitable Fund Reserves	24	**0**	0	**3,384**	2,678
Total taxpayers & others' equity		**115,397**	**105,683**	**118,781**	**108,361**

P Philip
Date: 24 May 2017

The notes on pages C18 to C55 form part of the financial statements.

Statement of changes in equity

	Parent - Pre Consolidated				Group Consolidated				
	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Charitable Funds Reserves £000	Total £000
Taxpayers' and Others' Equity at 1 April 2016 - as previously stated	61,512	11,522	32,649	**105,683**	61,512	11,522	32,649	2,678	**108,361**
Surplus/(deficit) for the year	0	0	12,919	**12,919**	0	0	12,602	1,023	**13,625**
Revaluation Impact	0	(3,205)	0	**(3,205)**	0	(3,205)	0	0	**(3,205)**
Public Dividend Capital received	0	0	0	**0**	0	0	0	0	**0**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	317	(317)	**0**
Taxpayers' and Others' Equity at 31 March 2017	**61,512**	**8,317**	**45,568**	**115,397**	**61,512**	**8,317**	**45,568**	**3,384**	**118,781**
Taxpayers' and Others' Equity at 1 April 2015 - as previously stated	**61,512**	**11,522**	**32,596**	**105,630**	**61,512**	**11,522**	**32,596**	**3,359**	**108,989**
Surplus/(deficit) for the year	0	0	53	**53**	0	0	(280)	(348)	**(628)**
Revaluation Impact	0	0	0	**0**	0	0	0	0	**0**
Public Dividend Capital received	0	0	0	**0**	0	0	0	0	**0**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	333	(333)	**0**
Taxpayers' and Others' Equity at 31 March 2016	**61,512**	**11,522**	**32,649**	**105,683**	**61,512**	**11,522**	**32,649**	**2,678**	**108,361**

Statement of cash flows

	Parent		Group	
	2016/17 £000	Restated 2015/16 £000	2016/17 £000	Restated 2015/16 £000
Cash flows from operating activities				
Operating surplus from continuing operations	**17,134**	3,848	**17,342**	3,241
Operating surplus	**17,134**	**3,848**	**17,342**	**3,241**
Non-cash income and expense:				
Depreciation and amortisation	**8,685**	8,150	**8,685**	8,150
Non-cash donations/grants credited to income	**(275)**	(291)	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**(3,595)**	4,103	**(3,564)**	4,081
(Increase)/Decrease in Inventories	**(81)**	(695)	**(81)**	(695)
Increase/(Decrease) in Trade and Other Payables	**1,780**	(2,988)	**1,779**	(2,988)
Increase/(Decrease) in Other Liabilities	**(173)**	(28)	**(173)**	(28)
Increase/(Decrease) in Provisions	**80**	(1,524)	**80**	(1,524)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**0**	0	**(179)**	155
Other movements in operating cash flows	**(31)**	(23)	**(31)**	(23)
NET CASH GENERATED FROM OPERATIONS	**23,524**	**10,553**	**23,858**	**10,369**
Cash flows from investing activities				
Interest received	**25**	44	**25**	44
Purchase of Property, Plant and Equipment	**(10,176)**	(18,682)	**(10,451)**	(18,973)
Sale of Property, Plant and Equipment	**10**	17	**10**	17
NHS Charitable funds - net cash flows from investing activities	**0**	0	**494**	62
Net cash generated used in investing activities	**(10,141)**	**(18,621)**	**(9,922)**	**(18,850)**
Cash flows from financing activities				
Loans received from the Department of Health	**10,400**	9,500	**10,400**	9,500
Other loans received	**0**	30	**0**	30
Loans repaid to the Department of Health	**(260)**	0	**(260)**	0
Other loans repaid	**(7)**	(4)	**(7)**	(4)
Capital element of Private Finance Initiative obligations	**(397)**	(186)	**(397)**	(186)
Interest paid	**(216)**	(50)	**(216)**	(50)
Interest element of Private Finance Initiative obligations	**(729)**	(741)	**(729)**	(741)
PDC Dividend paid	**(3,144)**	(2,990)	**(3,144)**	(2,990)
Net cash used in financing activities	**5,647**	**5,559**	**5,647**	**5,559**
Increase/(decrease) in cash and cash equivalents	**19,030**	(2,509)	**19,583**	(2,922)
Cash and Cash equivalents at 1 April 2016	**9,146**	11,655	**9,403**	12,325
Cash and Cash equivalents at 31 March 2017	**28,176**	**9,146**	**28,986**	**9,403**

1. Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern
These accounts have been prepared on a going concern basis.

The FT is facing, along with all other providers, a challenging financial environment. The FT has, however, submitted a surplus plan for 2017/18 to NHS Improvement, albeit one that contains risk and requires collaboration with NHS leadership organisations to deliver the plan. After due consideration, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

1.1 Consolidation

The NHS Foundation Trust is the corporate trustee to Luton & Dunstable Hospital NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Trust does not have any other subsidiaries, associates, joint ventures or joint operations as defined under International Financial Reporting Standards.

Unless otherwise stated the notes to the accounts disclose the group position.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of Secretary of State, in England and Wales.

It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The trust also has employees who are members of the NEST pension scheme. This is a defined contribution scheme and employers pension cost contributions are charged to operating expenses as and when they become due.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has an individual cost of at least £5,000; or
- the item forms a group of assets which individually have a cost of more than £1,000, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates and are under single managerial control.
- the item forms a group of assets which are the initial equipping costs of a new or reconfigured asset with a collective value of over £20,000 and the group of assets are under common managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. All property (land and buildings, excluding infrastructure assets) are restated to current value using professional valuations in accordance with IAS16 every five years. An interim valuation is also carried out.

The Trusts properties were valued on 31 March 2015 by an external valuer, Richard Ayres MRICS of Gerald Eve LLP. The total proportion of fees payable by the client during the preceding year relative to the total fee income of the firm during the preceding year are minimal. The valuations were in accordance with the requirements of the RICS Valuation – Professional Standards, January 2014 edition and the International Valuation Standards. The valuation of each property was on the basis of market value, subject to the following assumptions:

- for owner-occupied property: the property would be sold as part of the continuing business;
- for investment property: the property would be sold subject to any existing leases; or
- for surplus property and property held for development: the property would be sold with vacant possession in its existing condition.

The valuer's opinion of market value was primarily derived using:

- comparable recent market transactions on arm's length terms and;
- the depreciated replacement cost approach, because the specialised nature of the asset means that there are no market transactions of this type of asset except as part of the business or entity.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The land value for existing use purpose is assessed at existing use value. For non-

operational properties including surplus land, the valuations are carried out at open market value.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use where the capital cost is greater than £5m.

PFI scheme assets have been valued in accordance with the policy above.

Operational equipment is valued at depreciated historic cost. Equipment surplus to requirements is valued at net recoverable amount.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';

- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The lifecycle costs i.e. those costs anticipated to be incurred to maintain the asset to a specified standard, within the scheme form part of the liability of the Trust and consequently have been recognised as a separate asset within the Statement of Financial Position. The asset is amortised each accounting period in accordance with the lifecycle costs incurred in respect of the PFI scheme asset.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for

Property, Plant and Equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7 Revenue government and other grants

Government grants are grants from Government bodies other than income from clinical commissioning groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade/Settlement date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are categorised as 'fair value through income and expenditure', loans and receivables or 'available-for-sale financial assets'.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Financial Assets

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial Liabilities - Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

The bad debt provision comprises of specific bad debts for known disputed items, debtors greater than one year, and debtors where there is a history of non-payment.

1.10 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.11 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. For charitable funds decisions made by the Charitable Fund Committee for which there is a constructive obligation to undertake activities are recognised at the point the decision is made.

The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling
The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable, (iv) Sustainability & Transformation incentive and bonus fund elements.

1.13 Public dividend capital cont

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.14 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The majority of the Trust's activities are related to core healthcare and are therefore not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the corporation tax threshold, as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

1.16 Foreign exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM, see Note 25.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and special payments register which reports on a cash basis with the exception of provisions for future losses, see Note 32.

1.19 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.20 Judgements in applying accounting policies & key sources of estimation uncertainty

The following are the judgements and key sources of estimation uncertainty that management has made in the process of applying the NHS foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- review of operating leases to determine whether the significant risks and rewards of ownership of the leased assets have transferred. To mitigate the risk of incorrect conclusions an external advisor's opinion was obtained.
- allocation of lifes to acquired plant and equipment (excluding buildings for which a valuer's opinion is obtained) to calculate the depreciation charge. This is estimated based on the lives of similar assets and knowledge of the procurer.
- income generated from partially completed spells and non contract income. These are estimated assuming that patterns of provision of service are consistent from year to year.

- accrued expenditure for annual leave is estimated byapplying NHS employment contracts' terms and conditions and Trust policy to the average annual leave balance for a sample of departments.

1.21 Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17.
These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

2.1 OPERATING INCOME (by classification)

	2016/17 Total £000	2015/16 Total £000
Income from Activities		
Elective income	**40,291**	37,618
Non elective income	**83,384**	74,919
Outpatient income	**45,085**	39,460
A & E income	**13,343**	12,113
Other NHS clinical income	**87,831**	86,631
Additional income for delivery of healthcare services	**8,700**	2,000
Private patient income	**2,156**	1,954
Other clinical income	**792**	784
Total income from activities	**281,582**	**255,479**

2.2 Commissioner Requested Services

The Trust's provider licence specifies the Commissioner Requested Services, for details see www.improvement.nhs.uk. This note analyses income from activities between Commissioner Requested Services and Non Commissioner Requested Services.

	2016/17 £000	2015/16 £000
Commissioner Requested Services	**269,934**	250,741
Non Commissioner Requested Services	**11,648**	4,738
	281,582	**255,479**

2.3 Operating lease income

	2016/17 Total £000	2015/16 Total £000
Operating Lease Income		
Rents recognised as income in the period	**745**	719
TOTAL	**745**	**719**
Future minimum lease payments due on leases of Buildings expiring		
- not later than one year;	**169**	220
- later than one year and not later than five years;	**676**	878
- later than five years.	**578**	920
TOTAL	**1,423**	**2,018**

2.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17 £000	2015/16 £000
Income recognised this year	**123**	96
Cash payments received in-year	**137**	83
Amounts added to provision for impairment of receivables	**22**	23
Amounts written off in-year	**3**	86

2.5 Operating INCOME (by type)

	Parent		Group	
	2016/17 £000	Restated 2015/16 £000	2016/17 £000	Restated 2015/16 £000
Income from activities				
NHS Foundation Trusts	**573**	493	**573**	493
NHS Trusts	**1,391**	1,258	**1,391**	1,258
CCGs and NHS England	**261,036**	243,407	**261,036**	243,407
Local Authorities	**2,864**	1,632	**2,864**	1,632
Department of Health - other	**0**	20	**0**	20
NHS Other	**469**	470	**469**	470
Non NHS: Private patients	**2,156**	1,954	**2,156**	1,954
Non-NHS: Overseas patients (non-reciprocal)	**123**	96	**123**	96
NHS injury scheme (was RTA)	**792**	784	**792**	784
Non NHS: Other*	**3,478**	3,365	**3,478**	3,365
Additional income for delivery of healthcare services	**8,700**	2,000	**8,700**	2,000
Total income from activities	**281,582**	**255,479**	**281,582**	**255,479**

*Non NHS: Other relates to a contract with private sector provider, previously commissioned by NHS Bedfordshire

	Parent		Group	
	2016/17 £000	Restated 2015/16 £000	2016/17 £000	Restated 2015/16 £000
Other operating income				
Research and development	**826**	760	**826**	760
Education and training	**8,492**	8,253	**8,492**	8,253
Charitable and other contributions to expenditure	**275**	290	**0**	0
Received from NHS charities: Other charitable and other contributions to expenditure	**42**	42	**0**	0
Rental revenue from operating leases	**745**	719	**745**	719
Income in respect of staff costs where accounted on gross basis	**1,517**	812	**1,517**	812
NHS Charitable Funds: Incoming Resources excluding investment income	**0**	0	**1,113**	462
Sustainability and Transformation Fund income[1]	**10,078**	0	**10,078**	0
Other*[2]	**5,233**	4,815	**5,235**	4,815
Total other operating income	**27,208**	**15,691**	**28,006**	**15,821**
TOTAL OPERATING INCOME	**308,790**	**271,170**	**309,588**	**271,300**

[1] NHS Performance bonus received for achieving financial and performance targets

*[2] This includes car parking income of £1,703k (2015/16 £1,621k). This is strictly an income generation activity whereby income exceeds cost and the surplus is invested in the provision of patient care. There are other Trust objectives delivered through this activity including a contribution to the patient and staff safety and experience agenda (additional security and maximising the availability of car parking spaces).

3.1 OPERATING EXPENSES (by type)

	Parent		Group	
	2016/17 £000	Restated 2015/16 £000	2016/17 £000	Restated 2015/16 £000
Employee Expenses - Executive directors	**1,123**	935	**1,123**	935
Employee Expenses - Non-executive directors	**138**	136	**138**	136
Employee Expenses - Staff	**186,536**	176,587	**186,536**	176,587
Supplies and services - clinical (excluding drug costs)	**28,371**	25,284	**28,371**	25,284
Supplies and services - general[1]	**4,581**	5,761	**4,581**	5,761
Establishment	**6,066**	5,574	**6,066**	5,574
Transport	**88**	85	**88**	85
Premises1	**15,358**	11,740	**15,358**	11,740
Increase / (decrease) in provision for receivable impairments	**(10)**	67	**(10)**	67
Change in provisions discount rate	**44**	0	**44**	0
Drug costs (non inventory drugs only)	**1,551**	1,431	**1,551**	1,431
Drugs Inventories consumed	**26,007**	24,572	**26,007**	24,572
Rentals under operating leases - minimum lease receipts	**1,022**	1,698	**1,022**	1,698
Depreciation on property, plant and equipment	**8,615**	8,080	**8,615**	8,080
Amortisation on intangible assets	**70**	70	**70**	70
Audit fees payable to the External Auditor				
audit services- statutory audit[2]	**49**	48	**49**	48
other services: audit-related assurance services'	**7**	7	**7**	7
other auditor remuneration (external auditor only)[3]	**23**	22	**23**	22
Audit fees payable re charitable fund accounts	**0**	0	**3**	3
Clinical negligence (Insurance Premiums)	**7,443**	6,380	**7,443**	6,380
Legal fees	**123**	87	**123**	87
Consultancy costs	**1,724**	939	**1,724**	939
Internal Audit Costs - not included in employee expenses	**96**	80	**96**	80
Training, courses and conferences	**797**	746	**797**	746
Patient travel	**247**	197	**247**	197
Car parking & Security	**722**	693	**722**	693
Redundancy - (not included in employee expenses)	**166**	57	**166**	57
Early retirements - (not included in employee expenses)	**0**	0	**0**	0
Hospitality	**6**	7	**6**	7
Publishing	**47**	49	**47**	49
Insurance	**114**	110	**114**	110
Other services, eg external payroll	**230**	250	**230**	250
Grossing up consortium arrangements	**30**	88	**30**	88
Losses, ex gratia & special payments	**15**	9	**15**	9
NHS Charitable funds: Other resources expended	**0**	0	**587**	735
Other *4	**257**	(4,467)	**257**	(4,467)
TOTAL	**291,656**	**267,322**	**292,246**	**268,060**

*1 The Trust outsourced Soft FM (Catering, Domestics) during 2015/16 resulting in a reduction in staff and general supply costs and an off-setting increase to premises.
*2 Excluding non-recoverable VAT.
*3 Includes estimate for VAT advice provided March 2017.
*4 Negative value as a result of reversing unused provisions and accruals during 2015/16.

4.1 Employee Expenses (excluding non-executive directors)

	2016/17 Permanent £000	2016/17 Other £000	2016/17 Total £000	2015/16 Permanent £000	2015/16 Other £000	2015/16 Total £000
Salaries and wages	126,285	17,279	**143,564**	120,911	16,032	**136,943**
Social security costs	13,507	1,385	**14,892**	10,622	1,165	**11,787**
Pension costs - defined contribution plans Employers contributions to NHS Pensions "	14,778	870	**15,648**	14,316	633	**14,949**
Agency/contract staff	0	14,707	**14,707**	0	15,742	**15,742**
Costs capitalised as part of assets	(669)	(317)	**(986)**	(1,415)	(427)	**(1,842)**
TOTAL	**153,901**	**33,924**	**187,825**	**144,434**	**33,145**	**177,579**

4.2 Average number of employees (WTE basis)

	2016/17 Permanent Number	2016/17 Other Number	2016/17 Total Number	2015/16 Permanent Number	2015/16 Other Number	2015/16 Total Number
Medical and dental	534	117	**651**	501	109	**610**
Administration and estates	651	96	**747**	617	101	**718**
Healthcare assistants and other support staff[1]	574	210	**784**	652	230	**882**
Nursing, midwifery and health visiting staff	1,262	161	**1,423**	1,196	171	**1,367**
Nursing, midwifery and health visiting learners	5	0	**5**	5	0	**5**
Scientific, therapeutic and technical staff	345	11	**356**	345	8	**353**
Healthcare science staff	145	53	**198**	136	46	**182**
Other	3	0	**3**	3	0	**3**
Number of Employees (WTE) engaged on capital projects	(17)	(5)	**(22)**	(47)	(9)	**(56)**
TOTAL	**3,502**	**643**	**4,145**	**3,408**	**656**	**4,064**

[1] 116 wte reduction due to part year effect of transfer of 200 wte following outsourcing in 2015/16

4.3 Employee benefits

There were no employee benefits during either 2016/17 nor 2015/16.

4.4 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There was 1 (2015/16: 3) retirement, at an additional cost of £21k (2015/16: £248k). This information has been supplied by NHS Pensions.

4.5.1 Senior Managers Remuneration

Name and Title		2016/17 Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman				
Simon Linnett	Chairman	40 to 45	n/a1	50 to 55
Non Executive Directors				
Alison Clarke	Non-Executive Director	15 to 20	n/a	15 to 20
Ninawatie Tiwari	Non-Executive Director	10 to 15	n/a	10 to 15
John Garner	Non-Executive Director	10 to 15	n/a	10 to 15
Mark Versallion	Non-Executive Director	10 to 15	n/a	10 to 15
David Hendry	Non-Executive Director	15 to 20	n/a	15 to 20
Jill Robinson	Non- Executive Director	10 to 15	n/a	10 to 15
Clifford Bygrave	Non-Executive Director (from 11/1/17)	0 to 5	n/a	0 to 5
Executive Directors				
Pauline Philip	Chief Executive	205 to 210	n/a	205 to 210
David Carter	Managing Director	150 to 155	135 to 137.5	285 to 290
Andrew Harwood	Director of Finance	125 to 130	17.5 to 20	145 to 150
Danielle Freedman	Chief Medical Advisor	160 to 165	n/a	160 to 165
Patricia Reid	Director of Nursing (to 30/1/17)	95 to 100	25 to 27.5	125 to 130
Sheran Oke	Director of Nursing (from 30/1/17)[2]	80 to 85	17.5 to 20	100 to 105
Marion Collict	Director of Transformation (from 11/1/17)[2]	100 to 105	27.5 to 30	135 to 140
Angela Doak	Director of Organisational Development	120 to 125	17.5 to 20	135 to 140
Mark England	Director of Reengineering and Informatics	120 to 125	27.5 to 30	145 to 150

[1] Pension related benefits 2016/17 were in the band £7.5k to £10k, however the individual has since retrospectively opted out of the pension scheme with a full refund of the contributions.
[2] Salary is for full 2016/17 year (including period prior to appointment as voting Director)

		2015/16		
Name and Title		Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman				
Simon Linnett	Chairman	40 to 45	n/a	40 to 45
Non Executive Directors				
Clifford Bygrave	Non-Executive Director (left 31/07/15)	5 to 10	n/a	5 to 10
Alison Clarke	Non-Executive Director	10 to 15	n/a	10 to 15
Ninawatie Tiwari	Non-Executive Director	10 to 15	n/a	10 to 15
John Garner	Non-Executive Director	10 to 15	n/a	10 to 15
Mark Versallion	Non-Executive Director	10 to 15	n/a	10 to 15
David Hendry	Non-Executive Director	10 to 15	n/a	10 to 15
Jill Robinson	Non- Executive Director	10 to 15	n/a	10 to 15
Executive Directors				
Pauline Philip	Chief Executive	205 to 210	n/a	205 to 210
David Carter	Managing Director	130 to 135	27.5 to 30	160 to 165
Andrew Harwood	Director of Finance	125 to 130	17.5 to 20	145 to 150
Mark Patten	Medical Director (to 30/9/15)	160 to 165	25 to 27.5	185 to 190
Danielle Freedman	Chief Medical Advisor (from 1/10/15)[1]	150 to 155	n/a	150 to 155
Patricia Reid	Director of Nursing	115 to 120	15 to 17.5	130 to 135
Angela Doak	Director of Organisational Development	120 to 125	17.5 to 20	135 to 140
Mark England	Director of Reengineering and Informatics	120 to 125	25 to 27.5	145 to 150

[1] Salary is for full 2015/16 year (including period prior to appointment as Chief Medical Advisor)

For the purpose of this note Senior Managers are defined as being the Chief Executive, Non Executive Directors and Executive Directors. I.e. Those individuals with voting rights.

Senior Managers have not received any taxable benefits, annual performance-related bonuses or long-term performance related bonuses in either 2016/17 or 2015/16.

4.5.2 Pension benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2017 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real Increase in Cash Equivalent Transfer Value £000
			2016/17		
Pauline Philip[1] Chief Executive	-	-	-	-	-
David Carter Managing Director	5 to 7.5	140 to 142.5	640	500	140
Andrew Harwood Director of Finance	0 to 2.5	192.5 to 195	930	875	55
Danielle Freedman[1] Chief Medical Advisor	-	-	-	-	-
Patricia Reid Director of Nursing (to 30/1/17)	0 to 2.5	110 to 112.5	n/a	n/a	n/a
Sheran Oke Director of Nursing (from 30/1/17)	0 to 2.5	130 to 132.5	643	600	42
Marion Collict Director of Transformation (from 11/1/17)	0 to 2.5	132.5 to 135	711	646	65
Angela Doak Director of Organisational Development	0 to 2.5	182.5 to 185	848	798	50
Mark England Director of Reengineering and Informatics	0 to 2.5	17.5 to 20	210	181	29

[1] No longer contributing to pension scheme

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2016 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real Increase in Cash Equivalent Transfer Value £000
			2015/16		
Pauline Philip[1] Chief Executive	-	-	-	-	-
David Carter Managing Director	0 to 2.5	117.5 to 120	500	473	20
Andrew Harwood Director of Finance	2.5 to 5	187.5 to 190	875	840	23
Mark Patten Medical Director (to 30/9/15)	0 to 2.5	160 to 162.5	731	704	17
Danielle Freedman[1] Chief Medical Advisor (from 1/10/15)	-	-	-	-	-
Patricia Reid Director of Nursing	2.5 to 5	102.5 to 105	589	550	31
Angela Doak Director of Organisational Development	2.5 to 5	175 to 177.5	798	762	25
Mark England Director of Reengineering and Informatics	0 to 2.5	15 to 17.5	181	155	24

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.
Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in 2015/16 for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

4.5.3 Median Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

	2016/17	2015/16
Band of Highest Paid Director's Total Remuneration	205 to 210	205 to 210
Median Total	**27,361**	**25,047**
Ratio	7.6	8.3

The highest paid director's remuneration did not change during 2016/17. There was an increase in median pay due to the application of pay increases in line with national NHS contracts during the year and a higher proportion of more experienced staff members.

4.5.4 Staff Exit Packages

	2016/17		2015/16	
Exit package cost band (including any special payment element)	Total number of exit packages	Total cost of exit packages £'000	Total number of exit packages	Total cost of exit packages £'000
<£10,000	16	47	16	52
£10,001 - £25,000	4	45	0	0
£25,001 - 50,000	2	57	0	0
£50,001 - £100,000	1	83	1	55
£100,001 - £150,000	0	0	0	0
>£150,000	0	0	0	0
Total	**23**	**232**	**17**	**107**

	2016/17	2016/17	2015/16	2015/16
	Payments agreed	Total value	Payments agreed	Total Value
	Number	£'000	Number	£'000
Compulsory redundancies	6	166	0	0
Voluntary redundancies including early retirement contractual costs	0	0	2	59
Contractual payments in lieu of notice	17	66	15	48
	23	**232**	**17**	**107**

4.5.5 Expenses of Governors and Directors

The Foundation Trust had a total of 34 (34 in 2015/16) governors in office in 2016/17. 8 (11 in 2015/16) of these governors received expenses in 2016/17, with aggregate expenses paid to governors of £1,200 (£1,200 in 2015/16).

The Foundation Trust had a total of 17 (16 in 2015/16) directors in office in 2016/17. 9 (6 in 2015/16) of these directors received expenses in 2016/17, with aggregate expenses paid to directors of £8,000 (£2,400 in 2015/16)

5.1 Operating leases

	2016/17 £000	2015/16 £000
Minimum lease payments	1,022	1,698
TOTAL	**1,022**	**1,698**

5.2 Arrangements containing an operating lease

Future minimum lease payments due:	2016/17 £000 Land	2016/17 £000 Buildings	2016/17 £000 Other	2016/17 £000 Total	2015/16 £000 Total
- not later than one year;	80	120	263	463	184
- later than one year and not later than five years;	319	480	89	888	673
- later than five years.	792	1,394	0	2,186	1,944
TOTAL	**1,191**	**1,994**	**352**	**3,537**	**2,801**

The Trust does not have any significant leasing arrangements.

5.3 Limitation on auditor's liability

There is £1m limitation on the auditors liability.

5.4 The late payment of commercial debts (interest) Act 1998

£1k was paid in respect of the late payment of commercial debts (interest) Act 1998 (£0.1k in 2015/16)

5.5 Other Audit Remuneration

£23k expenditure was incurred with the external audit provider in respect of tax advice in 2016/17. (£22k 2015/16)

5.6 Impairment of assets (PPE & intangibles)

No impairments have been charged to expenditure in either 2015/16 nor 2016/17.

6.1 Finance income

	Parent		Group	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Interest on instant access bank accounts	**25**	44	**25**	44
Interest on held-to-maturity financial assets	**0**	0	**0**	0
NHS Charitable funds: investment income	**0**	0	**91**	91
TOTAL	**25**	**44**	**116**	**135**

6.2 Finance costs - interest expense

Group	Parent			
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Capital loans from the Department of Health	237	72	237	72
Interest on late payment of commercial debt	1	0	1	0
Finance Costs in PFI obligations				
Main Finance Costs	729	739	729	739
TOTAL	**967**	**811**	**967**	**811**

7.1 Intangible Assets 2016/17

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2016 as previously stated	536	**536**
Additions - purchased	0	0
Cost or valuation at 31 March 2017	536	**536**
Amortisation at 1 April 2016 as previously stated	272	**272**
Provided during the year	70	**70**
Amortisation at 31 March 2017	342	**342**
Net book value		
NBV - Owned at 31 March 2017	194	**194**
NBV total at 31 March 2017	**194**	**194**

7.2 Intangible Assets 2015/16

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2015 as previously stated	536	**536**
Additions - purchased	0	0
Cost or valuation at 31 March 2016	536	**536**
Amortisation at 1 April 2015 as previously stated	202	**202**
Provided during the year	70	**70**
Amortisation at 31 March 2016	272	**272**
Net book value		
NBV - Owned at 31 March 2016	264	**264**
NBV total at 31 March 2016	**264**	**264**

8.1 Property, plant and equipment 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016 as previously stated	10,650	80,026	438	7,302	27,464	3,900	15,105	210	**145,095**
Additions - purchased (including donated)	0	956	0	5,806	2,437	0	722	0	**9,921**
Reclassifications	0	4,250	0	(5,004)	0	0	754	0	**0**
Revaluations	0	(3,205)	0	0	0	0	0	0	**(3,205)**
Disposals1	0	0	0	0	(922)	0	(1,960)	0	**(2,882)**
Cost or valuation at 31 March 2017	**10,650**	**82,027**	**438**	**8,104**	**28,979**	**3,900**	**14,621**	**210**	**148,929**
Accumulated depreciation at 1 April 2016 as previously stated	0	3,124	13	0	18,472	1,538	6,302	202	29,651
Provided during the year	0	3,312	13	0	2,552	491	2,245	2	**8,615**
Disposals[1]	0	0	0	0	(915)	0	(1,960)	0	**(2,875)**
Accumulated depreciation at 31 March 2017	**0**	**6,436**	**26**	**0**	**20,109**	**2,029**	**6,587**	**204**	**35,391**
Net book value									
NBV - Owned at 31 March 2017	10,650	61,374	380	8,104	8,294	1,871	8,025	6	98,704
NBV - PFI at 31 March 2017	0	12,514	0	0	0	0	0	0	12,514
NBV - Donated at 31 March 2017	0	1,703	32	0	576	0	9	0	**2,320**
NBV total at 31 March 2017	**10,650**	**75,591**	**412**	**8,104**	**8,870**	**1,871**	**8,034**	**6**	**113,538**

[1] No assets used in the provision of commissioner requested services have been disposed of during the year.

8.2 Property, plant and equipment 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015 as previously stated	10,650	69,837	406	1,921	25,095	3,809	13,150	220	**125,088**
Additions - purchased (including donated)	0	2,140	0	13,567	2,479	97	2,287	0	**20,570**
Reclassifications	0	8,049	32	(8,186)	0	0	105	0	**0**
Disposals1	0	0	0	0	(110)	(6)	(437)	(10)	**(563)**
Cost or valuation at 31 March 2016	**10,650**	**80,026**	**438**	**7,302**	**27,464**	**3,900**	**15,105**	**210**	**145,095**
Accumulated depreciation at 1 April 2015 as previously stated	0	0	0	0	16,062	1,057	4,732	210	**22,061**
Provided during the year	0	3,124	13	0	2,446	488	2,007	2	**8,080**
Disposals1	0	0	0	0	(36)	(7)	(437)	(10)	(490)
Accumulated depreciation at 31 March 2016	**0**	**3,124**	**13**	**0**	**18,472**	**1,538**	**6,302**	**202**	**29,651**
Net book value									
NBV - Purchased at 31 March 2016	10,650	64,308	393	7,302	8,525	2,362	8,803	8	**102,351**
NBV - PFI at 31 March 2016	0	10,814	0	0	0	0	0	0	**10,814**
NBV - Donated at 31 March 2016	0	1,780	32	0	467	0	0	0	2,279
NBV total at 31 March 2016	**10,650**	**76,902**	**425**	**7,302**	**8,992**	**2,362**	**8,803**	**8**	**115,444**

[1] No assets used in the provision of commissioner requested services have been disposed of during the year.

8.3 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	n/a	n/a
Buildings excluding dwellings	0	80
Dwellings	0	80
Assets under Construction & POA	n/a	n/a
Plant & Machinery	0	15
Transport Equipment	0	15
Information Technology	0	8
Furniture & Fittings	0	5
Intangible Software Licenses	0	8

9 Other Property Plant & Equipment Disclosures

The Trust received £275k of donated property, plant and equipment from the charitable funds associated with the hospital.

The Trust entered into a 10 year contract for the provision of medical records in February 2013. Due to the length of the contract, the expected life of the equipment in question and, on the basis that the equipment is solely used by this Trust, the Trust has recognised this equipment as property plant and equipment. The value of this equipment as at 31 March 17 was £1,571k.

The Trust's estate, encompassing land and buildings was revalued as at 31 March 2015. This valuation was completed by Gerald Eve LLP, professional valuers in accordance with the RICS Valuation - Professional Standards published by the Royal Institution of Chartered Surveyors. Given the significant investment in one of the Trust's building assets over the last two years a valuation by Gerald Eve LLP was obtained in respect of this asset as at 31 March 2017 and is reflected in these financial statements. The Directors' opinion is that there are no property plant or equipment where the value is significantly different from the value included in the financial statements.

Land was valued using existing use value methodology at £10,650k using the concept of economic substitution of the service utility of the asset.

Given the specialised nature of the buildings the majority of the estate has been valued using depreciated replacement cost based on modern equivalent assets at a value of £76,005k.

There are various small assets which are temporarily idle, although not for sale, where the period for which the asset is idle is uncertain these have had their depreciation accelerated and are held on the Statement of Financial Position at values reflecting their short remaining economic lives.

10.1 Non-current assets for sale and assets in disposal groups

The Trust held no non-current assets for sale nor assets in disposal groups in 2015/16 or 2016/17.

10.2 Liabilities in disposal groups

The Trust held no liabilities in disposal groups in 2015/16 nor 2016/17.

11 Investments

	Parent		Group	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
NHS Charitable funds: Other investments				
Carrying value at 1 April 2016	0	0	3,072	3,208
Acquisitions in year - other	0	0	455	375
Fair value gains (taken to I&E)	0	0	408	0
Fair value losses (impairment) [taken to I&E]	0	0	(1)	(164)
Disposals	0	0	(859)	(347)
Carrying value at 31 March 2017	0	0	3,075	3,072

12 Associates & Jointly Controlled Operations

The NHS foundation trust is the corporate trustee to Luton & Dunstable Hospital Charitable Funds. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The main financial statements disclose the NHS organisation's financial position alongside that of the group (which is the NHS organisation and the NHS charity). The NHS charity's accounts, which have been prepared in accordance with UK Financial Reporting Standard (FRS) 102, can be found on the Charity Commission website and are summarised in note 24 to these accounts.

As the accounting policies applicable to both the Trust and the Charitable Funds are consistent no adjustment other than intra-group transactions has been required.

The Trust had no other associates nor jointly controlled operations in 2015/16 nor 2016/17.

13.1 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	1,023	983
Consumables	2,268	2,227
TOTAL INVENTORIES	**3,291**	**3,210**

Note 13.2 Inventories recognised in expenses

	2016/17 £000	2015/16 £000
Additions	47,347	44,301
Inventories recognised in expenses	(47,266)	(43,606)
MOVEMENT IN INVENTORIES	**81**	**695**

14.1 Trade receivables and other receivables

	Parent		Group	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Current				
NHS Receivables	**7,503**	6,754	**7,503**	6,754
Other receivables with related charitable funds	**51**	21	**0**	0
Other receivable with related parties	**614**	482	**614**	482
Provision for impaired receivables	**(943)**	(993)	**(943)**	(993)
Prepayments	**3,893**	3,202	**3,893**	3,202
Prepayments - Lifecycle replacements	**44**	44	**44**	44
Accrued income	**8,470**	6,775	**8,470**	6,775
PDC dividend receivable	**0**	23	**0**	23
VAT receivable	**1,298**	1,263	**1,298**	1,263
Other receivables	**2,735**	2,947	**2,735**	2,947
NHS Charitable funds: Trade and other receivables	**0**	0	**0**	6
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**23,665**	**20,518**	**23,614**	**20,503**
Non-Current				
Prepayments	**487**	109	**487**	109
Prepayments - PFI related	**350**	394	**350**	394
Accrued income	**1,080**	989	**1,080**	989
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**1,917**	**1,492**	**1,917**	**1,492**

14.2 Provision for impairment of receivables

	31 March 2017 £000	31 March 2016 £000
At 1 April 2016	993	1,085
Increase/(Decrease) in provision	(10)	67
Amounts utilised	(40)	(159)
At 31 March 2017	**943**	**993**

14.3 Analysis of impaired receivables

	31 March 2017 £000	31 March 2016 £000
Ageing of impaired receivables		
0 - 30 days	**35**	60
30-60 Days	**35**	32
60-90 days	**42**	32
90- 180 days	**110**	120
over 180 days	**721**	749
Total	**943**	**993**
Ageing of non-impaired receivables past their due date		
0 - 30 days	**326**	1,977
30-60 Days	**638**	836
60-90 days	**462**	259
90- 180 days	**1,564**	2,304
over 180 days	**5,227**	3,390
Total	**8,217**	**8,766**

The Trust has reviewed the not due and non impaired receivables and has satisfied itself that there is no evidence of impairment which have an impact on the estimated future cash flows of the assets.

14.4 Finance lease receivables

During 2016/17 the Trust did not have any finance lease receivables.

15 Other assets (Non Current)

	31 March 2017 £000	31 March 2016 £000
PFI Scheme - lifecycle costs	2,574	2,712
Total	**2,574**	**2,712**

16.1 Trade and other payables

	Parent		Group	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Current				
Receipts in advance	**0**	47	**0**	47
NHS payables	**3,829**	3,416	**3,829**	3,416
Amounts due to other related parties - revenue	**2,225**	2,109	**2,225**	2,109
Trade payables - capital	**2,229**	2,897	**2,229**	2,897
Other trade payables	**5,071**	3,035	**5,071**	3,035
Social Security costs	**3,884**	3,383	**3,884**	3,383
Other payables	**598**	682	**598**	682
Accruals	**6,201**	7,354	**6,201**	7,354
PDC Dividend Payable	**97**	0	**97**	0
NHS Charitable funds: Trade and other payables	**0**	0	**119**	147
TOTAL CURRENT TRADE & OTHER PAYABLES	**24,134**	**22,923**	**24,253**	**23,070**

There were no non current trade or other payables at either 31 March 2016 or 31 March 2017.

NHS payables do not include any outstanding pension contributions due to NHS Pensions Agency as at 31 March 2017.

17 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Deferred Income	**1,650**	1,823
TOTAL OTHER CURRENT LIABILITIES	**1,650**	**1,823**

There are no non current other liabilities in 2015/16 nor 2016/17.

18 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Capital loans from Department of Health	**835**	198
Other loans	8	26
Obligations under Private Finance Initiative contracts	**580**	393
TOTAL CURRENT BORROWINGS	**1,423**	**617**
Non-current		
Capital loans from Department of Health	**18,805**	9,302
Other loans	**11**	0
Obligations under Private Finance Initiative contracts	**10,795**	11,380
TOTAL OTHER NON CURRENT LIABILITIES	**29,611**	**20,682**

19. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2015 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

20. Finance lease obligations

The Trust had no finance lease obligations during 2016/17 other than the PFI scheme arrangement.

21.1 PFI obligations (on SoFP)

	31 March 2017 £000	31 March 2016 £000
Gross PFI liabilities	17,032	18,156
of which liabilities are due		
- not later than one year;	1,287	1,126
- later than one year and not later than five years;	5,459	5,335
- later than five years.	10,285	11,695
Finance charges allocated to future periods	(5,656)	(6,383)
Net PFI liabilities	**11,375**	**11,773**
- not later than one year;	580	393
- later than one year and not later than five years;	3,007	2,725
- later than five years.	7,788	8,655

21.2 The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 March 2017 Total £000	31 March 2016 Total £000
Within one year	1,762	1,676
2nd to 5th years (inclusive)	7,136	6,704
Later than 5 years	12,052	14,246
Total	**20,950**	**22,626**

The Trust incurred £584k expenditure in respect of the service charge under the PFI contract (£825k in 2015/16). This is shown within the Premises category in Note 3.1.

22 Provisions for liabilities and charges

Parent	Current		Non-current	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Pensions relating to other staff	**64**	64	**619**	650
Other legal claims	**295**	96	**0**	0
Redundancy	**152**	152	**0**	0
Other	**10**	96	**0**	0
Total	**521**	**408**	**619**	**650**

Group	Current		Non-current	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Pensions relating to other staff	**64**	64	**619**	650
Other legal claims	**295**	96	**0**	0
Redundancy	**152**	152	**0**	0
Other	**10**	96	**0**	0
NHS charitable fund provisions	**309**	384	**22**	105
Total	**830**	**792**	**641**	**755**

	Pensions - other staff £000	Other legal claims £000	Redundancy £000	Other £000	NHS charitable fund provisions £000	Total £000
At 1 April 2016	**714**	**96**	**152**	**96**	**489**	**1,547**
Change in the discount rate	44	0	0	0	0	44
Arising during the year	0	278	0	0	0	278
Utilised during the year	(63)	(29)	0	0	0	(92)
Reversed unused	(14)	(50)	0	(86)	0	(150)
Unwinding of discount	2	0	0	0	0	2
NHS charitable funds: movement in provisions	0	0	0	0	(158)	(158)
At 31 March 2017	**683**	**295**	**152**	**10**	**331**	**1,471**
Expected timing of cashflows:						
- not later than one year;	64	295	152	10	309	830
- later than one year and not later than five years;	252	0	0	0	22	274
- later than five years.	367	0	0	0	0	367
TOTAL	**683**	**295**	**152**	**10**	**331**	**1,471**

Provisions for legal claims represents the gross estimated liability from employer and public liability cases. These cases are managed by NHS Litigation Authority through the LTPS scheme, the amount of the provision recoverable from NHS Litigation Authority is included within debtors.

£101,859k is included in the provisions of the NHS Litigation Authority at 31/03/2017 in respect of clinical negligence liabilities of the Trust (31/03/2016 £114,813k).

Other provisions relate to various provisions for trading and employment contractual issues (all less than £1m).

23 Revaluation reserve

	Revaluation Reserve -property, plant and equipment £000	Total Revaluation Reserve* £000
Revaluation reserve at 1 April 2016	11,522	**11,522**
Revaluation Impact	(3,205)	**(3,205)**
Other Movements	0	**0**
Revaluation reserve at 31 March 2017	**8,317**	**8,317**
Revaluation reserve at 1 April 2015	11,522	**11,522**
Revaluation Impact	0	**0**
Other Movements	0	**0**
Revaluation reserve at 31 March 2016	**11,522**	**11,522**

* The Trust held no revaluation reserve in respect of intangible assets.

24 Charitable Funds Summary Statements

As per Note 12, below summarises the NHS Charity's accounts which have been consolidated within the Group's accounts in accordance with IAS 27.

	Subsidary 2016/17 £000	2015/16 £000
Statement of Financial Activities/ Comprehensive Income		
Incoming resources	1,113	**462**
Resources expended	(905)	**(1,071)**
Net resources expended	**208**	**(609)**
Incoming Resources: investment income	91	**91**
Fair value movements on investments	407	**(165)**
Net movement in funds	**706**	**(683)**

	31 March 2017 £000	31 March 2016 £000
Statement of Financial Position		
Non-current assets	3,075	**3,072**
Current assets	810	**262**
Current liabilities	(479)	**(551)**
Non-current liabilities	(22)	**(105)**
Net assets	**3,384**	**2,678**
Funds of the charity		
Endowment funds	1	**1**
Other Restricted income funds	1,320	**788**
Unrestricted income funds	2,063	**1,889**
Total Charitable Funds	**3,384**	**2,678**

25 Cash and cash equivalents

	Parent		Group	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
At 1 April (as previously stated)	**9,146**	11,655	**9,403**	12,325
Net change in year	**19,030**	(2,509)	**19,583**	(2,922)
At 31 March	**28,176**	9,146	**28,986**	9,403
Broken down into:				
Cash at commercial banks and in hand	**39**	60	**39**	60
NHS charitable funds: cash held at commercial bank	**0**	0	**810**	257
Cash with the Government Banking Service	**28,137**	9,086	**28,137**	9,086
Cash and cash equivalents as in SoFP	**28,176**	**9,146**	**28,986**	**9,403**
Cash and cash equivalents as in SoCF	**28,176**	**9,146**	**28,986**	**9,403**

The Trust held £2k cash at bank and in hand at 31/03/17 which relates to monies held by the Trust on behalf of patients.

26.1 Contractual Capital Commitments

The Trust had contractual capital commitments totalling £1.1m at 31 March 2017.

26.2 Events after the reporting period

There have been no events after the reporting period end requiring disclosure.

The Director of Finance authorised the financial statements for issue on 24 May 2017.

27. Contingent (Liabilities) / Assets

	31 March 2017 £000	31 March 2016 £000
Gross value of contingent liabilities	59	46
Net value of contingent liabilities	59	46
Net value of contingent assets	0	0

Contingent liabilities relate to claims that the NHS Litigation Authority is aware of and has requested that we disclose.

28 Related Party Transactions

The Luton & Dunstable Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the NHS Foundation Trust.

All bodies deemed to be within the remit of the United Kingdom 'Whole of Government' are regarded as related parties. During the year the Trust has had significant transactions with the bodies disclosed in this note.

The Trust is the Corporate Trustee for the Charitable Funds, the transactions for which have been consolidated within these financial statements in accordance with IAS 27.

	Income 2016/17 £000	Expenditure 2016/17 £000	Income 2015/16 £000	Expenditure 2015/16 £000
NHS and DH				
Aylesbury Vale CCG	**2,795**	**0**	2,745	0
Bedfordshire CCG	**65,708**	**0**	59,335	0
Department of Health	**8,702**	**3,167**	2,020	2,960
Health Education England	**8,427**	**0**	8,116	0
Herts Valleys CCG	**21,640**	**0**	19,271	0
Luton CCG	**125,962**	**0**	118,388	0
NHS England: East Commissioning Hub	**30,355**	**0**	27,690	0
NHS England: Central Midlands Local Office	**9,701**	**0**	8,944	0
NHS England: Core	**10,261**	0	29	0
NHS Litigation Authority	**0**	7,447	0	6,384
Central Government				
HM Revenue and Customs	**0**	**14,893**	0	11,787
National Health Service Pension Scheme	**0**	**15,647**	0	14,949

28 Related Party Transactions continued

Related Party Balance	Receivables 31 March 2017 £000	Payables 31 March 2017 £000	Receivables 31 March 2016 £000	Payables 31 March 2016 £000
NHS and DH				
Aylesbury Vale CCG	**165**	**0**	232	0
Bedfordshire CCG	**2,182**	**33**	1,395	0
Department of Health	**1**	**139**	23	22
Health Education England	**134**	**2**	45	6
Herts Valleys CCG	**1,755**	**0**	2,225	0
Luton CCG	**831**	**0**	2,692	0
NHS England: East Commissioning Hub	**1,928**	**0**	1,961	0
NHS England: Central Midlands Local Office	**748**	**0**	0	762
NHS England: Core	**3,435**	**0**	29	223
NHS Litigation Authority	**0**	**0**	0	0
Central Government				
HM Revenue and Customs	**1,298**	**3,884**	1,263	3,383
National Health Service Pension Scheme	**0**	**2,193**	0	2,079

29.1 For PFI schemes deemed to be off-SoFP

The Trust ended the off SoFP PFI scheme relating to the provision of the electronic patient record system in 2011/12. There are no transactions within either 2015/16 or 2016/17 relating to an off-SoFP PFI scheme.

29.2 Further narrative on PFI schemes

The Trust had two capital schemes arranged under PFI arrangements, one of these ended in 2011/12.

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 13 years remaining. The operator is responsible for maintaining the building during this period and ownership reverts to the Trust at the end of the contract. There are no break clauses nor re-pricing dates (On-SoFP)

2. The contract for the electronic patient record scheme has now finished. This contract was for 10 years.

There were no new PFI schemes in the year and any future schemes are unlikely as they would be funded either through internally generated resources or external financing using the additional freedoms granted to Foundation Trusts.

30.1 Financial assets by category

	Parent		Group	
	Loans and receivables £000	Total £000	Loans and receivables £000	Total £000
Assets as per SoFP				
Trade and other receivables excluding non financial assets (at 31 March 2017)	13,852	**13,852**	13,801	**13,801**
Cash and cash equivalents (at bank and in hand (at 31 March 2017))	28,176	**28,176**	28,175	**28,175**
NHS Charitable funds: financial assets (at 31 March 2017)	0	**0**	810	**810**
Total at 31 March 2017	**42,028**	**42,028**	**42,786**	**42,786**
Trade and other receivables excluding non financial assets (at 31 March 2016)	20,239	**20,239**	20,219	**20,219**
Cash and cash equivalents (at bank and in hand (at 31 March 2016))	9,146	**9,146**	9,146	**9,146**
NHS Charitable funds: financial assets (at 31 March 2016)	0	**0**	262	**262**
Total at 31 March 2016	**29,385**	**29,385**	**29,627**	**29,627**

Financial Assets risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS receivables	Low	Low	Low
Accrued income	Low	Low	Medium
Other debtors	Low	Low	Medium
Cash at bank and in hand	Low	Medium	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

The Trust has a robust, audited, debt management policy that mitigates against the debtor liquidity risk. The Trust mitigates the cash credit risk by investing only in line with the NHS Improvement compliant Treasury Management Policy.

30.2 Financial liabilities by category

	Parent		Group	
	Other financial liabilities £000	Total £000	Other financial liabilities £000	Total £000
Liabilities as per SoFP				
Borrowings excluding finance lease and PFI liabilities (at 31 March 2017)	19,659	**19,659**	19,659	**19,659**
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2017)	11,376	**11,376**	11,376	**11,376**
Trade and other payables excluding non financial liabilities (at 31 March 2017)	20,152	**20,152**	20,152	**20,152**
NHS Charitable funds: financial liabilities (at 31 March 2017)	0	**0**	172	**172**
Total at 31 March 2017	**51,187**	**51,186**	**51,359**	**51,358**
Borrowings excluding finance lease and PFI liabilities (at 31 March 2016)	9,526	**9,526**	9,526	**9,526**
Obligations under Private Finance Initiative contracts (31 March 2016)	11,773	**11,773**	11,773	**11,773**
Trade and other payables excluding non financial liabilities (31 March 2016)	22,923	**22,923**	22,923	**22,923**
NHS Charitable funds: financial liabilities (31 March 2016)	0	**0**	167	**167**
Total at 31 March 2016	**44,222**	**44,222**	**44,389**	**44,389**

Financial Liabilities risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS creditors	Low	Low	Low
Other creditors	Low	Low	Low
Accruals	Low	Low	Low
Capital creditors	Low	Low	Low
Provisions under contract	Low	Low	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

All major contractors are credit checked prior to the awarding of the contract, thus limiting credit risk

The Trust mitigates the liquidity risk via 12 month forward cash planning.

30.3 Maturity of Financial Liabilities

			31 March 2017 £000	31 March 2016 £000
In one year or less			22,843	**23,392**
In more than one year but not more than two years			1,480	**1,145**
In more than two years but not more than five years			4,868	**3,549**
In more than five years			21,996	**16,303**
Total	**51,187**	**44,389**		

30.4 Fair values of financial assets at 31 March 2017

The fair value of the Trust's financial assets were the same as the book value as at 31 March 2017 (and 31 March 2016).

30.5 Fair values of financial liabilities at 31 March 2017

	Parent		Group	
	Book Value £000	Fair value £000	Book Value £000	Fair value £000
Non current trade and other payables excluding non financial liabilities	0	0	0	0
Provisions under contract	0	0	0	0
Loans	19,659	19,659	19,659	19,659
NHS Charitable funds: non-current financial liabilities	0	0	0	0
Total	**19,659**	**19,659**	**19,659**	**19,659**

31.1 On-Statement of Financial Position pension schemes.

The Trust has no on Statement of Financial Position Pension Scheme transactions.

31.2 Off-Statement of Financial Position pension schemes.

NHS Pension Scheme
See Note 1.3 for details of the accounting treatment of the NHS Pension Scheme.

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

National Employment Savings Trust (NEST)
The Trust offers employees an alternative pension scheme, NEST. This is a defined contribution, off statement of financial position scheme and the number of employees opting in and the value of contributions have been negligible (£6k employers contribution costs in year.)

32 Losses and Special Payments

	2016/17 Total number of cases Number	2016/17 Total value of cases £000's	2015/16 Total number of cases Number	2015/16 Total value of cases £000's
LOSSES:				
1. c. other causes	2	0	0	0
2. Fruitless payments and constructive losses	1	7	0	0
3.a. Bad debts and claims abandoned in relation to private patients	0	0	13	2
3.b. Bad debts and claims abandoned in relation to overseas visitors	7	3	39	86
3.c. Bad debts and claims abandoned in relation to other	35	2	48	67
TOTAL LOSSES	**45**	**12**	**100**	**155**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	0	0	1	0
7.a. Ex gratia payments in respect of loss of personal effects	21	6	16	4
7.c. personal injury with advice	0	0	6	4
7.d. Ex gratia payments in respect of other negligence and injury	9	2	9	1
TOTAL SPECIAL PAYMENTS	**30**	**8**	**32**	**9**
TOTAL LOSSES AND SPECIAL PAYMENTS	**75**	**20**	**132**	**164**

There were no compensation payments received.

33 Discontinued operations

There were no discontinued operations in 2016/17.

34 Corporation Tax

Corporation Tax is not due as the Trust is below the de minimis threshold as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

35 Segmented Operations

The Trust operates in one segment, that of the provision of healthcare, as reported to the Chief Operating Decision Maker, the Board.

36 Foundation Trust Income Statement and Statement of Comprehensive Income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's surplus for the period was £12,919k (2015/16: £53k). The trust's total comprehensive income for the period was £9,714k (2015/16 comprehensive income: £53k).


NHS

Appendix 1 Quality Account

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 2015/16 is included in this account alongside our priorities and goals for quality improvement in 2016/17 and how we intend to achieve them. This report summarises how we did against the quality priorities and goals that we set in 2015/16.

How is the 'quality' of the services provided 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 seven sections.

- The first section contains a statement on quality from the Chief Executive and sets out our corporate objectives for 2017/18.
- The second section looks at our performance in 2016/17 against the priorities that we set for patient safety, clinical effectiveness and patient experience.
- The third section sets out our quality priorities and goals for 2017/18 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.
- The fourth section includes statements related to the quality of services that we have provided and includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.
- The fifth section is a review of our quality performance and includes performance against national priorities and local indicators. It also provides examples of how we have improved services for patients.
- The sixth section of the report includes a statement of Directors' responsibility in respect of the quality report.
- The seventh section contains comments from our external stakeholders.
- Some of the information in the Quality Account is mandatory; however most is decided by our staff and Foundation Trust Governors.

* Pauline Philip was the Chief Executive for 1 April 2016 to the 31st March 2017. Therefore although she went on secondment on the 1st May 2017, it was agreed with External Audit that she should still sign off the Annual Report (including the Quality Account) and Accounts.

About Our Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital 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 90,000 admitted patients, nearly 400,000 outpatients and Emergency Department attendees and we delivered over 5,300 babies.

We serve a diverse population most of whom are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile. There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 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 L&D has developed a range of specialist services including cancer, obesity, neurophysiology and oral maxillofacial (jaw) surgery. We have the responsibility for treating the most premature and critically ill newborn babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

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

The Trust has a strong and robust clinical management culture; all clinical services are managed by Clinical Chairs, Divisional Directors, supported by Clinical Directors, General Managers and Senior Nurses.

Division	Specialties	
Medicine	Paediatric Surgery Trauma & Orthopaedic Hospital at home Critical Care	Anaesthetics Pain Management Orthodontics Audiology
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

Division	Specialties	
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 2016/17 Divisional Directors, General Managers and Executive Directors met in the Executive Board Meeting.

Divisional Executive Meetings are also in place with each of the Clinical Divisions in order to increase clinical accountability at specialty level.

Other Executive meetings are dedicated to the Clinical Operational Board that reviews the clinical performance of the Trust and Re-Engineering programmes that focus on the quality improvement programmes and efficiency including financial recovery plans.

1. A Statement on Quality from the Chief Executive

Part 1

Improving clinical outcome, patient safety and patient experience remain the core values of the L&D. This can be seen by reading our corporate objectives and understanding the progress that we are making year on year delivering sustained improvement.

During the year, we have continued our focus on quality improvement initiatives. We received our CQC Report in June 2016 which rated the Trust as 'Good'. This was an excellent result and the Inspection Report did not mandate any must do actions for the Trust. There were some improvements identified that the Trust has taken forward and this is reported within this Quality Account.

We launched our Advancing Quality and Patient Safety Framework at our Staff Engagement Event in December 2016 where over 2000 staff were engaged in delivering our plans. This will be further developed throughout 2017/18.

As in previous years we consistently delivered against national and local quality and performance targets. We continued to be one of the best performing hospitals in the country for the waiting time targets in A&E and we achieved the 18 week and cancer performance. We also maintained a low number of C Diff with 8 cases.

Our quality priorities set out for 2016/17 have been embedded into our systems and processes and we made considerable progress. We

- Maintained over 90% compliance with the 3 day anti-biotic reviews in all clinical areas.
- Maintained a high focus on mortality and further improved on the mortality review processes and we have started to see the HSMR reduce towards the end of 2016/17.
- Have made exceptional progress in the reduction of hospital acquired pressure ulcers from 11 grade 3 and 4 in 2015/6 to just three in 2016/17.
- Maintained a falls rate of below the national average and a reduction in the number of falls that resulted in harm.
- Maintained a cardiac arrest rate below the national average and continued to learn from each incident to further strengthen our processes.
- Improved our stroke audit compliance scores considerably with plans in place to improve further.
- Implemented a number of end of life care measures to further improve communication and training across healthcare.
- Achieved an improving outpatient experience with a reduction in short notice appointments rescheduled and a reduction in patients who do not attend their appointments.

This Quality Account also focuses on how we will deliver and maintain our progress against our key quality practices in the coming year. These priorities have been developed from our own intelligence of where we need to improve, commissioning quality goals (CQUIN) and our CQC report.

Pauline Phili
Chief Executive
24th May 2017

Corporate Objectives 2017/18

This document updates our 2014-2019 Strategic Plan and our 2017/19 Operational Plan. Progress against the plan is reported in the Annual report.

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

1. Deliver Excellent Clinical Outcomes

- Year on year reduction in Hospital Standardised Mortality Ratio in all diagnostic categories

2. Improve Patient Safety

- Year on year reduction in clinical error resulting in harm
- Year on year reduction in Hospital Acquired Infection

3. Improve Patient Experience

- Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance

4. Deliver National Quality and Performance Targets

- Deliver sustained performance with all CQC outcome measures
- Deliver nationally mandated waiting times and other indicators

5. Implement our New Strategic Plan

- Deliver new service models:
  - Emergency Hospital
  - Women's and Children's Hospital
  - Elective Centre
  - Academic Unit
- Implement preferred option for the re-development of the site.

6. Secure and Develop a Workforce to meet the needs of our Patients

- Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.
- Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes.
- Deliver excellent in teaching and research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

7. Optimise our Financial Plan

- Deliver our financial plan

2. Report on Priorities for Improvement in 2016/17

Part 2

Last year we identified three quality priorities. This section describes what we did and what we achieved as a consequence. All of these priorities continue to be relevant and will be further developed during this current year.

We had key priorities each for patient safety, patient experience and clinical outcome. Our remaining priorities are detailed in the annual plan.

Priority 1: Clinical Outcomes

Key Clinical Outcome Priority 1

- **Improve the management of patients with acute kidney injury (AKI)**

Why was this a priority?

AKI is a sudden reduction in kidney function. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. It is a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. This was a key priority for the Trust last year and we focused on implementing a Trust wide electronic system to improve detection, developed an AKI management care bundle and further improved AKI diagnosis and treatment.

What did we do?

- We provided training and education for junior doctors in the management of patients with AKI.
- We have continued to emphasise the importance of timely recognition of a patient with AKI, and have set the standard of four hours from arrival to recognition.
- We have continued to use an alerting system set up in our results reporting system to notify clinicians that a patient has renal impairment. We explored updating this system in line with the upgrade of the Laboratory Information Management System planned for 2017/18.
- We have continued to utilise a care bundle approach to provide junior doctors with guidance as to what action to take following identification a patient has AKI. As part of that innovation we have implemented a 'Door to Treatment time' of six hours. We have reviewed our bundle in line with the Patient Safety Alert and made modifications to ensure the Trust is compliant with the Alert.
- We provide GPs with information about their patients presenting with AKI, and suggest a plan of care to optimise and monitor patient's renal recovery post discharge.
- We have revised the standard fluid chart, and devised a 'Red, Amber, Green' (RAG) rated Early Warning System for monitoring patients intake and output, which will provide guidance for when to escalate for medical intervention.

How did we perform?

- We continued to actively support early recognition and optimal management of all patients presenting with AKI and acquiring AKI as part of their in-patient disease process. The average compliance with 'Door to Recognition Time' has been 87% over the last year. The average compliance with 'Door to Treatment Time within 6 Hours' was 92%.
- We provided GPs with a plan of care to monitor and optimise renal recovery for those patients with Stage 2 & 3 AKI – which are the most serious forms of renal impairment. Compliance with providing GPs with a plan of care at discharge has been 70% over the past year.
- The new fluid charts innovations are in the pilot stage.

Key Clinical Outcome Priority 2

- **Improve the management of patients with severe sepsis**

Why was this a priority?

Sepsis is a common and potentially life threatening condition where the body's immune system goes into overdrive in response to infection. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis. Early detection and effective management of patients presenting with sepsis will reduce morbidity and mortality.

Improving the management of patients with severe sepsis, septic shock and red flag sepsis has been a CQUIN 2016-17, both for in-patients and for patients presenting to the Emergency Department with sepsis.

What did we do?

The Trust has utilised NICE guidance published in July 2016 and revised screening tools and recommendations for optimal management of patients presenting with Sepsis in the Emergency Department and developing Sepsis as part of their in-patient disease process.

The screening tools and updated management recommendations have been implemented both in the Emergency Department and throughout all in patient areas of the Trust.

Sepsis Champions have been nominated in all clinical areas to lead the Sepsis Improvement work in the Divisions and individual Directorates. Clinical Champions are supporting the audit of compliance with timely Screening, Antibiotic administration, and antibiotic reviews after three days.

How did we perform?

- Compliance with appropriate sepsis screening (audit) for emergencies and ward –based patients, and 3 day antibiotic reviews has been above 90% in all clinical areas.
- Timely compliance with antibiotic delivery for patients presenting with severe sepsis and septic shock (audit) for emergencies and ward –based patients, is showing compliance with the CQUIN targets to date.

Key Clinical Outcome Priority 3

- **Improve our approach to mortality surveillance, identifying and reducing avoidable deaths**

Why was this a priority?

The Trust's 12 month rolling HSMR remains statistically high, but the monthly trend has seen five consecutive months of improvement within expected ranges. It is likely that the 12 month HSMR will remain elevated until the particularly high values seen in January, April and May 2015 fall out of the indicator. This monitoring and reduction of our HSMR remains a critical priority in the year ahead.

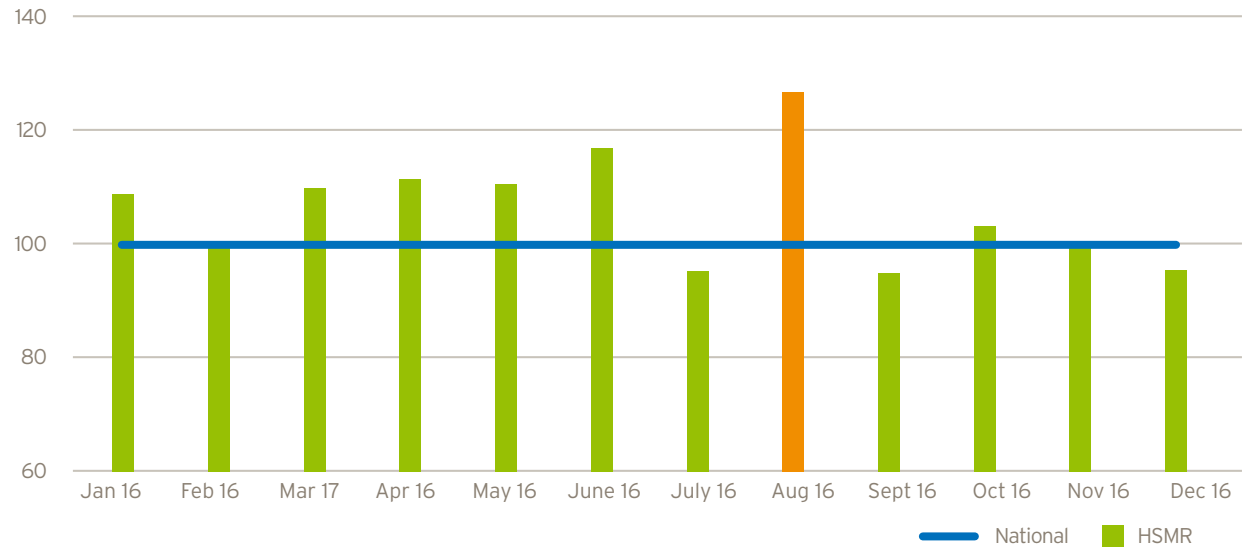
What did we do?

The Mortality Board commissioned an independent review into the Trusts HSMR performance in 2016. The review was undertaken by Dr Bill Kirkup CBE (Chairman of the Morecambe Bay Investigation in July 2013) and the terms of reference included how the Trust has responded to the deterioration as well as the possible reasons for the same. The report was supportive of the work that Trust had undertaken to date and made further recommendation for the ongoing programme of work .This included; a review of all deaths using a standardised Mortality tool; improving the access to specialist palliative care; establishing Mortality and Morbidity meetings in all of the Divisions and changes to coding. The Mortality Board monitors the progress against the review action plan and ensures learning is shared across the Trust.

How did we perform?

The Trust has seen an improvement in the HSMR for the 12 months ending December 2016. The value is no longer statistically significantly high for the last four months of the year. The Trust has introduced daily screening of all deaths using a standardised format and any deaths that trigger a request for a more detailed review are forwarded to the appropriate consultant and the outcome is reported through local Governance meetings and the Trust's Mortality Board.

Hospital standardised mortality ratio (HSMR) - monthly



Key Clinical Outcome Priority 4

- **Reduce our antibiotic consumption**

Why was this a priority?

Anti-Microbial Resistance (AMR) has risen over the last 40 years with inappropriate and overuse of antimicrobials being a key driver. The number of new classes of antimicrobials coming into the market has reduced in recent years, whilst at the same time total antibiotic prescribing has increased by 6%. Widespread antimicrobial resistance increases the prospect of fewer effective treatment options for infections where antimicrobials can be life-saving and significant increased risk attached to standard surgical procedures.

What did we do?

There are two parts to the quality priority CQUIN for 2016/17:

a). To achieve a reduction in both the total amount of antibiotic consumption and in 2 categories of broad spectrum antibiotic consumption compared to 2013/14.

In order to achieve the targets several different workstreams were initiated with the intention of ensuring improvements were initiated and embedded into ongoing antimicrobial stewardship practice.

Workstreams included:

- Monthly analysis of antimicrobial usage such as piperacillin/tazobactam, meropenem, co-amoxiclav, ciprofloxacin and cefuroxime for directorates (General Medicine, General Surgery, A&E and DME), identification of areas with variation against guidelines in antimicrobial prescribing and tracking the link between use of these antibiotics and incidence of C.difficile infection.
- Feedback of analysis to Clinical Governance meetings with recruitment of junior doctors to carry out further audits on antibiotic usage. (Management of Urinary Tract infections).

b). To drive forward improvements in the number of antibiotic prescriptions reviewed within 72 hours with the aim of achieving more than 90% prescription review.

Although the standard has been set at this level, we are committed to a programme of continual improvement of care. An action plan has been developed which includes a range of improvements.

The action plan includes:

- An extensive drive to educate the doctors, nurses and pharmacy staff, the importance of documenting the indication and reviewing antibiotics and using narrow spectrum antibiotics by following the Start Smart then Focus (SSTF) initiative. (Presentations, posters, a stand during the World Antibiotic Week, patient safety newsletters and encouraging doctors to carry out audits).
- Pharmacy staff attending the white board rounds (which was implemented on the 19th September 2016) where patients' antibiotics are reviewed on a regular basis by pharmacists chasing up course lengths and changing to oral. Pharmacists document the indication and doctors are also encouraged to document review and changes when appropriate. The impact of this initiative is being measured.

Success Criteria

- Although the Trust seems to be on target for Total Antimicrobial consumption and Piperacillin/ Tazobactam, the data for Quarter 4 which covers the second part of the winter pressures is yet to be submitted for analysis.
- The target for the carbapenems was not achievable as usage in the year 2013/14 was very low.
- The Trust has consistently achieved over and above the standards for all 4 Quarters (91%, 95%, 97% and 98.3%).

Priority 2: Patient Safety

Key Patient Safety Priority 1

- **Ongoing development of the Safety Thermometer, improving performance year on year**

Why was this a priority?

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism during their working day.

This is a point of care survey that is carried out on 100% of patients on one day each month across the whole of the NHS. One of its most unique aspects is the concept of a 'harm free care' measure, the proportion of patients who are free from any of the harms measured. Using a composite measure such as this provides us with a more positive view of the care we deliver, and ensures that we move away from thinking about harms in a siloed way (www.safetythermometer.nhs.uk).

Safety Thermometer prevalence data supplements our more detailed incidence data and other intelligence about harms, to direct quality improvement initiatives and monitor the effectiveness of actions put in place.

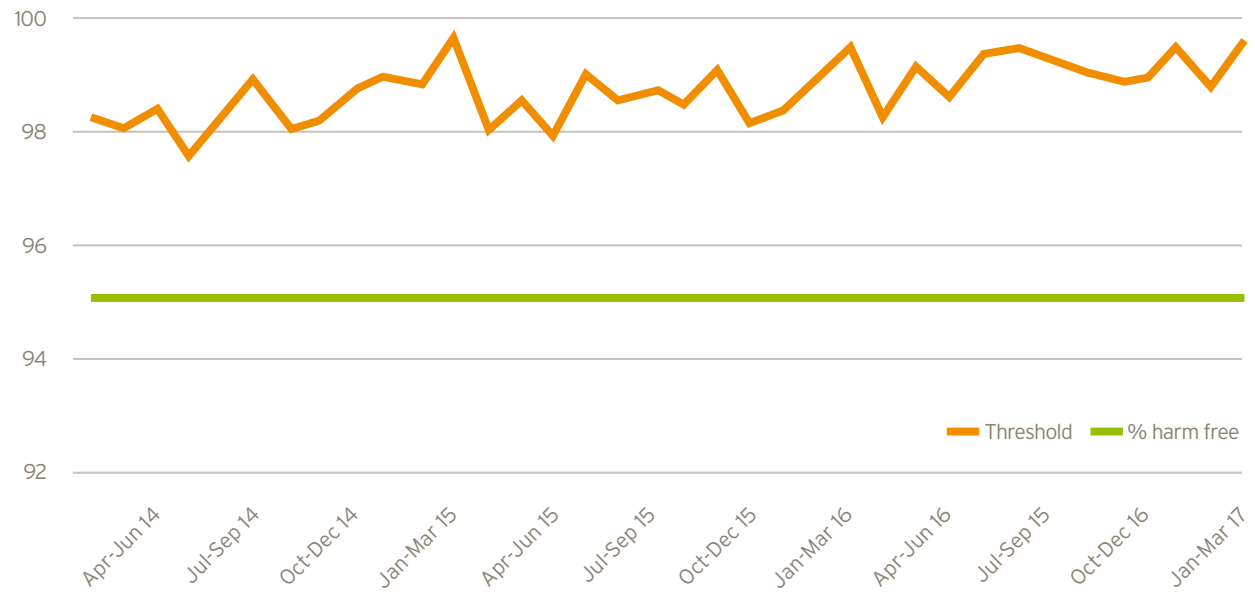
What did we do?

During 2016/17 we continued to participate in the NHS Safety Thermometer, measuring the prevalence of any new harms incurred during a person's inpatient stay. Ward staff were supported to review their results each month and discuss their findings at the Quality Performance Review meetings with the Director of Nursing. The data from Safety Thermometer is considered alongside Trust incidence data and the learning that resulted from investigations into patient safety incidents. Episodes of patient harm were analysed using root cause analysis with the support of the appropriate specialist nurses. The detailed analysis supports the identification of learning and enables teams to implement actions to prevent recurrence. Learning is shared through the Ward Sisters forums and through the patient safety newsletter.

How did we perform?

During 2016/17 we successfully achieved harm free care of over 98% of our patients, and for six months of the year, we achieved more than 99% harm free care. In January, the harm free care score peaked at 99.54%, which was a real credit to the endeavours of all our staff who kept patients safe at a time when the Trust was extremely busy.

% Harm free care



Pressure Ulcers - The Trust has made exceptional progress in the reduction of hospital acquired, avoidable pressure ulcers over the past year. During 2016/17, there were a total of two Grade 3 pressure ulcers compared with 11 in the previous year – a reduction of 82%. For grade 2 pressure ulcers, 26 were acquired this year compared with 96 in the previous year – a reduction of 73%.

We understand these great successes to be attributable to a number of initiatives:

- A sustained, robust training programme for all nursing staff which has undoubtedly raised the profile and importance of having a relentless focus on skin inspections and skin care for our patients.
- A tissue viability risk assessment and care plan has been incorporated into the newly updated nursing documentation booklet which helps to streamline the process.
- An *Incontinence Associated Dermatitis Pathway* has been introduced, along with the introduction of two new barrier products.
- A *Heel Protection Pathway* has been introduced, along with the switch to new improved heel protectors.
- Nasal cannulae for the delivery of oxygen therapy have been switched for a product which includes ear protection. This has led to a reduction in pressure damage to patients' ears which was a particular problem for patients on long term oxygen therapy.
- The Tissue Viability Team continues to have a very high profile in the clinical areas and this enables swift intervention when any issues or learning are identified.

Falls - During 2016/17 the safety thermometer audits identified 11 patient falls over the year where harm was sustained. The harm ranged between low harm (nine patients) and severe harm (two patients). This is an

improvement on 2015/16 where we reported 21 falls with harm on the safety thermometer.

The Falls Nurse, in partnership with the senior leadership team and Matrons, keeps falls incidence constantly under review. During the year, it has been noted that the number of patients suffering harm from a fall has reduced. One Serious Incident was raised following a fall resulting in a fractured hip and robust root cause analysis undertaken. The majority of falls result in no harm or low harm to patients.

During the year the trust implemented new nursing documentation which now incorporates the multifactorial falls risk assessment recommended by NICE and the Royal College of Physicians. The Trust is piloting a new approach to enhanced observations for patients who are at higher risk of harm.

Catheter Related Urinary Tract Infections (CAUTI) – the aim for this year was to ensure that no more than 16% of inpatients had a catheter in situ. Whilst this aim was not achieved, there was a small reduction with an average of 17.75% per month. Usage is largely determined by the acuity of patients at the time of the prevalence study. The Continence Nurse Specialist (CNS) has continued to work closely with ward teams to ensure that a robust process is in place to evaluate every catheter on a daily basis. The Continence CNS has established a closer working relationship with the infection control team and now has direct use of the ICNET system (an infection control IT system) to enable better identification of CAUTI'S , so that training can be targeted to areas where problems are being identified. During 9 months of the past year, there were no CAUTIs reported, with an average of prevalence of 0.5% for the remaining months.

Venous Thromboembolism (VTE) – VTE is an important patient safety issue nationally. Hospital Associated Thrombosis can result in significant mortality, morbidity and healthcare costs. The two primary aims of the Trust are to ensure that patients are appropriately assessed for their risk of developing a thrombosis, and ensuring that appropriate prophylaxis is prescribed and administered reliably. We monitor our achievement of appropriate assessment and during 2016/17, we screened more than 95% of patients (the national aim is 95%) in all but one month (93.5% in May). For every patient who is identified as having thrombosis, a review is undertaken to assess whether the thrombosis is Hospital Associated and if so, whether it was preventable. The learning from robust Root Cause Analysis investigations is shared and used to inform our quality improvement work. Two key themes to have emerged recently relate to the development of thrombosis in patients with lower limb injuries who are not admitted to hospital; and those patients who develop thrombosis despite receiving prophylaxis who have a raised Body Mass Index. The Trust follows national evidence based guidance; however, for these two groups of patients, this is not reliably preventing thrombosis.

Key Patient Safety Priority 2

- **Improve the management of the deteriorating patient**

Why was this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians' may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2015 -16 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration.

What did we do?

We continued to conduct reviews into all cardiac arrests to identify any learning points
As part of the review process we have monitored:

- Compliance with observations protocols for deteriorating patient
- Compliance with the correct process for escalating concerns
- Whether Medical response was timely
- Critically analysing the decisions made by medical staff prior to the arrest to identify whether management was optimal to prevent further deterioration. In addition we have monitored the setting of appropriate ceilings of care, and the use of Personal Resuscitation Plans and where appropriate and Do Not Attempt Resuscitation (DNAR) orders.

As a result of the reviews a number of cases have required serious incident case reviews or directorate level investigations, and action plans put in place to minimise re-occurrence of any issues identified. Where it has been deemed following review of the case that there is local learning only, then clinical areas have been requested to devise a local action plan to address any issues.

To achieve improvements in the use of appropriate setting of Personal Resuscitation plans and DNAR orders,

the University of London Partnership (UCLP) have supported the Trust in providing training and education to medical staff. This training has included guidance in having difficult conversations, and the legal and ethical position regarding DNAR Care Plans. Case scenarios have been used to illustrate key learning points.

How did we perform?

We have continued to maintain our average cardiac arrest rate below the National Average rate. We have continued to conduct reviews into all cardiac arrest to identify any learning points.

Key Patient Safety Priority 3

- **Further development of stroke services**

Why was this a priority?

Central to the Trust strategy to become a 'Hyper-Acute Emergency' hospital, is to deliver optimum stroke care through further investment in our 'Hyper-Acute' stroke Unit. Following an increase in therapies staffing and an additional two Stroke Physicians, 2016 focussed on the recruitment of additional speech and language staff and a senior Clinical Nurse Specialist to improve nurse leadership and ensure all performance targets are met. Data capture for the Sentinel Stroke National Audit Programme (SSNAP) improved to ensure that all activity and key clinical interventions are accurately recorded. More ambitiously, the senior nursing team in conjunction with the new specialist nurse designed a revised educational programme to train nurses in key competencies. Multi-agency working will focus on further developing our repatriation policy to improve direct access to the unit.

What did we do?

Service Development
Stroke Action Group, Stroke Development Meeting, SSNAP proforma, SSNAP root cause analysis, engagement with ED, education, therapy groups, stroke study days, clinical research trials, and changes to policy and pathways.

Reporting
Monthly SSNAP illustrations, national audits, dash boards, clinical governance, stroke specific mortality review, datix reviews, complaint analysis, and strong communciation between clinicians and management

Lead Stroke Nurse

Stroke Therapy Service Manager

Speech and Language Therapists

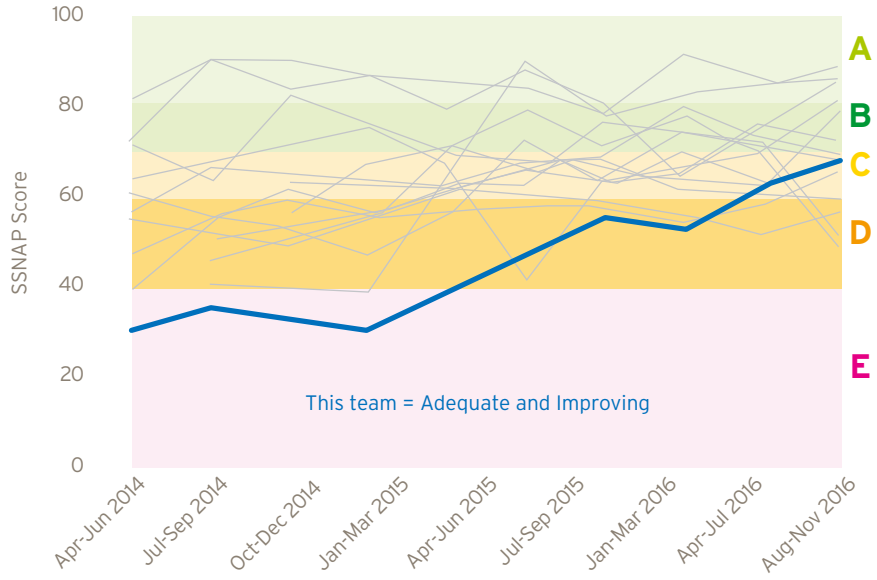
New Consultant Posts

How did we perform?

The unit's overall SSNAP score has improved from a performance score of an E to a C. Table one demonstrates how there has been a trajectory of improvement throughout the year. Moving from an E to a C means that the Trust has improving evidence of stroke services. However, having a score of A will mean that the Trust is able to demonstrate that it has all the evidence in place.

Table 1

Overall SSNAP score performance from April 2014 to November 2016



Performace recently has been generally

Adequate

This hospital performace over the two and a half years has been generally

Improving

Table 2

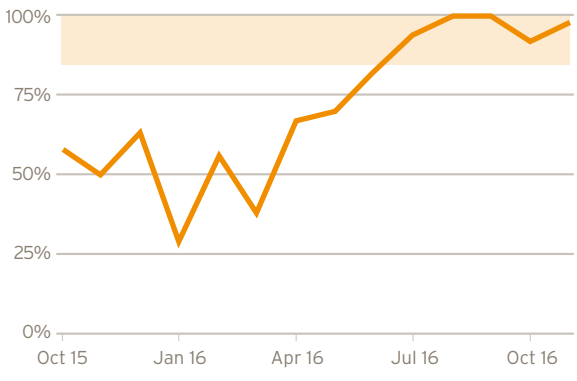
Luton and Dunstable Hos ital - SSNAP Executive Summary			
Activity and length of stay			
In August-November 2016 this hospital treated 260 patients, of which:			
256 patients were first admitted to this hospital		4 patients v1ere transferred in from another hospital	
leneth of stay:	For all routinely admittine teams nationally N=27,507	For all patients treated at this team N=260	For patients discharged/transferred alive from this team N=233
0-3 days	40.3% (11,087 patients)	42.7% (111)	41.6% (97)
4-7 days	20.3% (5,580 patients)	17.3% (45)	18.0% (42)
8-21 days	21.4% (5,886 patients)	26.2% (68)	27.5% (64)
22-30 days	5.3% (1,446 patients}	4.2% (11)	4.3% (10)
31+days	12.8% (3,508 patients)	9.6% (25)	8.6% (20)
Mean	14.0 days	11.0 days	10.8 days

Table two demonstrates how we now discharge more patients within the first 3 days after stroke and significantly fewer patients stay for 30+ days compared with stroke units nationally. Our length of stay is also three days shorter than the national stroke unit average.

As a result of investment in staff and targeted service development, there have been significant improvements in the quality of care offered to stroke survivors. This includes our stroke specialist nurse having been appointed, resulting in substantial improvements in assessments being completed in a timely manner (figure 1) and patients receiving stroke specialist nursing care (figure 2).

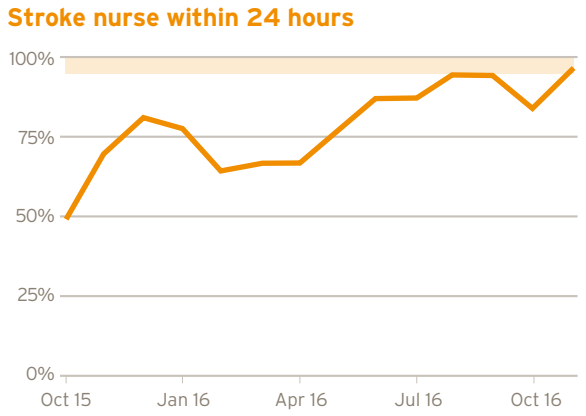
Figure 1

Swallow screen within 4 hours



Source SSNAP Aug-Nov 2016
Team centred results at team level for Key Indicator 4.5B (Team 185)

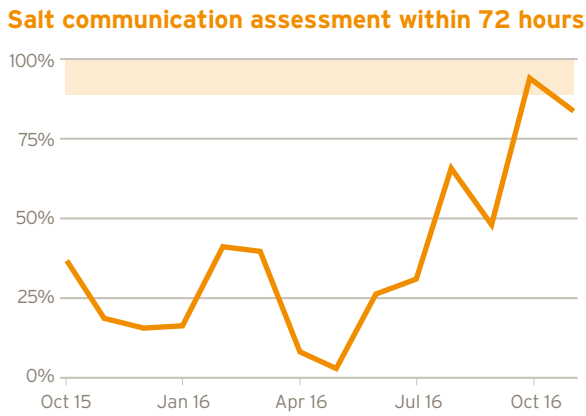
Figure 2



Source SSNAP Aug-Nov 2016
Team centred results at team level for Key Indicator 4.3B (Team 185)

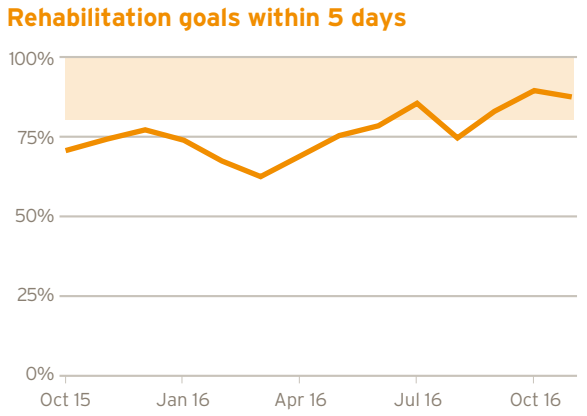
There has also been a stroke therapy service manager appointed who has been responsible for improving: Physiotherapy; Occupational Therapy; Speech and Language Therapy; and Dietetics. Physiotherapy and Occupational Therapy for the unit continues to be rated as Excellent (OT) and Good (PT). Locum SLT staff have been used during the recruitment process of appointing two specialist speech and language therapists. Although results have not translated into SSNAP publication, due to the lag in data, figure three demonstrates the early improvements SLT are now offering to the patients. Therapists are also working together to improve the patient experience and discharge pathways with figure four

Figure 3



Source SSNAP Aug-Nov 2016
Team centred results at team level for Key Indicator 8.5B (Team 185)

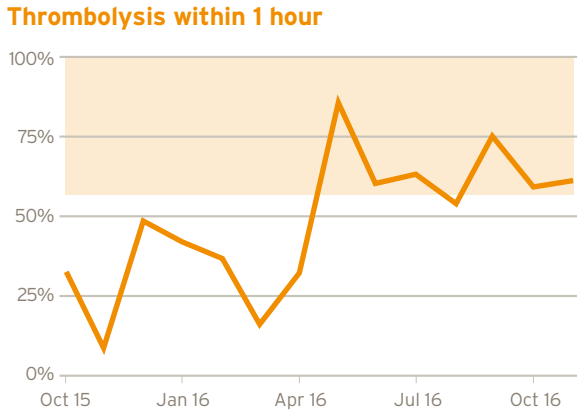
Figure 4



Source SSNAP Aug-Nov 2016
Team centred results at team level for Key Indicator 8.7A (Team 185)

Finally, the appointment of the additional consultant posts and respective projects, has resulted in improvements both in scan times and the percentage of patients having thrombolysis treatment within the one hour target (figure five).

Figure 5



Source SSNAP Aug-Nov 2016
Team centred results at team level for Key Indicator 3.3B (Team 185)

In summary, the appointment of new staff in conjunction with a drive in service development projects, and work across the stroke MDT has resulted in significant improvements. However, we accept there is more work to be done. We continue to work on specific challenges such as stroke specialist nursing recruitment, pathways and priorities to ensure our patients arrive on the unit and stay there, and to further improve the overall unit from a C to a B or an A. This year has been a success for stroke at the Luton & Dunstable Hospital and trajectories suggest further improvements are possible.

Central to the Trust's strategy of delivering hyper acute stroke services across Bedfordshire, during 2016/17 the Trust is now providing a consultant service to the acute stroke beds at Bedford Hospital.

Priority 3: Patient Experience

Key Patient Experience Priority 1

Why was this a priority?

Improving End of Life Care (EOLC) is a priority if we are to ensure the best possible quality of care for our patients and their families. The Trust's strategy for improving the care our patients receive at the end of life is based on two key documents; NHS England's 'Actions for End of Life Care 2014-16' which sets out NHS England's commitments for adults and children emphasising that not only living well but also dying well is a key quality priority. The narrative for 'person-centred coordinated care' (Every Moment Counts) produced for NHS England by National Voices in 2014, in conjunction with its partners, sets out critical outcomes and success factors in end of life care, support and treatment, from the perspective of the people who need that care, and their carers, families and those close to them.

What did we do?

End of life care continues to be a key priority for the Trust. The most sensitive and difficult decision making that our clinicians have to make continues to be around recognition of the dying phase. However it is recognised that such decision making remains a challenge. Engaging patients and their families where possible, putting them at the centre of their care remains a key priority. The following actions were undertaken:

1. Improved communication
The programme has been on improving communication across Luton with all stakeholders involved in the management of End of Life Care. The focus is on referring all patients in the last 18 months of life to MCCT (My Care Communication Team)/PEPS, a central point that coordinates care and provides a 24 hour helpline. Working towards a truly collaboration approach by sharing information to ensure care is timely, ensuring patients achieve their preferred place of death by enabling Trust staff access to advanced care plans.

2. Implemented the Amber Care Bundle
The Amber Care Bundle provides a systematic approach to managing the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in 1-2 months. This contributes towards patients being treated with greater dignity and respect, enabling patients to achieve their preferences and also having a positive impact on multi-professional team communication and working.

3. Complete a training programme
The team have continued to develop strategies to enhance Palliative Care/EOLC training across the Trust to ensure the best care and experience is delivered. These have included the introduction of ward champions, and the development of a package of training as part of the EOL CQUIN. To enable staff access a course entitled, "An introduction to Palliative Care" has been introduced, this will be delivered monthly. Courses in communication and Advanced Care Planning are also being introduced this year. In addition to this the palliative team are providing regular input with:

- Medical Colleagues via Grand Round, Department and Clinical meetings
- Ad Hoc sessions in Statutory Training as requested
- Regular sessions with medical students
- "Last 48 Hours" with Nursing Preceptors.
- EOLC with new overseas nurses
- 1-1 sessions on wards
- Ward Team meetings
- Department meetings with AHPs
- 1-1 sessions with ward champions
- Nursing and medical students 'shadowing' members of the team
- Educating and training ward staff who are managing palliative care patients.
- Providing written materials in the palliative resource folders on each ward
- E-Learning opportunities available to all on the Intranet
- A competency course has been designed by the End of Life Care Nurse aimed particularly at Ward Champions but appropriate for any professional wanting to enhance their EOLC competencies
- Volunteers Companionship – This has been introduced offering support for patients and families.

How did we perform?

- EOLC received a rating of 'Good' from the CQC inspection team. This demonstrates the considerable improvements that have been made across the Trust since the last inspection and the commitment from all staff to implement the improvement plan that is monitored through the Trust EOLC Strategy group.
- Completed a comprehensive training programme to ensure staff have received training informing them of the benefits of referring to MCCT/PEPS, the target for eligible staff to be trained has been met.
- Met the target set to increase referrals to increase referrals to MCCT/PEPS.
- Implemented Amber Care Bundle on wards 14, 15, 16, 17, 18 and wards 10-12 are planned for Spring 2017.
- Discussions are underway to provide Trust staff access

to System One, the community patient electronic record which enables key people to access important advanced care plans and preferred place of death information.

Key Patient Experience Priority 2

- **Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium**

Why was this a priority?

Patients with Dementia and Delirium can have complex care needs. This care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge. The care provided has a direct impact on the experience for patients and carers.

What did we do?

- Continued to screen inpatients over 75yrs on admission to hospital. This enabled further cognitive screening and investigations to be carried out or recommended to GP's.
- Continued to utilise the butterfly symbol as an identifier, which alerts staff to special needs. Now using labels in the Emergency Department and Outpatients Department to identify additional needs.
- Utilised the Psychiatric Liaison Service (PLS) for inpatient assessment and reviews where appropriate to identify Delirium and cognitive impairment.
- Introduced a cognitive assessment in medical proforma to enable recognition of Delirium and appropriate management and prevention.
- Continued with in house Dementia training programme aligned with national framework for skills and knowledge for our staff.
- Took part in the national audit of Dementia with the Royal College of Psychiatrists Reports to be published in 2017.
- Purchased distraction trolleys for all ward areas to standardise distraction equipment for patients and facilitate social interaction.
- Initiated signage improvements.
- Carers pack now provided to carers of people with Dementia offering contact support and sign posting.
- Continued to seek and review feedback from service users (patients & Carers) to improve service delivery.
- Utilised complaints to provide a framework of improvements to services across the site.
- Introduced a vulnerable adult nurse to work alongside safeguarding and dementia thus providing some resilience to the Dementia service for carers and staff on the wards.
- Developed a nursing discharge summary letter to standardise discharge information to care homes for the person with Dementia aligned with NICE QS 136.

How did we perform?

- Following complaint and patient experience feedback we have initiated a surgical pathway review for patients with dementia.
- Newly diagnosed in-patients are referred by PLS to Dementia CNS- improved networking and collaborative working.
- Monthly monitoring contract figures for screening and referral continue to be achieved.
- Used feedback from a carer to develop a training video of carer/patient experience.
- Trained two further Dementia Champions to facilitate 'Dementia Friends' sessions across the Trust.

Patient Experience Priority 3

- **Key Completing the Roll Out of Partial Booking across the Trust**

Why was this a priority?

Outpatients successfully piloted partial booking in several specialties in Medicine and Surgery over the course of 2015/16. The initiative demonstrated benefit for clinicians, business managers and most importantly for our patients. The new appointment system facilitated substantial benefits in terms of improved waiting list management and service capacity planning, reducing the multiple rescheduling of patient appointments and helping to reduce DNA rates in these specific specialty areas. Having more responsive booking processes ensured that the patient experience was improved by having less cancellations and more streamlined access to appointments.

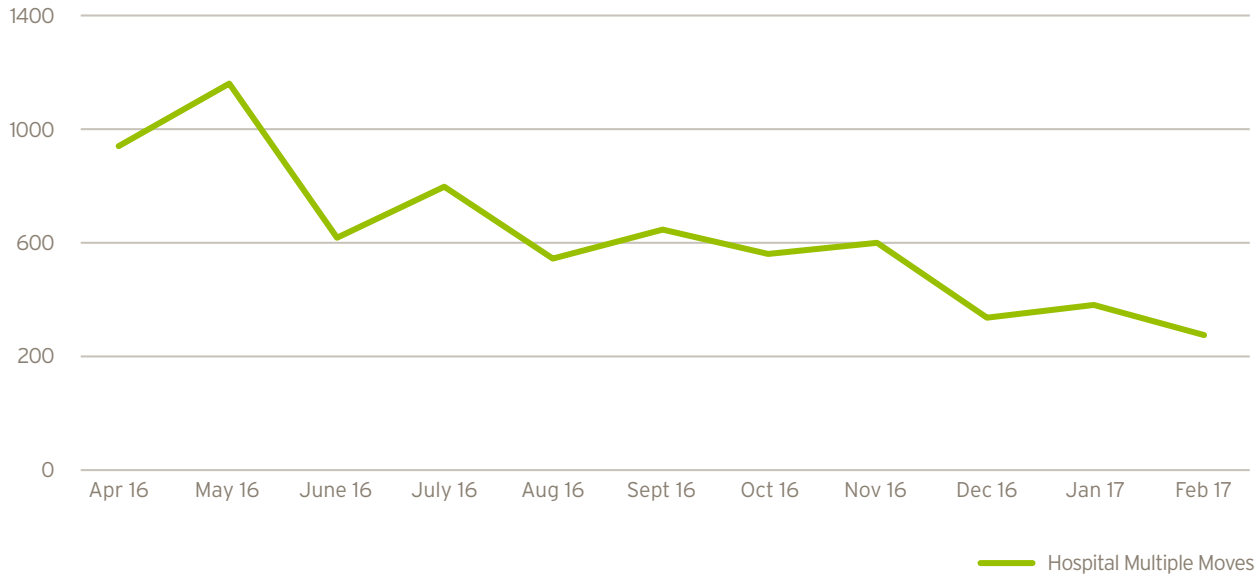
What did we do?

The roll out of partial booking has continued in 2016/17, with a significant number of additional specialties, representing 87.5% of the whole Trust, which are now live and benefiting from improved waiting list management. Each area is managed by a specialty specific pathway co-ordinator working with the relevant service leads. Those specialities most recently added include diabetes and endocrinology, care of the elderly, cardiology, paediatrics, stroke services and oral maxillo-facial services. It is anticipated that the roll out plan will be concluded by the end of May 2017, with four more specialties planned to go live.

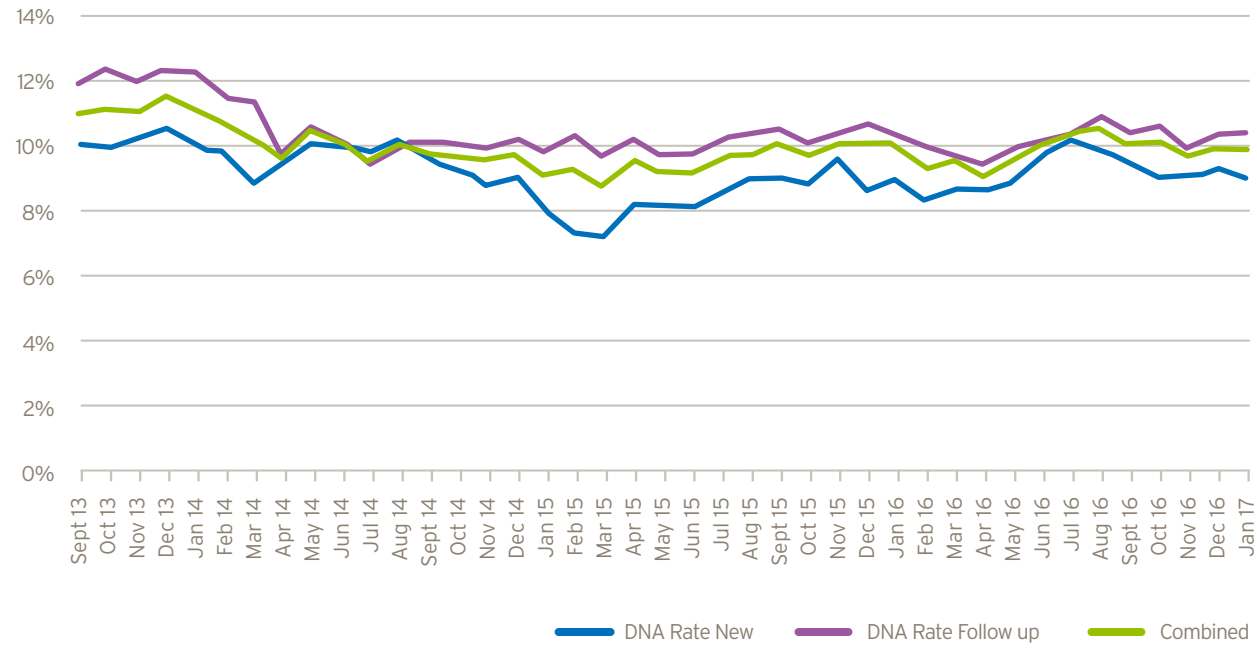
How did we perform?

There has been a significant reduction in hospital initiated multiple rescheduled appointments, as patients in partial booking specialties are no longer future dated beyond six weeks, improving patient experience.

Hospital initiated multiple moves



DNA rates



3. Priorities for Improvement in 2017/18

Improving clinical outcomes, safety and experience for our patients while delivering value for money is key to the Trust's overarching quality strategy. To meet the short term challenges that we face, we have developed a number of ambitious Trust-wide quality priorities. These are based on local as well as national priorities including the need to ensure ongoing CQC compliance and to implement the recommendations from our own internal review of the Francis, Berwick and Keogh reports.

We have key priorities each for clinical outcome, patient safety and patient experience

Priority 1: Clinical Outcome

Key Clinical Outcome Priority 1

- **Improve our approach to mortality surveillance, identifying and reducing avoidable deaths**

Why is this a priority?

The Trust had an extensive focus on hospital mortality during 2016/17 which was reflected in a comprehensive programme of work. A report was commissioned for an independent review into the Trusts HSMR performance in February 2016 by Dr Bill Kirkup CBE. The report was supportive of the work undertaken to date and made further recommendation which was added to the programme.

Overall the program included, the review of all deaths using a standardised Mortality tool; improving the access to specialist palliative care; establishing Mortality and Morbidity meetings in all of the Divisions and changes to coding. The Mortality Board monitors the progress of the programme and ensures learning is shared across the Trust.

During the latter part of 2016/17, the HSMR has reduced to below the national average demonstrating that the actions that we have been taking are making and impact. However, the number of crude deaths in the first two months of 2017 has been higher than expected and could see the HSMR rise again. This monitoring and reduction of our HSMR remains a critical priority in the year ahead.

What will we do?

The Trust Mortality Board will oversee the delivery of:

- A Mortality Policy that sets out the Trust's approach to mortality review, the monitoring of progress and the way learning is shared.
- Using external benchmarks, the Trust will complete on-going reviews for trends and correlations with other Trust clinical information.
- Reviewing all deaths in line with National Guidelines.
- Improvement in our benchmarked mortality to the upper quartile of performance.

Work with the Clinical Commissioning Groups and Local Authorities to improve the acute support available to end of life patients resident in care homes to avoid unnecessary admissions to hospital within the last few days of life.

Delivering a model of clinical care that has continuity of care towards needs based care is key principle that may impact on mortality and length of stay. This is a quality priority for 2017/18 and is (see Patient Safety Priority 2)

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Improving HSMR performance
- Reduction in the number of patients from care homes who die within 72hrs of admission.
- Roll out of Needs Based Care within Medicine and DME (see Patient Safety Priority 2)

Key Clinical Outcome Priority 2

- **Reduce the impact of serious infections (Antimicrobial Resistance and Sepsis)**

Why is this a priority?

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these, it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. This quality improvement initiative (which is also a National CQUIN scheme), is aimed at embedding NICE guidance to improve sepsis management. Furthermore, the approach taken to combine a responsive approach to the detection and treatment of sepsis needs to be balanced with a rigorous approach to the stewardship of antibiotics. Antimicrobial resistance has increased in recent years and the Chief Medical Officer believes that it is a major risk for healthcare. Without a reversal of the trend, we may find we have no drugs to treat serious infections in the future. The approach to these two key areas for improvement is taken from the viewpoint that the issues of sepsis and antimicrobial resistance are

complementary and that developing and implementing a joint improvement scheme (CQUIN) will support a coherent approach towards reducing the impact of serious infections.

What will we do?

The Trust will build on the work undertaken in 2015/16 with a particular focus on:

- Continuing to deliver and improve upon the timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Continuing to deliver and improve upon the timely treatment of sepsis in emergency departments and acute inpatient settings
- To continue to deliver upon the 24-72 hour review of antibiotics for patients with sepsis who are still inpatients at 72 hours and to continue to improve upon the quality of those reviews
- Ensure that Trust guidelines and protocols continue to meet best practice standards
- To reduce total antibiotic consumption per 1,000 admissions in three domains:
  - Total antibiotics
  - Carbapenems
  - Piperacillin-tazobactam

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- To consistently screen 90% or more of the relevant patients for sepsis.
- To deliver antibiotics within one hour of identification of sepsis to at least 90% of those patients.
- To undertake an empiric antibiotic review between 24-72 hours in at least 90% of patients with sepsis.
- To reduce antibiotic consumption by at least 1% for total, carbapenems and pipericillin-tazobactam during the year compared to 2016 consumption data.

Key Clinical Outcome Priority 3

- **To improve services for people with mental health needs who present to Accident and Emergency**

Why is this a priority?

People with mental health problems are three times more likely to present to AA&E than the general population. Nationally, more than 1 million presentations are currently recorded as being directly related to mental ill health. Furthermore, evidence has shown that people with mental ill health have 3.6 times more potentially preventable emergency admissions than those without mental ill health and that the high levels of emergency care use by people with mental ill health indicate that there are opportunities for planned care to do more. A large majority of the people with most complex needs who attend AUE the most frequently are likely to have significant health needs including physical and mental comorbidities and may benefit from assessment and review of care plans with specialist mental health staff and further interventions from a range of health and social services. This is a National priority and a CQUIN has been developed to support cross-provider working to deliver improvements in care to this group of patients by providing enhanced packages of care from the most appropriate services.

What will we do?

- The Trust will work in partnership with East London Foundation Trust, the provider of our mental health services and a range of other partners including ambulance service, primary care, police, substance misuse services, 111
- A group of patients who attend A&E most frequently will be reviewed in order to identify those who would benefit from assessment, review and care planning with specialist mental health staff
- Appropriate models of service delivery will be considered and adopted in order to provide specialist input for people who frequently attend A&E with primary mental health problems
- To co-produce, with the patients, a care plan and ensure that these are shared, with the patient's permission, with partner care providers across the system
- Review and refine the IT systems to ensure that information about the conditions of our patients is more accurately collected in order to help target improvements to the most appropriate patients
- Develop a method to assess patient satisfaction and experience of the new services

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- To reduce the number of attendances for the group of frequently attending patients by 20% over the next year, amongst the patients who would benefit from mental health and psychosocial interventions
- To have collected patient experience feedback in order to further develop the service

Key Clinical Outcome Priority 4

- **To provide services to patients experiencing frailty in line with best practice**

Why is this a priority?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this quality improvement initiative is to implement best practice guidance to enable us to take action to prevent these adverse outcomes and help people live as well as possible with frailty. Appropriate services, delivered effectively to this group of patients will support a reduction in length of stay, reduced morbidity and mortality and a better experience for patients and their carers. Furthermore, the initiative will support the delivery of the Trust priority to deliver Continuity of Care and improve the flow of patients admitted as emergencies to the hospital.

What will we do?

- To establish models of care and service delivery in line with standards set by the British Geriatric Society "Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings"
- Identify and develop/provide the resources required to deliver a high quality service
- Establish referral criteria and care pathways
- Ensure that there is rapid access to appropriately trained and skilled staff to undertake a comprehensive, early assessment and care planning in order to deliver early intervention by the multidisciplinary team
- Ensure that clinical navigation is embedded within the service delivery plan

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- That a frailty service is operational and receiving appropriate referrals
- That patients and their carers are satisfied with the service and that feedback is used to help further improve and develop the service
- A reduction in the number of frail patients being admitted to hospital via A&E or EAU
- A reduction in the length of stay for patients with frailty
- An increase in the proportion of patients with frailty who, following comprehensive assessment and care planning, are able to be discharged to their usual place of residence
- A decrease in the proportion of patients with frailty who are admitted to hospital for an overnight stay

Priority 2: Patient Safety

Key Patient Safety Priority 1

- **Improving Continuity of Care and delivering Needs Based Care model**

Why is this a priority?

The delivery of 7 day consultant led services and early senior review and decision making for patients admitted to hospital as an emergency has been a significant area of quality improvement for the Trust, with significant increases in consultant presence out of hours and at the 'front-door' of the hospital over the last few years. However, as our model for emergency care has gradually evolved, an unintended consequence has been an increase to the number of consultants that have sequential input into a patient's care. It is not unusual for a patient admitted to a medical specialty as an emergency to receive care from a number of different consultants during their hospital stay. This can lead to confusion for the patient and their family as to what is happening, difficulties in co-ordinating the plan where the owning consultant is not following it through, and does not make it easy for senior medical staff to closely monitor a patient's progress and assess the effectiveness of treatment. By improving the continuity of consultant care for an individual patient, we will improve patient experience, reduce length of stay and minimise the

clinical risk of patient management plans being handed over between senior clinical staff multiple times.

Within the range of emergency admissions to hospital, there will be some patients who will benefit from being cared for by physicians with a particular specialist interest, such as stroke, cardiology or respiratory. There are other patients who may be admitted with a straightforward medical issue, such as an infection or after a fall, but have very complex needs perhaps because of underlying long term conditions, poly-pharmacy, or extensive social or support needs. These patients require care from a senior general medical physician, with support from a wide range of professionals, and carefully managed transitions between hospital and usual place of residence. Getting the patient to the right specialty team as early in their admission as possible is really important to avoid unnecessary investigations, support the patient to be managed at home wherever possible and to enable rapid and targeted treatment and intervention without having to wait for advice from another specialist.

What will we do?

The Medical Division have been working on developing a model of Needs Based Care since late 2015, and has already embedded ambulatory care pathways, which are now running 7 days, and opened a cardiac ward for patients to be admitted under cardiologists where appropriate, rather than being admitted under a general physician who would then seek advice from a cardiologist. This has shown a dramatic reduction in length of stay for patients with cardiac diagnosis, and the initial data review suggested that this change was saving up to 15 medical beds. The next steps for implementation of Needs Based Care are to;

- Deliver admission for patients directly to respiratory specialists 7 days a week
- Complete works to the lifts in the medical block to facilitate specialty ward moves and create a larger flexible EAU bed base at the front of the hospital
- Complete the design of the complex and general medical senior medical model to enable movement to full needs based care for all specialties

In terms of facilitation of increased continuity, there are three transitions of care to be considered:

- When a patient with a long term medical condition comes into hospital, they should be cared for by a consultant who has been managing their outpatient care with their GP
- When a patient is admitted to hospital, they should have the same consultant for as much of their stay as possible, with no avoidable handovers.
- When a patient comes into hospital for a second time, they should return to the care of the consultant who discharged them, so that the treatment and plan can be reviewed in the context of the patient's prior admission

It is our intention to remodel the way the consultant care of inpatients is delivered to maximise consultant continuity for patients against each of these three elements of the pathway. This will require changes to consultant timetables, to enable ongoing care of patients rather than the traditional 'on-ward, off-ward' patterns of work.

Furthermore, by implementing length of stay reductions through delivery of the Red to Green initiative* and focussed management of patients with length of stay in hospital of over 7 days, we will reduce the number of patients that are not admitted to the right bed first time, and so will reduce avoidable handovers that result from patient movement between wards.

* a visual management system to assist in the identification of wasted time in a patients journey. If it is red, the patient has not progressed, green they have.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Reduction in the number of consultant handovers within an inpatient episode
- Increase the % of patients discharged by the same consultant for a related re-admission
- Increase the % of patients discharged by their named outpatient consultant where applicable
- Reduction in length of stay for emergency medical patients
- Improved patient satisfaction regarding communication and involvement in decision making around their care
- Fewer non-value adding days to patient hospital stays due to improved co-ordination of the treatment plan

Key Patient Safety Priority 2

- **To reduce the incidence of falls amongst patients staying in hospital**

Why is this a priority?

Over the past five years, the Trust has shown a year on year improvement in the prevalence of falls with harm but the incidence of falls (rate per 1000 bed days) has remained relatively static. Whilst the Trust has a lower incidence of falls than the national average, we are committed to refocusing our multidisciplinary team efforts in order to reduce our rate of falls. When a patient has a fall in hospital, the effect can be both physically and psychologically detrimental and in many cases may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the efficiency of delivery of services to patients by less effective use of beds. Research has shown that when staff such as doctors, nurses and therapists work more closely together, they can reduce falls by 20-30% (RCP 2016). The Trust plans to build upon the work already undertaken to strengthen our approach to the prevention of falls thereby improving patient safety and experience.

What will we do?

- Ensure that the membership of the Falls Steering Group is in line with the recommendations of the RCP
- Continue to embed the multifactorial risk assessment in practice for all patients aged 65 and over and for those aged 18-64 who are have a clinical risk factor for falling.
- Educate staff, audit practice and undertake targeted improvement work to ensure that the best practice guidelines of NICE and the Royal College of Physicians is consistently implemented for all our patients.
- Complete the roll-out of the new Falls Prevention Leaflet which has been published for patients in hospital and their families and carers
- Implement the recommendations following the most recent bed rails audit
- Continue to review assistive technology to enhance the delivery of safer care for patients at risk of falls
- Undertake a review of the bed stock to ensure that there are appropriate numbers and types of beds
- Undertake focused quality improvement initiatives to reduce the number of falls associated with use of bathrooms and toilets
- Continue with the review and implementation of best practice standards for enhanced care for our most vulnerable patients
- Implement, as a priority, the frailty best practice standards
- Continue to investigate and analyse themes and trends from falls to inform the implementation of appropriately targeted actions for improvement

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria:

- The Falls Steering Group has membership and engagement in line with RCP recommendations
- A reduction in the rate of falls to a consistent rate of less than 4 per 1000 bed days
- A reduction in the rate of falls specifically associated with patient use of toilets and bathrooms
- Patients, their families and carers routinely receive and are asked to read the Falls Prevention Leaflet
- The Trust falls prevention action plan is regularly updated to include the learning from the analysis of falls

Key Patient Safety Priority 3

- **Improve the management of deteriorating patients**

Why is this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2016-17 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, there is a need to continue in our improvements to deliver more sensitive, appropriate care at the end of a person's life. It is vital that for those patients, nearing the end of their life, that appropriate, timely decisions are made and care plans put in place to provide compassionate dignified care when aggressive treatment or resuscitation are not appropriate.

What will we do?

- Continue to embed the implementation of the Treatment Escalation Plans
- Continue to deliver training and support to clinical teams in the assessment of patients nearing the end of their life and in having effective, sensitive conversations with the patient and their family or carers.

- Continue to audit the observation and treatment of patients who deteriorate and implement learning from the findings.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria:

- Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline.
- To continue to sustain improvements all along the deteriorating patient pathway ensuring:
  1. Timely and appropriate observations
  2. Timely escalation of concerns to medical staff
  3. Timely medical response times,
  4. Improvement in timely and appropriate decision making by medical staff.
- Patients nearing the end of their life are appropriately assessed and provided with a careplan to ensure the most appropriate care delivery

Key Patient Safety Priority 4

- **To reduce the incidence of medication errors for inpatients**

Why is this a priority?

Every step in the processes associated with the use of medicines has the potential for failure to a varying degree. Medication safety is therefore, the responsibility of all staff and most effective when underpinned by a culture of openness and honesty when things go wrong. It is vital that we learn and use our developing understanding of medication safety incidents to most effectively deal with the causes of failure. The reporting, analysis of and learning from medication safety incidents is vital even where no harm has occurred to a patient. This allows the best quality learning to take place as the 'what', 'how' and 'why' things went wrong, so that effective and sustainable solutions can be put in place to reduce the risk of similar incidents occurring.

Research evidence (NHS England 2014) indicates the following medication error rates in the medicine use process nationally:

- Prescribing error rate in hospital, 7% of prescription items;
- Medicine administration errors in hospital, 3 - 8%;
- Dispensing error rate in hospitals, 0.02 - 2.7% of dispensed items;

Drug incidents accounted for 7% of all incidents reported on the Trust's patient safety incident reporting system during 2016/17, 95% of which caused no harm or low harm. However, there is opportunity to increase reporting rates of medication incidents following an apparent reduction in reporting during some parts of the year.

Since being chosen as one of the pilot sites for the 'Safer Patient Initiative' over a decade ago, significant progress has been made through an organisation-wide approach to patient safety and medication safety. The findings of the Francis Report also resulted in measures being put in place to address areas of concern relating to medicines use. The Trust Medication Safety Review Group (MSRG) reviews medication error reports each month, identifying themes and ensuring multidisciplinary, trust-wide learning is shared. This priority, aims to refocus attention across all professions to maximise the opportunities afforded by learning for quality improvements to further drive up our safety in medicines management.

What will we do?

- Improve the patient safety reporting system (DATIX) to more effectively support the medication safety agenda
- Continue to embed the culture of reporting, investigating and learning from medication safety incidents
- Monitor and identify trends and themes in medication related incidents e.g. audit of missed and omitted doses
- Targeted quality improvement work to reduce incidence of the most prevalent error types
- Focus on reducing errors associated with the use of high risk medicines
- Ensure that Trust practices are fully in line with NHS Improvement Patient Safety Alerts
- Promoting safe medication use on the wards through new ways of working (MDT) e.g. board rounds, safety briefs, huddles
- Ensure that the dissemination of lessons learned from medication errors through various mechanisms is consistent and robust. This will be achieved by using a range of communication channels e.g. newsletter, IT screensavers, clinical governance meetings, prescribing error sessions
- Further promote good leadership and a culture of openness (duty of candour) amongst clinical staff and between staff and patients
- Continued education and training to highlight the role of all healthcare professionals in medication safety

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria:

- An increase in the rate of reporting of no harm medication safety incidents
- A reduction in the rate of medication errors due to errors in prescribing
- A reduction in the rate of medication errors due to administration errors
- A reduction in the incidence of missed or delayed doses

Priority 3: Patient Experience

Key Patient Experience Priority 1

- **Improve the experience and care of patients at the end of life and the experience for their families**

Why is this a priority?

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. The last two years have seen improvements in communication with patients and families, improved symptom management and spiritual care, investment in training and education and reduction in inappropriate cardiac arrests through more timely decisions regarding DNACPR. This year, the focus will be on working with our community colleagues and our commissioners to ensure patients achieve their choice of 'place to die' and that this is achieved in a timely manner.

What will we do?

- Continue to build and develop the Palliative Team raising the profile of specialist palliative care expertise and the new EOLC Nurse role.
- Continue to present to clinical meetings across the multidisciplinary teams in order to promote the EOL Individualised Care plan and embed the national guidelines of palliative care. In particular helping to identify the dying patient and foster appropriate, timely conversations around EOL.
- Continue to promote "small things make a difference"- i.e. introduction of new linen patient property bags.
- Continue to strengthen the EOL Strategy Group making it a robust steering group for the delivery of palliative care standards we can be proud of.
- Supporting our staff on the wards and promoting our ethos that palliative care is everyone's business from the cleaner to the consultant.
- Improve communication through additional and improved leaflets available to our patients.
- Palliative Care champions have been identified on each ward and equipping them to be advocates and role models of palliative care.
- Work with our chaplaincy team to improve the delivery of good spiritual and religious care to this cohort of patients, family and friends.
- Continue to audit of the EOL Individualised Care Plan and enhancing its correct use.
- Gather feedback on patient and carers experience.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Improved performance in the national 'Care of the Dying' audit
- Improved performance in the further local audits of the EOL Individualised Care Plan
- A reduction in incidents and complaints through the End of Life Steering Group
- Continued improved feedback from patients and carers

Key Patient Experience Priority 2

- **To improve the experiences of people living with dementia and their carers when using our outpatient services.**

Why is this a priority?

Patients with Dementia can have complex care needs. These care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their care pathway, provide good quality patient care and experience whilst they are attending hospital and communicate effectively with primary care in order to more effectively address their specific needs and provide a better

quality experience. Service user feedback provided by the Alzheimer's Society has shown that there is an opportunity to improve the experiences of the person with dementia and their carer who attend our out-patient departments. The Trust is committed to focusing on this element of patient experience for the coming year.

What will we do?

This has been a key quality priority for the Trust for some years with improvements in timely assessment, referral, treatment and support for carers. 2017/18 will focus on delivering improvements in the care and experience for the person with dementia and their carers who are using our out-patient services:

- Develop a process to ensure that people living with dementia who are referred to our outpatient services are identified before their attendance to enable special needs and requirements to be met
- Work in close partnership with primary care colleagues in order to improve referral pathways and sharing of information
- To provide additional focused training and support for all staff working within outpatient settings across the Trust to enable them to better address the needs of people with dementia and their carers
- Embedding the use of the butterfly symbol to support easy identification of people with dementia to facilitate continuity of care
- The impact of the environment on the person with dementia will be recognised as a fundamental influence on the wellbeing and experience. Opportunities to make improvements to the environment such as signage, layout of consulting rooms and distraction facilities will be the focus of a quality improvement initiative

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- The reported experiences of patients and their carers will be improved
- The reported experiences of staff working in the outpatient setting is that they feel more confident, skilled and knowledgeable in caring for people living with dementia and their carers
- Staff report higher levels of satisfaction in the service that they are able to provide for these patients and carers

Key Patient Experience Priority 3

- **Ensure proactive and safe discharge in order to reduce length of stay**

Why is this a priority?

There is considerable national evidence for the harm caused by poor patient flow. Delays lead to poor outcomes and experiences for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has a serious impact across health and care systems, reducing the ability of emergency departments to most efficiently and effectively respond to people's needs, and increasing costs to local health economies.

Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend – between 2013 and 2015, recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million beds days. For older people in particular, long stays in hospital can lead to worse health outcomes and can increase their long term care needs.

This is a national issue and, as such, local A&E Delivery Boards are being asked to implement key initiatives to address some of the major underlying issues causing delayed discharges. The National CQUIN scheme builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways.

What will we do?

- Map and streamline existing discharge pathways across acute, community and NHS care home providers, and roll-out protocols in partnership across the whole system.
- Develop and agree, in partnership with our commissioner, a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver a reduction in length of stay
- To upgrade our IT system and train staff so that the Emergency Care Data Set can be collected and returned with the required additional data and improved accuracy
- To embed the implementation and roll-out of Red Days and Green Days in order to identify wasted time much earlier in the patient's journey
- To use the intelligence offered by the Red and Green Days analysis to focus quality improvements aimed at reducing the issues which cause delays
- Undertake daily situation report meetings and daily escalation meetings to review patient pathways towards discharge

- To review the synergies and opportunities afforded by the use of the Productive Ward "Planned Discharge" module to be used alongside the programmes of improvement activities that are currently in progress

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Red and Green Days is part of business as usual and used consistently to assess the value of each patient's day
- By the end of the year, a 2.5% increase in the number of patients discharged to their usual place of residence within 3-7 days who were admitted via non-elective route and are aged 65 and over
- There will be no increase in the readmission rate as a result of the decrease in length of stay

Key Patient Experience Priority 4

- **Improving experience of care through feedback from, and engagement with, people who use our services**

Why is this a priority?

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. Patients and their carers are at the heart of what we do and seeking a better understanding of, and responding more effectively to, their experiences is a core element of how we deliver our services.

Furthermore, the NHS Five Year Forward View says that 'we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services'1 (2014). The concept of patient leadership is emerging as one important new way of working collaboratively with patients and carers. 'One new concept – patients as leaders – is beginning to gain popularity' (Kings Fund 2013). Nationally, initiatives are emerging which place high priority on involving patient leaders in the endeavours of NHS organisations to secure better information from service users and to support

In addition to this priority for our patients' experience, it is also a priority to improve the experiences of staff. The 2016 national staff survey results showed our Trust to be in the lower 20% of Trusts in England for effective use of patient/service user feedback. Our key priority therefore needs to be to ensure that we increase the opportunities to gain feedback from our patients and carers, that we seek to increase the usefulness and quality of the information we gather and that we increase the scale and pace of quality improvement initiatives which are directly responding to our patient experience feedback.

What will we do?

- Embed the use of iPads on wards and in departments to collect feedback from more patients
- Implement a texting service to seek feedback from patients visiting A&E, outpatients and those who have delivered a baby in hospital
- Supplement the FFT question routinely asked on discharge, with a range of questions to provide a better understanding of patient experience
- Ensure that ward and departmental managers receive regular reports of their feedback in a format that is easy to understand, share with their teams and use with their teams to drive improvements
- Ensure that patient experience findings and related quality improvements are a standard agenda item on Departmental and Divisional Governance and Board meetings with the expectation that actions to respond are discussed and agreed
- Ensure that the findings of patient experience surveys are widely publicised for staff and patients/visitors so that everyone has easy access to information which shows what the feedback is and how we are using it
- For our top four languages, ensure that patient experience surveys are translated and offered to those patients for whom those are their preferred spoken language
- Explore the use of Patient Leaders to further enhance our capacity and capability in the collection of patient experience feedback, in line with the NHS England Patient Leader initiatives
- Establish a Patient Experience Board to lead and monitor progress with the patient experience strategy
- Maximise the opportunities to make direct links between staff experience and patient experience
- Continue to build on a culture where patient and carer experience is everybody's business

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Patient experience feedback is displayed alongside staff experience feedback
- Patient experience feedback and quality improvement action plans is a standing item on the agenda of meetings in all divisions
- Staff see and believe that the Trust acts on feedback provided by patients
- Staff receive regular updates on patient/service user experience in their department
- Feedback from patients/service users is used to make informed decisions within departments
- There will be an increase in the number of patients providing feedback to the Trust
- The teams will have access to an enhanced range of feedback which they use to tailor local quality improvement initiatives

Key Patient Experience Priority 5

- **To support the continued delivery of care within residential and nursing homes to patients nearing the end of their life**

Why is this a priority?

People nearing the end of their life who are living in nursing or residential homes are sometimes brought into hospital because of a failure in provision in the community. 30% of patients stay in hospital for less than one day and a significant number die within 48 hours of admission because they are patients who are at the end of their life. These two groups of patients particularly have the potential to receive more appropriate care if it were able to be delivered within their place of residence. Evidence suggests that staff within nursing homes and residential homes are often reluctant to call an ambulance because they are aware that the patients' needs could be adequately provided for within the community had the appropriate services been consistently available. The effect is that people may be dying in hospital unnecessarily and that some beds are being used for less appropriate admissions. The service we aim to deliverghgau will provide an alternative to calling for an emergency ambulance when intervention in the home would effectively prevent the patient transfer.

What will we do?

- Work in partnership with SEPT and CCS to create a clinical outreach team to ensure 24 hour cover, seven days per week who are able to provide care and treatment to patients within residential or nursing homes
- To provide support to the staff within the nursing and residential homes in order to maintain continuity of care for patients within their usual place of residence
- To build on the strengths of the Hospital at Home and Clinical Navigation Teams to build a team who can rotate into roles in order to deliver a responsive service
- To work with the primary care providers and ambulance service to ensure that appropriate screening and referral criteria are established and implemented to enable an effective, safe referral pathway to be put in place

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- The outreach service is in place providing interventions in nursing and residential homes which result in an avoided admission to A&E
- The service will not be limited by postcode but will be available for any home from where the patient would otherwise have been conveyed to the Luton and Dunstable Hospital A&E department

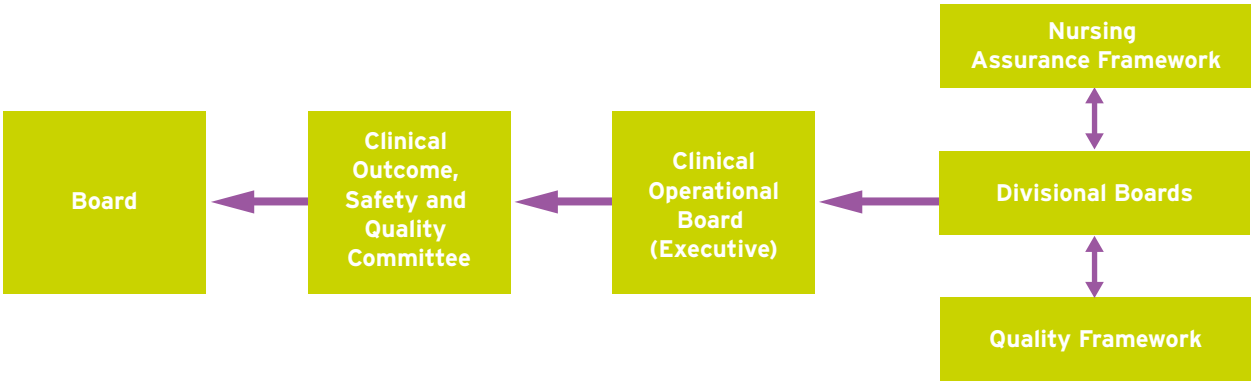
4. Statements related to the quality of services provided

4.1 Review of Services

During 2016/17 the Luton and Dunstable University Hospital 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 the Clinical Outcome, Safety and Quality sub committee. Quality is managed by the Divisional Boards and the Clinical Operational Board providing assurance to the Clinical Outcome, Safety and Quality Committee. These reports include domains of patient safety, patient experience and clinical outcome. During 2016/17 the Executive Board commissioned a number of external experts and external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- External reviews of two Serious Incidents
- Mortality review received by Dr Bill Kirkup
- Support from the Institute for Health Improvement to support our Advancing Safety and Quality Framework

In addition, the Board receives reports relating to complaints and serious incidents.



The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2016/17.

4.2 Participation in Clinical Audits and National Confidential Enquiries

During the period the Trust was eligible to participate in 35 of the 52 National Clinical Audits that met the Quality Accounts inclusion criteria.

The Trust participated in 33/35 (94%) of the eligible national audits

The audits that we were eligible to participate in but did not were:

- National Ophthalmology Audit - due to software issues. Business Case for the Electronic Patient Records system called Medisoft submitted
- BAUS Urology Audits – nil return

Clinical audits are a mixture of National and local priorities which each directorate is responsible for as part of their Clinical Audit Forward programme. The data collected for Quality accounts includes mandatory audits on the National Clinical Audit and Patient Outcomes Programme which directorates must participate in. Other audits whether local or national may not have been deemed as high priority or reflects the audits which directorates have prioritised.

Name of audit / Clinical Outcome	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	Apr 2016 to Mar 2017	All cases with diagnoses of MI	2016/17 Ongoing Approx 400 cases YTD - 12th May 2017 closing date
Adult Asthma	Yes	Yes	Sep 2016 to Jan 2017	40 cases	40 cases submitted
Adult Cardiac Surgery	No	No	Apr 2016 to Mar 2017	Not undertaken at Centre	
BAUS Urology Audits - Female Stress Urinary Incontinence Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	No	2014-2016 (data collated three year rolling cycle)	All eligible cases	Nil return
BAUS Urology Audits - Radical Prostatectomy Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	No	No	Apr 2016 to Mar 2017	We do not perform radical prostatectomy here as the pts are sent to Lister- hence not relevant to us.	
BAUS Urology Audits - Nephrectomy audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	23 cases submitted
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL) BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	Apr 2016 to Mar 2017	PCNLs performed during 2014 to 2016 inclusively	25 cases submitted as at 21.3.17
Bowel Cancer (NBOCAP)	Yes	Yes	Apr 2016 to Mar 2017	All patients with a confirmed cancer diagnosis for 'tumour grp'	Apr 15 to mar 16 cases 153 cases submitted. 2016/17 cases ongoing (Data submission required by Oct 2017)
Cardiac Rhythm Management (CRM)	Yes	Yes	Apr 2016 to Mar 2017	100%?	Ongoing - 125 YTD (Anticipated cases 350-400)
Case Mix Programme (CMP)	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	ITU (April 16 to March 17) - 387 cases HDU (Oct 16 to Mar 17) - 379 cases
Child Health Clinical Outcome Review Programme	Yes	Yes	Apr 2016 to Mar 2017 Apr 2016 to Mar 2017	Please see 4.3 of the Quality Accounts Schedule	
Chronic Kidney Disease in primary care	No	No	Apr 2016 to Dec 2016		
Congenital Heart Disease (CHD)	No	No	Apr 2016 to Mar 2017		
	No	No	Apr 2016 to Mar 2017		
Diabetes (Paediatric) (NPDA)	Yes	Yes	Apr 2016 to Jun 2016	All eligible cases	148 cases submitted

Name of audit / Clinical Outcome	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Elective Surgery (National PROMs Programme)	Yes	Yes	Apr 2016 to Sept 2016 on-going	**Pre-operative** Knee Rep. 153 Hip Rep. 116 Varicose Vein 25 Groin Hernia 171 **Post-operative** Knee Rep. 50 Hip Rep. 37 Varicose V. 3 Groin Hernia 82	**Pre-operative** Knee Replacement 128 Hip Replacement 103 Varicose Vein 9 Groin Hernia 124 **Post-operative** Knee Replacement 21 Hip Replacement 11 Varicose Vein 2 Groin Hernia 42
Endocrine and Thyroid National Audit **BAETS operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec**	Yes	Yes	Apr 2016 to Mar 2017	All cases	55 cases submitted
Falls and Fragility Fractures Audit programme (FFFAP)	No	No	Apr 2016 to Mar 2017		
	N/A for 2016/17	N/A			
	Yes	Yes	1st January to 31st December 2016	FNOF aged 60 years and above Cases Submitted	308 cases submitted
Head and Neck Cancer Audit	Yes	Yes	November 2016 to March 2017	All patients with a confirmed cancer diagnosis for 'tumour grp'	Not due to start 1st April 2017 (Historic DHANO data submitted x194 pt records uploaded for the period 01.11.14 to 31.10.16
Inflammatory Bowel Disease (IBD) programme / IBD Registry **The IBD audit that ran until 28/02/2017 was an NCAPOP project.**	Yes	Yes	Apr 2016 to Mar 2017 (managed by BSG via IBD Registry)	10 cases	(20 cases 2015/16) Cases in 2016/17 10 cases submitted
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	Apr 2016 to Mar 2017 There is a staged introduction of the programme across England (see website for roll out details) - all to be reporting deaths by the end of 2017.	Due to start April 2017	

Name of audit / Clinical Outcome	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Major Trauma Audit	Yes	Yes	Apr 2016 to Mar 2017	Lorraine Varney ext 7420 still entering data - 300 required	24 cases submitted (calender year) of an approx. expected number of 300 (with 50 created but a/w information prior to submission and 256 on the backlog project).
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	15 cases submitted and a further 7 to be uploaded
	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	Late fetal loss - a baby delivered without signs of life from 22+0 to 23+6: · 2016: 5 cases · 2017: 5 cases (4 cases are not yet uploaded to MBRRACE)
	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	2016: 8 cases 2017: 4 cases (3 cases are to be uploaded to MBRRACE)
	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	7 cases submitted
	Yes	Yes	Apr 2016 to Mar 2018	All eligible cases	2016:1 case uploaded to MBRRACE 2017:1 case uploaded to MBRRACE
	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	2016: 1 case uploaded to MBRRACE 2017: 1 case uploaded to MRRACE
Medical and Surgical Clinical Outcome Review Programme **Selection for 2 additional topics will be carried out in 2017**	Yes	Yes	Apr 2016 to Mar 2017	Please see 4.3 of the Quality Accounts Schedule	
			Apr 2016 to Mar 2017		
			Apr 2016 to Mar 2017		
			Not collecting 2016/2017 data		
			Apr 2016 to Mar 2017		
			Apr 2016 to Mar 2017		
Mental Health Clinical Outcome Review Programme	N/A		Not collecting 2016/2017 data		
	N/A		Apr 2016 to Mar 2017		
	Not collecting 2016/2017 data - AUDIT TO RE-START LATE 2017/EARLY 2018				
Moderate & Acute Severe Asthma - adult and paediatric (care in emergency departments)	Yes	Yes	Apr 2016	All eligible cases	54 cases submitted
National Audit of Dementia	Yes	Yes	Apr 2016 to Nov 2016	50	55

Name of audit / Clinical Outcome	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	Apr 2016 to Mar 2017	400 cases required	2016 data 233 cases
National Audit of Pulmonary Hypertension	No	No	Apr 2016 to Mar 2017		
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Apr 2016 to Mar 2017	Cardiac Centre	Ongoing: 115 cases YTD
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	No	No	Jan 2017 to Mar 2017		
	Yes	Yes	Continuous clinical data collection to start in February 2017, with snapshot organisational data collection Apr-Jun 2017	All patients admitted with exacerbation of COPD	Ongoing - 70 cases YTD
	No	No	Two extractions scheduled between November 2016 and November 2017		
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA) Audit not currently running and will be recommissioned by HQIP in 2017	Not collecting 2016/2017 data				
	Not collecting 2016/2017 data				
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Not collecting 2016/2017 data				
National Comparative Audit of Blood Transfusion programme	Yes	Yes	July - August 2017	20	Ongoing August 2017
	Yes	Yes	March 2017 (see 2017/18 column for further info on data collection period)	20	Data collection in progress
	Yes	Yes	Jul 2016	No Min. required	28 cases submitted
	Yes	Yes	Data collection ended December 2015	No Min. required	27 cases submitted

Name of audit / Clinical Outcome	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
National Diabetes Audit - Adults	No	No	Apr 2016 to Mar 2017	Local Diabetes Podiatry service provided by SEPT	
	Yes	Yes	Sep 2016	All eligible cases	97 cases submitted
	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	32 cases submitted
	N/A				
	Yes	Yes	Jan -Mar 2016	All eligible cases	3997 cases
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Jan 2015 to Nov 2016	All eligible cases	Cases submitted 267
National End of Life Care Audit **Audit not currently running and will be recommissioned by HQIP in 2017**	N/A				
National Heart Failure Audit	Yes	Yes	Apr 2016 to Mar 2017	Heart Failure Diagnoses	125 cases submitted
National Joint Registry (NJR)	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	316 cases (Knee)
	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	270 cases (Hip)
National Lung Cancer Audit (NLCA)	Yes	Yes	Jan - Dec 2016	All 100%	130 cases submitted
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Apr 2016 to Mar 2017	All eligible cases	Ongoing data submission to 31st March 2017 - Cases submitted YTD 510
National Ophthalmology Audit	Yes	No	Apr 2016 to Mar 2017	100 cases/ surgeons	Medisoft required for data submission.
National Prostate Cancer Audit	Yes	Yes	Apr 2016 to Mar 2017	All patients with a confirmed cancer diagnosis for 'tumour grp'	April 16 to Jan 2017 Total cases submitted 185 YTD
National Vascular Registry	N/A				
Neurosurgical National Audit Programme	N/A				
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	Apr 2016 to Mar 2017	All patients with a confirmed cancer diagnosis for 'tumour grp'	Apr 15 to Mar 16 cases 74 cases submitted. 2016/17 cases ongoing (Data submission required by Oct 2017)
Paediatric Intensive Care (PICANet)	No	No	Apr 2016 to Mar 2017		
Paediatric Pneumonia	Yes	Yes	Nov 2016 to Apr 2017	All eligible cases	Ongoing data submission to 30th April 2017 (2/3 of cases entered)

Name of audit / Clinical Outcome	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Prescribing Observatory for Mental Health (POMH-UK) **NOTE: Subscription-based programme**	No	No	N/a N/a Apr 2016 to May 2016 Jun 2016 to Jul 2016 July 2016 to Oct 2016 Not collecting 2016/2017 data 1 February 2017-31 March 2016	N/A	
Renal Replacement Therapy (Renal Registry)	No	No	July 2016 - Jun 2017		
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Apr 2016 to Mar 2017	All Strokes	Ongoing as at 28.3.17 760 cases submitted
Severe Sepsis and Septic Shock (care in emergency departments)	Yes	Yes	Aug 2016 to Dec 2016	50 cases	58 cases submitted
UK Cystic Fibrosis Registry	No	No	Apr 2016 to Mar 2017		
	No	No	Apr 2016 to Mar 2017		

Local Clinical Audits
In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of seventeen local clinical audits were completed during the reporting period which were project managed by the Trust's Clinical Audit Department (Appendix A).

4.3 National Confidential Enquiries

	Topic/Area	Database/ Organiser	% return*	Participated Yes/No
1	Mental Health	NCEPOD	100%	Yes
2	Acute Non Invasive Ventilation	NCEPOD	75%	Yes
3	Chronic Neurodisability	NCEPOD	17%**	Yes
4	Young People's Mental Health	NCEPOD	67%**	Yes
5	Cancer in Children, Teens and Young Adults	NCEPOD	0%**	Yes
4	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

* The number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry
** This study is still open and returns being made

4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2016/2017 and who were recruited during that period to participate in research approved by a Research Ethics Committee was **658**. This research can be broken down into **171** research studies (**148** Portfolio and **23** Non-Portfolio).

Participation in clinical research demonstrates the Luton and Dunstable University Hospital'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.

4.5 Goals agreed with Commissioners of Services – Commissioning for Quality and Innovation

A proportion of Luton and Dunstable University Hospital income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Luton and Dunstable University Hospital NHS Foundation Trust and NHS Luton as lead commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. During 2016/17, a number of CQUIN schemes were agreed – some of which were national schemes and the remainder, locally agreed quality improvement initiatives.

Indicator Number	Indicator Name	% of the Value
1a	Staff Health and Wellbeing: Introduction of health and wellbeing initiatives	0.25%
1b	Staff Health and Wellbeing: healthy food for NHS staff, visitors and patients	0.25%
1c	Staff Health and Wellbeing: improving the uptake of flu vaccination by frontline clinical staff to 75%	0.25%
2a	Sepsis Timely identification and treatment for sepsis in emergency departments	0.125%
2b	Sepsis Timely identification and treatment for sepsis in acute inpatient settings	0.125%
3a	Cancer 62 Day Waits Urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first treatment within 62 days	0.2%

Indicator Number	Indicator Name	% of the Value
3b	Cancer 62 Day Waits Root-cause analysis on all long waiters and a clinical harm review for a positive diagnosis	0.05%
4a	Antimicrobial Resistance and Antimicrobial Stewardship Reduction in antibiotic consumption per 1,000 admissions	0.2%
4b	Antimicrobial Resistance and Antimicrobial Stewardship Empiric review of antibiotic prescriptions	0.05%
5	Development of Shared Decision Making for Patients Requiring Same Day Urgent Care	0.7%
6	System wide Palliative Care and End of Life	0.2%
7	Integrated care for complex patients South Bedfordshire	0.2%

The Trust monetary total for the associated CQUIN payment in 2016/17 was £5,900,000 and the Trust achieved 97% of the value. The 2015/2016 value was £4,800,000 and the Trust achieved 88% of the value.

4.6 Care Quality Commission Registration

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

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

The Luton and Dunstable University Hospital NHS Foundation Trust is fully registered with the CQC and its current registration is Registration without Conditions.

No enforcement action has been taken against the Trust during the reporting period April 1st 2016 and 31st March 2017 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

The CQC monitor, inspect and regulate care services to ensure patients receive safe, effective, compassionate, high quality care. To really measure the patient's experience of care, they have identified five key questions based on the things that matter to patients. The CQC will ask these questions of every service.

- Are they safe? By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?
- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?
- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.
- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.
- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016.

Our ratings for Luton and Dunstable Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	★ Outstanding	★ Outstanding	★ Outstanding
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	★ Outstanding	Good	Good	★ Outstanding	★ Outstanding
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	★ Outstanding	★ Outstanding	★ Outstanding

Report did not mandate any actions for the Trust however it did highlight a number of areas for further improvement. Each Division was asked to undertake a detailed review of the inspection report and develop an action plan paying particular attention to the "Requires Improvement" ratings within Medicine and Critical Care.

Progress against specific action plans is monitored through the various Divisional Governance processes and oversight of compliance and progress is monitored through the Clinical Outcome, Safety and Quality Sub-Committee of the Board. Any key areas have also been included in our Quality Priorities for 2017/18.

Medicine

1. A number of the key areas highlighted for improvement formed part of the Trust's quality priority for 2016/17. These included the timely administration of antibiotics for patients with sepsis and completion of VTE assessments. Ongoing audits are in place to monitor progress and have demonstrated an improvement in performance.
2. Another of the key areas for improvement was the medical model of care within Acute Medicine and Elderly Medicine. The report highlighted the number of Consultant handovers that resulted in a lack of continuity of care. The Trust has committed to an ambitious programme that will see the Trust move from an Age Based to a Needs Based Care model that has continuity of care as its key principle. This work will continue in 2017/18 and will be considered across all specialties and forms one of the Quality Priorities for 2017/18.
3. A comprehensive Stroke Action Plan was further developed to incorporate feedback from the CQC report. The actions have been aggressively progressed with significant improvements across all the component parts. This is also monitored at each meeting of the Board of Directors to monitor compliance.
4. Mandatory training compliance, particularly for conflict resolution, safeguarding children level 3 and infection control has improved with clear expectations and monitor processes in place.
5. The report raised some concerns with the inconsistency in the recording of medicine administration and delays in dispensing discharge medication. The Trust has invested in an electronic prescribing system that has removed the inconsistency in recording medicine administration and this has been rolled out to the majority of clinical areas. A pilot project was run that used pharmacists on ward rounds to write take home medications which resulted in a reduction in the discharge delays. A business case has been prepared to support the roll out across all wards.
6. The rising Trust HSMR was a key area of concern raised by the Trust to CQC in the preparation for the Inspection. Within the Inspection Report a number of recommendations were made to support the ongoing work on the Trust in relation to this matter. At the time of the inspection, mortality was discussed as part of governance meetings within Medicine. However, the Division agreed to ensure that these have more focused attention and quarterly Mortality Meetings are in place where case reviews are shared

and learning takes place. Mortality meetings are held in all Divisions within the Trust. The Mortality Board oversees the review of deaths across the Trust, monitors trends and receives reports from any alerts raised through the Dr Foster benchmarking system. We have also maintained HSMR as a Quality Priority for 2017/18.

7. Delays to discharge were highlighted as an area for further improvement. A Discharge Hub has been developed to provide a focus on understanding the delays within the patient pathways and expediting and escalating any delays in patient progress through the pathways or barriers to discharge. Daily meetings with Executive level oversight are in place to monitor progress. Reducing length of stay will form part of our Quality Priority for 2017/18.

Critical Care

During the inspection concerns were raised in relation to the environment and bed spacing within the High Dependency Unit. Immediate action was taken at the time of the inspection and the number of beds reduced from 15 to 11.

A further concern was raised in relation to the lack of a clear policy on the sedation of patients with delirium in HDU. This was investigated immediately and before the end of the inspection process we had assurance that all relevant staff had read and understood that this policy was in place.

This immediate response was commended by the CQC.

The Inspection process provided opportunities to further improve systems and processes within the HDU:

1. Electronic prescribing and pharmacist rounds in critical care were introduced and the recruitment of a practice development nurse improved training opportunities.
2. A blood gas analyser was made available on HDU and the training was put in place accordingly.
3. Clinical management model has changed making it easier for staff to know who had clinical ownership of the patient.

A number of improvements remain in progress:

1. Discharging patients from the Unit during working hours remains challenging due to the high bed occupancy across the clinical specialties. Every effort is made to step patients down from Critical Care during working hours however it is not always possible. The Critical Care Outreach team has been expanded to provide 24/7 cover for the wards. This mitigation is in place to support the late transfer out of patients while work is ongoing to reduce length of stay and bed occupancy.
2. The importance of HDU contributing to the ICNARC database was raised within the report. This is planned for 2017/18
3. It is recognised best practice to offer a Rehabilitation of the Critically Ill Patient follow up clinic to patients who have been treated in Critical Care. Unfortunately this service is not currently commissioned by the CCG however the Trust is working with the CCG to agree how we might be able to deliver these clinics.

Other Service Improvement

The CQC Inspection Report provided opportunities to make further improvements. This included areas that had been given a Good or Outstanding rating. The following improvements have been achieved in 2016/17:

The End of Life Care Team put in place regular audit processes to review the patients' preferred place of dying and monitor whether that was achieved. The results are fed back into a working group. There is one ongoing action for full access to System One to view all the Advanced Care Plans completed in the community and to share changes made during admission to the Trust. This forms part of the surgical division plans for 2017/18.

Maternity and Gynaecology metrics and parameters were agreed for the gynaecology dashboard; a substantive bereavement midwife is now in post; information leaflets in relation to terminations are now provided in other languages and CCTV has been installed throughout the maternity unit.

Surgery teams have made good progress with their action plan ensuring that audit data is complete before submission and that the audit results, incident reporting and friends and family scores are shared at their Clinical Governance meetings. There has been good progress ensuring that the VTE re-assessments are completed. A number of actions remain ongoing for delivery in 2017/18;

- New guidance on consent has recently been received from the Royal College of Surgeons regarding standards when consenting patients for theatre and this has delayed the changes planned following the CQC visit. The Trust Policy has now been updated and it is anticipated that the new consent form will be available in other languages in early 2017/18.
- High bed occupancy rates within surgery leads to delays in patients leaving theatre recovery and this in turn is not a good experience for the patient. Work is underway to look at a number of measures that can be implemented to improve the flow from recovery. A recent workshop between Patient Flow and theatres has ensured joint ownership and further actions have been agreed.
- Infection rates for knee replacement are higher than

the national average. A key component of the patients' care is to provide rapid assessment of patients with potential infections (via rapid assessment clinic). The teams began a pilot in quarter 4 of 2016/17 to address this issue and recommendations for the future service will be agreed following this pilot.

Outpatients, Diagnostics & Imaging team has ensured that cleaning schedules are visible in all clinical areas and have refurbished imaging and the outpatient's staff room that were in need of modernisation. Partial Booking has been rolled out across the Trust and this has had a positive impact on the number of cancelled appointments and the number of patients that are not attending their appointments.

Children and Young People electronic prescribing system has been implemented in paediatrics. The Surgical and Paediatric teams have worked together to agree a process that ensures a Paediatric nurse is present in theatre and this post is currently open for recruitment as at April 2017.

The Urgent and Emergency Care team have improved processes to ensured there is always consistency between the electronic and the paper record in ED in relation to the information they hold on safeguarding. Recording of ambulance arrivals was improved with an interim solution and in March 2017, the Symphony system was upgraded to allow this to be recorded electronically.

Non-Executive Assessments (3x3)
The assessment process is further enhanced by Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.

Transforming Quality Leadership 'Buddy' System
During 2016/17, we re-launched a programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation are assigned a 'buddy' area and are required to complete a cycle of visits across the domains and escalate any issues. The process involved Executive leadership across the domains with champions supporting the implementation. All clinical areas across the Trust are included in the programme.

This process provides board to ward reviews and also supports staff to raise concerns and issues to the management team. This programme developed into a revised quality monitoring framework to provide assurance of ongoing compliancy against the CQC Core Standards.

4.7 Statements on Relevance of Data Quality and Action to Improve Data Quality

The accuracy and completeness of the data we use to support the delivery of high quality care is of the utmost importance to the Trust.

The Trust has been making progress with data quality during the year 2016/17. There are many processes carried out by the Information Team, which identify data quality issues.

Listed below are a few of the processes that are either carried out on a routine or ad hoc basis by the Department:

- CCG challenges
- Monthly and weekly Outpatient data quality reports sent out to users e.g. attendance not specified
- Theatre reports
- Inpatient reports
- Referral reports
- Benchmarking analysis – SUS dashboards
- Data Quality Improvement Plan
- Data Accuracy checks
- Completeness and Validity checks
- A&E not known GP checks
- A&E wait - arrival – departure times

During 2016/17 we have taken the following actions to improve data quality:

- Developed the role of the Senior Data Quality Analyst and confirmed recruitment of a Data Quality Analyst to support the role.
- Continued our extensive programme of data quality checks and initiatives involving staff and managers at all levels
- Added additional Data Quality Procedures to improve on areas e.g. overnight stays on day wards and incorrect neonatal level of care.
- Increased the use of automated reporting to increase the visibility of any data quality problems and expanded our contacts within the departments
- Continued to work with Commissioners to monitor and improve data quality pro-actively in key areas.

NHS Code and General Medical Practice Code Validity

Luton and Dunstable University Hospital NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS number was:

- 99.4% for admitted patient care; 99.8% for outpatient care and 95.9% for A&E care.

The percentage of records in the published data which included the patient's valid General Medical Practice was:

- 100% for admitted patient care; 100% for outpatient care and 100% for A&E care

Action Plan for Data Quality Improvement for 2017/18

Information Governance

- Data Quality Accuracy Checks - Maintain the number of audits on patient notes.
- Completeness and validity checks - Remind staff about the importance of entering all relevant information as accurately as possible via Email and liaising with IT Applications Training Team for individual ad hoc refresher training.

1) CCGs Challenges

- Continue to work with Outpatients, IT & Divisions to improve other areas of known data issues (Admission Method vs A&E Attendance)
- Continue to communicate with users the importance of recording the current GP at time of attendance or admission.
- Continue to improve the NHS Number coverage
- Continue to monitor Multiple Firsts and highlight areas that are consistently creating first appointments

2) Outpatients

- Continue to produce weekly and monthly lists identifying those patients with an attendance status of 'not specified'. Also work with the Outpatients, IT and Divisions to reiterate the importance and financial impact of not recording information accurately
- Continue Regular Outpatient Data Quality meetings.

3) Inpatients

- Continue to work with General and Ward Managers, Ward Clerks to improve the data that is entered and identify good working processes

4) Waiting List

- Continue Regular Waiting List Data Quality meetings.

5) Theatres

- Changes in General Management has resulted in the current DQ reports stopping and new Theatres reports to be considered with the department and Finance

6) Referrals

- Continue to send out referrals to users to rectify the referral source and highlight within the Outpatient Data Quality Meeting the importance of the source being entered

7) Patient Demographics

- Continue to monitor and update Invalid Postcodes, DBS errors and missing NHS numbers. Highlight within DQ meetings the importance of QAS and up to date GP information.

8) A&E

- Continue to improve the NHS Number coverage
- Continue Regular Outpatient Data Quality meetings.

9) SUS dashboards

- Work with Divisions to improve the completeness of the fields where the National Average is not being met
- Use the dashboard to identify areas that require improvement (e.g. Ethnic Group Collection in Outpatients and NHS Number in AE needs to improve

Other Data Quality meetings

The Information Team are holding regular data quality meetings with A&E, Theatres, Inpatients and Maternity (still to be confirmed).

Clinical coding error rate

The Luton and Dunstable University Hospital NHS Foundation Trust was subject to an audit during 2016/17, carried out in by an established coding agency.

An error rate of 9.5% was reported for primary diagnosis coding (clinical coding) and 6.6% for primary procedure coding. This demonstrates good performance when benchmarked nationally and achievement of level 2 attainment in the Information Governance Toolkit.

Information Governance toolkit attainment levels

The Luton and Dunstable University Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2016/17 was 69% and was graded as satisfactory.

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes within an organisation.

5. A Review of Quality Performance

Part 3

5.1 Progress 2016/17

A 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. We have continued to follow the selected data sets and any amendments have been described below the table as they are still considered relevant and are reviewed annually by the Council of Governors through their External Audit review indicator section.

Performance Indicator	Type of Indicator and Source of data	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	3	3 ***	1	1	N/A	The Trust has a zero tolerance for MRSA. During 16/17 there was an isolated case.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	96*	106*	112*	108.7*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	19	10	11	8	N/A	Demonstrating an stable position. Remains one of the lowest in the country
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	30	19	11	3	N/A	Demonstrating an excellent position.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	4	3	2	4	N/A	Maintaining low numbers
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.6	1.6	1.04	1.4	1.6	Maintaining good performance below the national average
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.6 days	3.4 days	3.2 days	3.2 days	N/A	Maintaining the LOS
Rate of falls per 1000 bed days	Clinical Effectiveness Trust Board Report	4.87	4.25	4.32	4.06	5.5	Maintaining good performance.

% of stroke patients spending 90% of their inpatient stay on the stroke unit (n)	Clinical Effectiveness	84.7%	79.5%	69.4%	78.3% (to Nov)	Target of 80%	This has continued to be a challenge and the Trust has a robust action plan in place to improve performance.
% of fractured neck of femur to theatre in 36hrs (n)	Clinical Effectiveness Dr Foster	82%	75%	78%	62%	N/A	Significant impact of Novel Oral Anticoagulants (NOAC's) which preclude surgery for 48 hours after the last dose. Some delays due to lack of Trauma capacity
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	76*	79*	69.7*	70.79*	100	This is demonstrating the Trust as a positive outlier and improved performance on the previous year.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	91*	109*	112.8*	89.56*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Readmission rates*: Knee Replacements Trauma and Orthopaedics (n)	Clinical Effectiveness Dr Foster	4.7%	6.7%	7.2%	7.09%*	N/A	There has been a slight increase. A review of Trust data has been undertaken and no concerns were identified.
% Caesarean Section rates	Patient Experience Obstetric dashboard	25.7%	27.8%	28.3%	32.9%	25%	The Trust is a level 3 NICU and received high risk patient transfers
Patients who felt that they were treated with respect and dignity**	Patient Experience National in patient survey response	9.0	8.9	9.0	Available after Inpatient Survey May 2017	Range 8.5 - 9.7	Demonstrating an improving position
Complaints rate per 1000 discharges (in patients)	Patient Experience Complaints database and Dr Foster number of spells for the year	7.01	7.12	6.29	6.64	N/A	The Trust continues to encourage patients to complain to enable learning.

% patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	7.9	7.8	7.4	Available after Inpatient Survey May 2017	Range 7.0 – 9.3	Demonstrating a slightly poorer position but still within range.
Venous thromboemolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95%	Achieved >95%	Achieved >95%	Achieved >95%	N/A	Maintaining a good performance.

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

* Denotes calendar year
** Patients who felt that they were treated with respect and dignity is now reported in place of % patients who would rate the service as excellent, very good or good (in-patients). This is no longer asked within the national annual in-patient survey.
*** Public Health England Healthcare Acquired Infection Surveillance Group identifies the number of MRSA bacteraemia "allocated" to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.

5.2 Major quality improvement achievements within 2016/17

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

Improving Quality

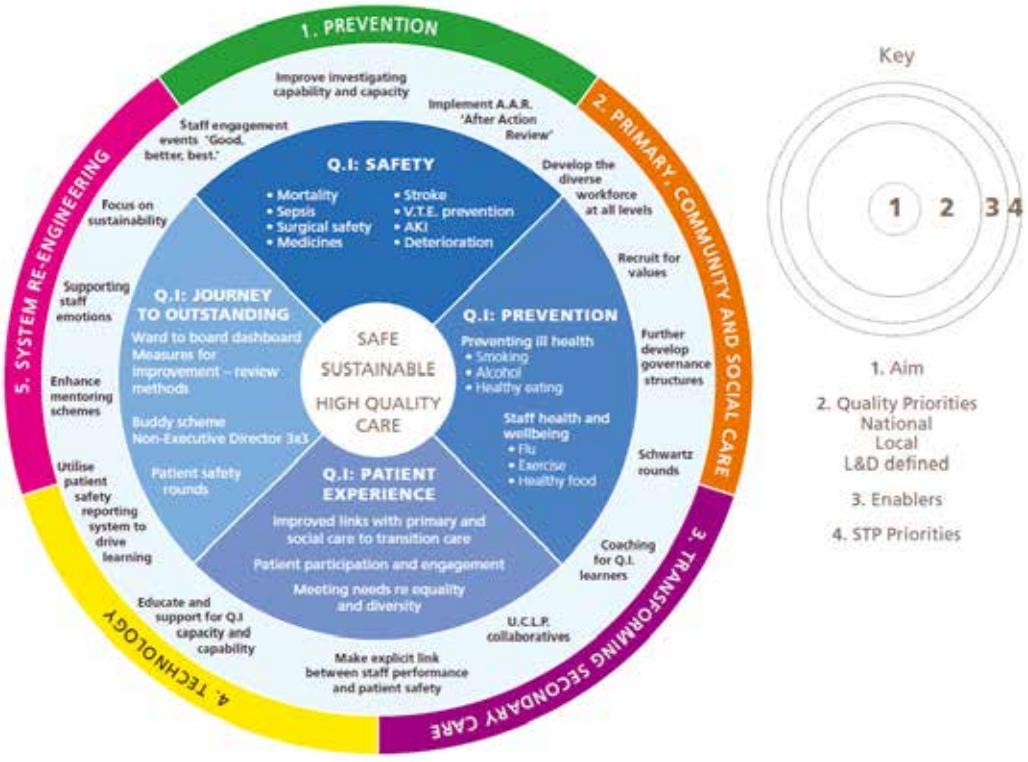
The CQC report was published in June 2016 and although the CQC Inspection Report did not mandate any actions for the Trust it did highlight a 'requires improvement' for safety.

Our ratings for Luton and Dunstable Hospital NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Overall	Requires improvement	Good	Good	★ Outstanding	★ Outstanding	Good

As part of the Trust commitment to patient safety we:

- Took some immediate steps to improve the environment for patients within the High Dependency Unit
- Reviewed our HSMR Action Plan and introduced new measures to understand variation and drive the learning across the Trust through Mortality and Morbidity Review meetings.
- Initiated processes to improve Continuity of Care and Needs Based Care which is a Quality Priority for 2017/18.
- Focused our Quality Priorities for 2016/17 on key areas for improvement e.g. VTE and Sepsis
- Used patient safety as a focus for the Staff Engagement Events in both July and December 2016.
- Invited the Institute for Healthcare Improvement (IHI) to complete a diagnostic and help us to develop our 'Advancing Safety and Quality Framework' and future strategy.
- Further collaboration with the IHI will be undertaken to support ongoing patient safety initiatives
- Re-launched a wider more focussed programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete a cycle of visits every two months against one of the CQC domains, starting with patient safety. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team. Our 'Advancing Safety and Quality Framework', the 'Quality Wheel', outlines the key five core themes with specific action areas needed to achieve our strategy for safe and high quality care. These provide a mechanism for refocusing current safety and quality improvement activities and designing goals for health service improvement.



Our Quality Impact Assessment process

The Trust has a Quality Impact Assessment procedure in place. All Cost Improvement Programmes (CIP) and service change proposals are subject to a Quality Impact Assessment.

The CIP / QIA processes:

- Provide robust assurance to the Trust Board that work is being undertaken to deliver the key financial sustainability targets, within a context that does not compromise delivery of clinical quality and care;
- Provide a means of holding to account those accountable for safe and effective delivery of CIP;
- Manage the delivery of sustainable financial balance through the Cost Improvement Programme;
- Provide a robust but fair challenge to the planning and performance of the programme ensuring that all projects have clear objectives, performance indicators, key milestones, savings targets (including phasing), timescales and accountability;
- Provide summary reports that highlight areas of concern and resultant contingency plans that have been implemented to mitigate the risks associated with the delivery of planned savings.

The Trust's position for undertaking risk assessment is outlined in the Risk Management Framework. The Trust's top 5 risks for 2017-18 are detailed in the Annual Governance Statement. With regards to the risk assessment of CIPs and associated QIAs, this includes an outline of the programme in detail and the associated assessment of the likely quality impact and financial impact, in line with NHS Improvement recommendations. The Executive Board oversees the programme. Internal Audit periodically review the process.

The triangulation of quality with workforce and finance

Scrutiny of triangulated data of quality, workforce and finance is undertaken at ward/departmental level, Divisional Level and by the Trust Board, with the analysis being used to prioritise quality and efficiency improvements.

Quality, Workforce and Financial indicators are shared and discussed at the Quarterly Public Board of Directors meeting and published on the Trust website www.ldh.nhs.uk/boardpapers. Furthermore, each month, there is detailed scrutiny of triangulated data by the membership of The Clinical Outcome, Safety and Quality Committee

(COSQ - a sub-committee of the Trust Board and Chaired by a Non-Director lead for Quality). Membership of COSQ and the Finance, Investment and Performance Committee include cross membership to ensure that there is oversight of each of the agendas through any decision making process.

The Trust continues to consider how information can be better presented to more clearly articulate to our Board and the public, the actions in place to address any areas requiring improvement.

The Trust uses the information collated to effectively make informed, evidence based decisions about future developments. For example, two major initiatives underway to address quality and efficiency and deliver better services for patients include the establishment of a haemato-oncology unit and the restructuring of our non-elective pathway to provide Needs Based Care.

Our Quality Improvement Implementation

The Quality Wheel was presented to staff attending the Good, Better, Best Event in December 2016. The central aim is for the delivery of safe, sustainable, high quality care. Around this aim sit four quality improvement (QI) domains namely: Safety; Prevention; Patient Experience and Journey to Outstanding. These four domains of quality improvement encompass a broad range of workstreams, many of which are already in progress or soon to begin and have been identified through national, local or Trust initiatives.

A number of enablers are identified as being required to support the quality improvement to maximum benefit for patients, staff and the organisation. It is vital to get the enablers in place and right for staff so that they are supported in their endeavours and that their endeavours are targeting Trust priorities and objectives. The Trust sees the benefits and rewards that staff gain from being involved in quality improvement programmes integral to how we value our workforce.

A number of developments are already underway including:

Schwartz Rounds: a review has been undertaken and a plan made to continue with further development over the next year.

University College of London Partnership (UCLP) collaborative: The Trust has committed to working with the Sepsis and AKI collaborative led by the University College of London Partnership (UCLP) for an extended period, until June 2017.

Educate and support for QI capability and capacity: A number of Trust staff are undertaking a national QI programme with the intention to train as trainers. Within the Trust, a first cohort of QI trainees is underway, the programme being led by our own accredited trainer supported by trainers from UCLP.

Utilise patient safety reporting system to drive learning: an extensive quality improvement programme is underway to redevelop and redesign the incident reporting system to create a system that is more streamlined and user friendly for both reporters, incident investigators and for those responsible for reviewing trends, themes and sharing the learning. The Head of Clinical Risk and Governance now manages the complaints team which will afford a more robust approach to triangulating the learning from incidents, complaints, claims and litigation.

Development of a Quality Improvement Faculty: The first steering group meeting has been held to consider our ambition to create a Faculty for Quality Improvement. The key aims of the Faculty were agreed as supporting:

- The development of groups of skilled individuals to undertake improvement projects
- Coordinated approach to Service Improvement
- Processes that will enable Divisional Governance Structures to support the Quality Improvement progress
- Prioritisation of improvement activity with a focus on delivering the corporate objectives
- the alignment of quality improvement work to key themes such as reduction in mortality and harm; improving the patient and staff experience; building a safety culture
- the use of recognised QI methodology to help staff deliver tangible outcomes
- the development of systems that provide support to those undertaking quality improvement, to include Improvement buddies, mentoring, coaching and celebrations of success
- Oversight of improvement projects – all individuals carrying out an improvement project should submit a project brief to ensure it is using established improvement methodology and consideration and support are given to help ensure success

The Faculty will enable the realisation of the following enablers from the Quality Wheel:

- Focus on sustainability
- Coaching for QI learners
- Enhanced mentoring schemes
- Educate and Support for QI capability and capacity

After Action Review
This established system for learning and staff support is to be adopted from its origin in UCLH. Four questions are asked by skilled facilitators: What should have happened? What actually happened? Why was there a difference between what should and what did happen? What is the learning? There are strict ground rules to support a meaningful experience for those participating. A plan is in development for the implementation over the next year coordinated by the Director for Medical Education and the Associate Director of Nursing (patient experience and quality).

Engagement Events – 'Good Better Best'

At the heart of the L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important was the large scale, trust wide 'Good, Better, Best' events where all staff came together to identify quality priorities and monitor progress in improving clinical outcome, patient safety and patient experience. The events also provided the opportunity to feedback the progress on quality, reflect on patient safety and the patient experience and hear about new initiatives for health and wellbeing and the Freedom to Speak Up Guardian.

Raising Concerns and Freedom to Speak Up Guardian

We have continued our focus on encouraging our staff to raise any concerns. In October 2016 we appointed a new Freedom to Speak Up Guardian. The new role was presented to over 2000 staff at the Trust Engagement Events. The role has a dedicated email and telephone number so that staff can access it confidentially. A report is made to the Board of Directors and an oversight of the process is reviewed by the Audit and Risk Committee.

5.3 Friends and Family Test

The organisation continues to participate in the Friends and Family Test (FFT), submitting information on a monthly basis to NHS England. We are also able to view other Trust's scores which enable us to benchmark our scores against both regional and national scores. We use the FFT to provide us with real time feedback from our patients and carers. The information continues to be reviewed for trends and themes across the organisation and at ward and department. There were no particular trends or themes noted from the information collected.

Response rates to the FFT have increased steadily throughout the year and various ways of collecting the data help to improve the number of responses. Not only do patients and their carers have the opportunity to complete response cards, we have also introduced iPADs making the information quicker to collect and analyse. We also rely on the link on our website and calls made from the Patient Experience Call centre. Volunteers have been extremely valuable in helping us to collect this data spending time on the wards and in clinics. Some areas have had a bigger challenge in collecting the data and where this is the case we have provided extra support to help improve their scores.

The FFT question has remained unchanged:

How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

And we continue to collect information from the same clinical areas as last year for adult and paediatric services. Those are;

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

A quarterly report of the patient experience feedback is reviewed at the Clinical Outcomes, Safety and Quality Committee and by the Patient and Public Participation Group.

Tables 1-4 show the percentage recommend scores across all areas of the Trust. These statistics are reported monthly to NHS England.

2016/17 has seen variable response rates for Friends & Family Test. In March 2017 the Trust achieved a response rate of 24.3% for inpatients which is an improvement from 18.5% in 2015/16.

The latest data published by NHS England shows the Trust remains comparable to the national average for response rate and recommend percentage. There was a slight reduction in response rate in Q3 but otherwise no significant difference was seen. We are assisted by volunteers who visit the inpatient wards to collect data. We continue to promote the importance of the Friends & Family Test, in order to monitor and manage improvements in patient experience and a Friends & Family Test Masterclass was held with all the ward sisters to raise the profile and understand the importance of the feedback from patients and how to use their feedback to make improvements.

Comparison	Total Responses	Total Eligible	Response Rate	Percentage Recommend	Percentage Not Recommend
England excluding independent providers (Q1)	215,706	866,254	24.9%	96%	2%
Trust (Q1)	1,207	4,473	27.0%	96%	2%
England excluding independent providers (Q2)	213,961	874,563	24.5%	97%	1%
Trust (Q2)	1145	4,502	25.4%	97%	1%
England excluding independent providers (Q3)	223,106	904,437	24.7%	95%	2%
Trust (Q3)	1,233	5,626	21.9%	96%	1%
England excluding independent providers (Q4)	201,533	827,936	24.3%	96%	2%
Trust (Q4)	1100	4533	24.3%	96%	2%

Table 1 Inpatients Percentage Recommend Scores 2016/17

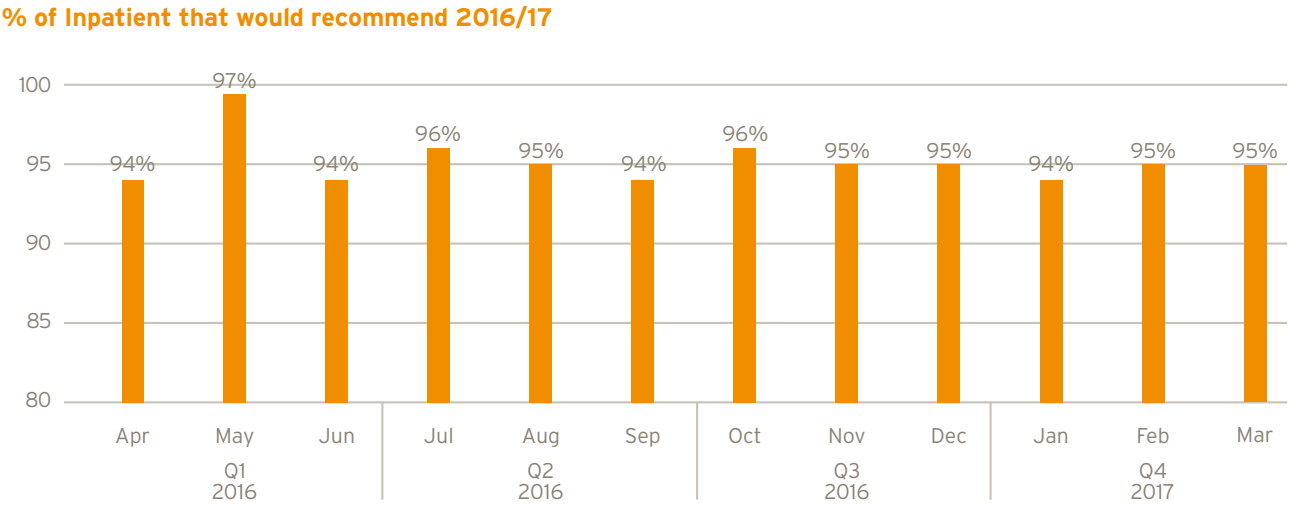


Table 2 Accident and Emergency Percentage Recommend Scores 2016/76

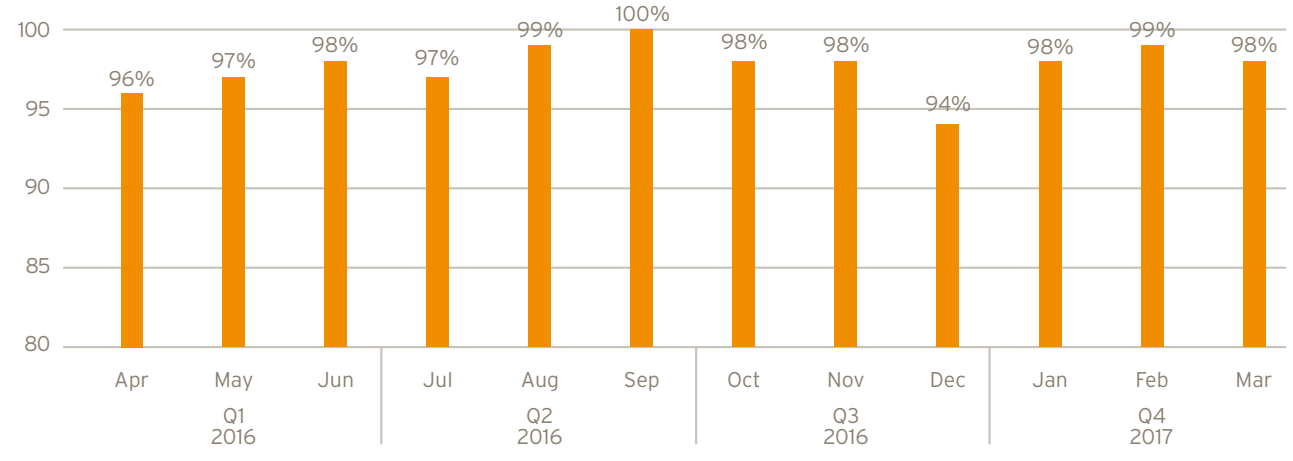


Table 3 Maternity Percentage Recommend Scores 2016/17

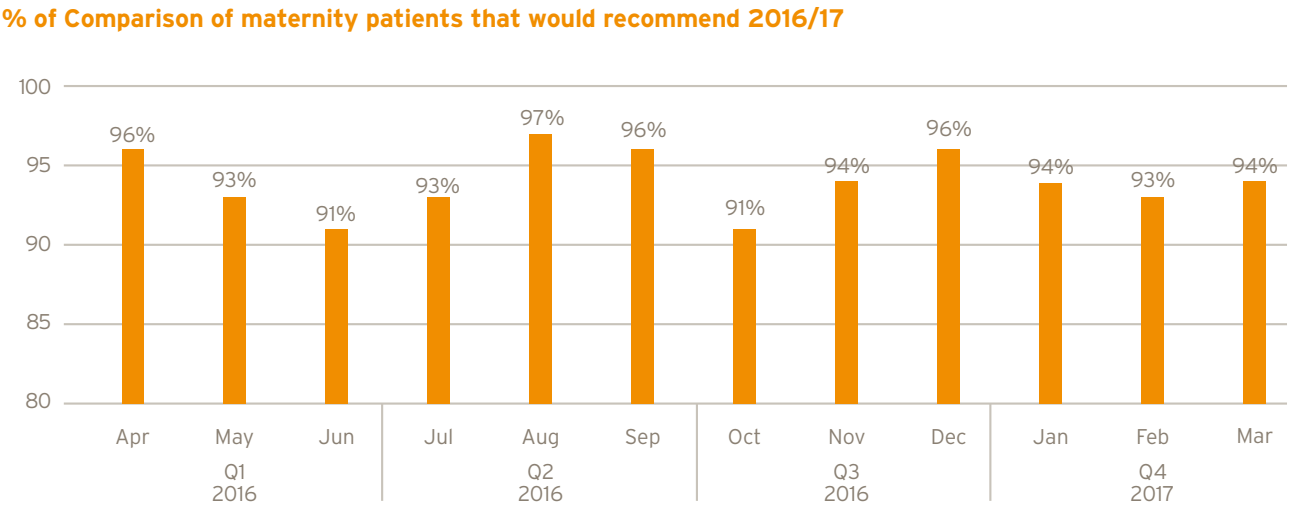
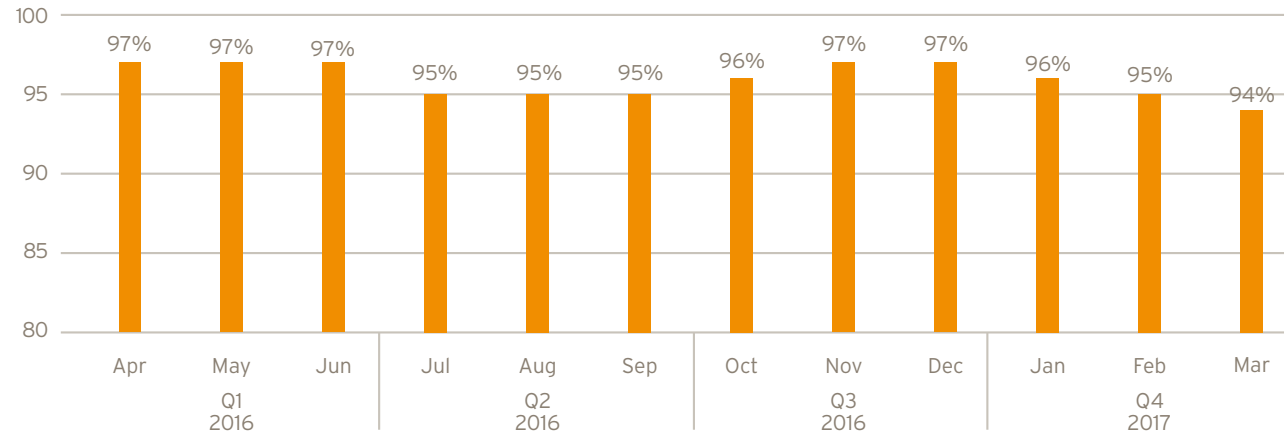


Table 4 Outpatients Percentage Recommend Scores 2016/17



The following are examples of action taken in response to feedback about individual wards:

- Reducing the risk of falls for patients by ensuring that they have a risk assessment completed within 6 hours of admission.
- Patients at risk of falls cohorted into one bay where possible to enable staff to monitor them more closely and easily.

Wards use the Quality and Safety Information Boards to report on the FFT recommend score and to display 'You Said/We Did' information for their patients to see. This information is updated monthly.

National Inpatient Survey 2016

The report of the L&D inpatient survey was received on the 31st May 2017 and the results detailed in the table below are published by the Care Quality Commission. Detailed management reports are shared internally and a programme of work will be developed and monitored at Clinical Outcomes, Safety and Quality meetings. Patients who were treated in July 2016 were surveyed. The Trust had a response rate of 43% against a national average of 44%.

Results of the national in-patient survey 2016

The emergency / A&E department, answered by emergency patients only	8.4	8.4	8.2	8.6	8.5	Decreased	The same
Waiting lists and planned admission, answered by those referred to hospital	9.0	9.1	8.9	8.8	8.8	No change	The same
Waiting to get to a bed on a ward	7.0	6.5	7.1	7.3	6.7	Decreased	Worse
The hospital and ward	8.1	8.1	8.0	8.0	7.6	Decreased	The same
Doctors	8.2	8.4	8.4	8.3	8.3	No change	The same
Nurses	8.1	8.2	8.1	8.3	7.7	Decreased	The same
Care and treatment	7.5	7.6	7.6	7.7	7.5	Decreased	The same
Operations and procedures, answered by patients who had an operation or procedure	8.3	8.2	8.4	8.4	8.5	Increased	The same
Leaving hospital	7.0	7.1	6.8	6.8	6.8	No change	Worse
Overall views and experiences	5.5	5.5	5.5	5.3	5.2	Decreased	The same

Note all scores out of 10

Hospital and Ward category asks questions about cleanliness, hospital food and sleeping areas. The category Doctors and Nurses includes questions on confidence and understanding staff and Care and Treatment covers privacy, information on treatment and decisions about care.

Patient Stories and Improvements following patient feedback.

Story One

Learning Disabilities

A patient who had severe learning disabilities and autism was admitted to ward 21. He had several needs relating to these diagnoses that made the hospital setting very difficult for him. Ward staff responded to these by making the following reasonable adjustments.

1). At a time when the patient was feeling particularly anxious, the ward sister found out that he likes washing machines (and other appliances!) and so showed him around the sluice room as a way to distract him from the things making him anxious.
2). Familiarity was extremely important, so the ward supported the patient's carers to bring in his own bedding from home.
3). He was given a side room, as noise, strangers and busy environments were extremely hard for him to manage, and he was able to leave the ward with a carer at regular intervals (e.g. to visit the canteen).
4). Ward staff responded in a very quick and considerate manner to his carer's needs; giving them regular breaks, enabling them to stay overnight with the patient, and keeping them up to date with his care.

Without these adjustments the family feel that he would have left the ward, and behaved in a way that would have become increasingly challenging for the ward staff to manage

Story Two

Distraction Toys

An 11 year old child was booked into the Paediatric Emergency Department with a mental health issue. The patient was triaged within fifteen minutes of arrival by a nurse. At triage it became apparent that this child and family were having a troubled time, the patient had expressed suicidal ideation and there was evidence of planning again. The family had been engaging with the community Mental Health Teams as the patient had been becoming more withdrawn,

however a crisis response was not immediately available, this is why they attended the Emergency Department.

The nurse was able to offer the family a side room where they could sit without the distress of sitting in the busy waiting room. The nurse tried to engage by offering some distraction toys that the department owns. The child was not interested in watching DVD's and the other toys were more suitable for toddlers. The child said that he would rather play a board game; this is something the department doesn't have.

The child was referred to the child and adolescent mental health service (CAMH) and seen the following morning after an overnight stay as the referral was made out of hours.

The nurse from the Emergency Department was left feeling that more could have been done to put the child at ease and make his time in the Emergency Department more bearable. As a result the department now has a box of toys and games suitable for this age group and is intended for patients presenting with mental health problems. CAMH have also started a pilot trialling an extension to their hours of cover. The aim is to ensure children are seen more quickly and receive definitive management.

Improvement One

ITU Memorial Service
A non-religious service was held in the hospital chapel, having been organised by one of the Healthcare Assistants from ITU. The main aim of the service was to allow relatives and friends of those who had died in ITU over the previous year, to come and remember their loved one whilst gaining support from staff who had cared for them during their stay. The staff involved in organising and holding this service do so in their own time and on a purely voluntary basis.

The most recent service was held in October and was attended by approximately 40 relatives. The order of service included poems read by staff, the reading out of the names of those who had died and a few words said by the Hospital Chaplain. The relatives were given an opportunity to light a candle for their loved one and to say a few words if they wished to.

Following the service, the relatives were shown to a room in the Comet centre where they were served with refreshments brought in by staff.

Some of the feedback we received following this service was that 'it was a beautiful service, you have done us proud', 'a wonderful caring organisation of a delicate service' and 'found it comforting and healing'

Improvement Two

"Please Call, Don't Fall"

As part of their Safeguarding Champions course, delegates are set a project to identify an area in their workplace that could be a safeguarding issue and to then look at ways of improving practice to reducing the risks.

Two nurses recognised that whilst staff aim to promote independence in activities of daily living, the variety of health conditions that affected their patients potentially increased the risk of falls particularly in bathrooms and toilets.

They have created an information poster to be placed in bathrooms and toilets to raise both patient and staff awareness of the risks. The poster explains how to keep safe and asks patients to call if they need help.

We plan to display the poster in all patient areas to promote a Trust wide patient safety message around falls prevention.

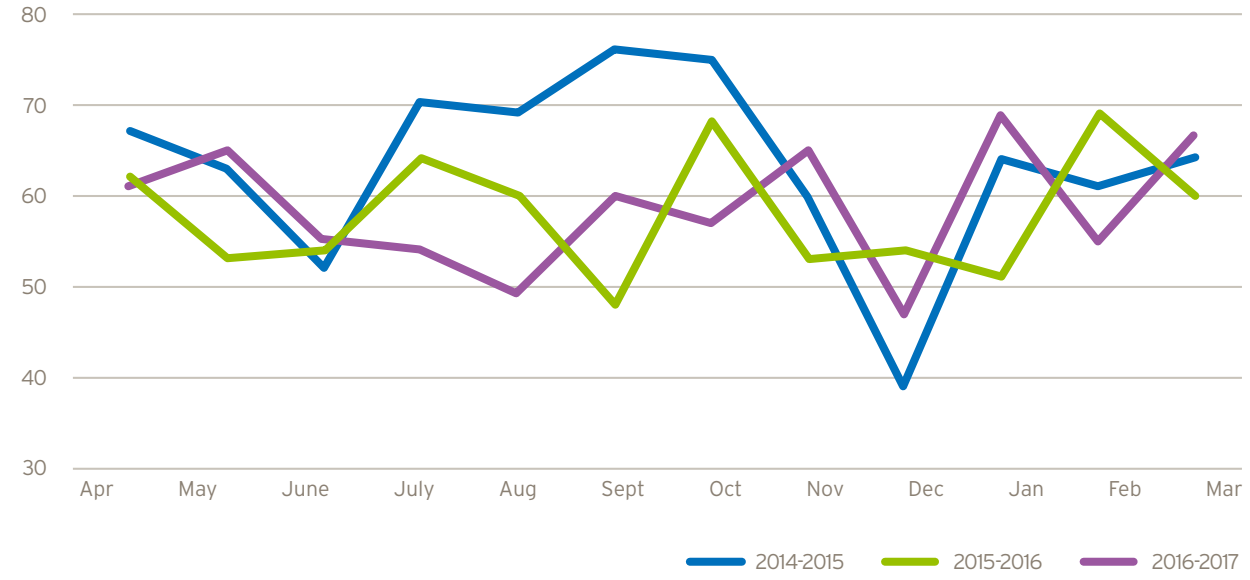
5.5 Complaints

During 2016/17 the Trust has concentrated on developing a process which allows the learning from complaints to be shared with staff and we have continued to welcome patient feedback. Following review of the Complaints and Concerns Policy in 2016 there has been a continuing focus to ensure that we efficiently answer complaints and concerns in a timely manner and continually use this information to improve our services.

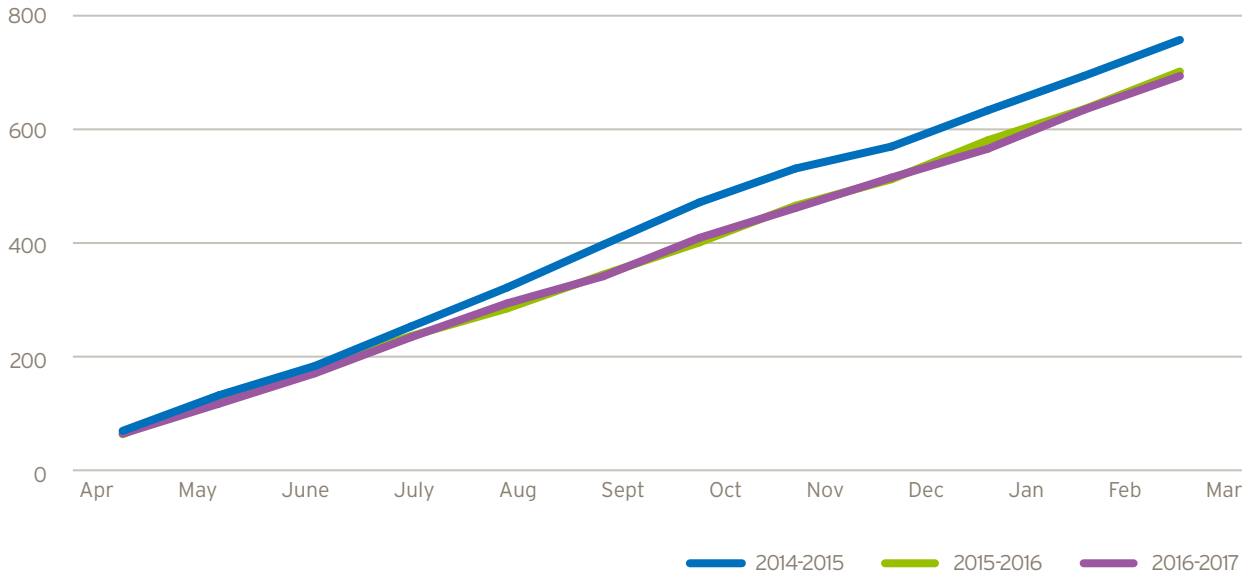
The Trust has made significant efforts to resolve people's concerns quickly, thereby reducing the need for them to follow the formal complaints process.

During 2016/17 we received 704 formal complaints compared to 696 in 2015/16 and 760 in 2014/15. Whilst the number of complaints has remained static, with no significant increase or decrease, it is recognised that there is a heightened public awareness of the option to complain.

Formal Complaints - 2014/15 to 2016/17



Formal Complaints received in 2016/17 ompared with 2014/15 and 2015/16 (Cumulative)



We continue to make improvements to our reporting and investigation of complaints by implementing the use of the recommended coding from NHS Digital. As we enter the new financial year, this will help us to better understand the nature of our complaints so that we can deal with them well in a timely way.

This will also enhance our internal and external reporting, highlighting specific areas where we can improve.

We have improved the way we acknowledge complaints. We work hard to acknowledge all complaints within 3 days and have achieved over 97% with 100% achieved in 4 out of the 12 months. It is not always possible to formally acknowledge a complaint within 3 days if the complaint has been raised via the hospital's website and not all relevant details are available. The information required when submitting a complaint has now been highlighted on the hospital website to prevent unnecessary delay.

We aim to respond to complaints within 35 days but this has been difficult to achieve in some cases, often because of reasons outside of the investigators control. The Patient Affairs Team currently sends out a weekly report of breached responses to the divisions but to help us meet the target in 2017/18 we are developing a tracking system to monitor complaints through each stage of the complaints process. In 2017/18 the weekly report will include the status of all open complaints.

The monitoring and tracking of complaints handling is now part of the Divisional Performance Meeting monitoring agenda and the Board maintain oversight and are committed to increasing the response times.

In 2016/17 we re-opened 73 complaints. The graph below shows the number of formal complaints re-opened in comparison to the number received. Our aim for 2017/18 is to reduce the number of re-opened complaints by ensuring 'first time right' responses.

Formal Complaints received versus reopened for 2016/17

Learning from Complaints

This year we have strengthened our complaints process to ensure that we are learning from complaints to improve the services we provide. Complaints where recommendations have been made have an action plan that is monitored by the divisions with assurance provided to the Complaints Board. Below are examples of some of the improvements made during 2016/17:

- There were concerns raised about clinics over-running and clinicians seemed distracted at times. As a result of these concerns, the number of patients seen in a clinic has been reduced to a more manageable number with an increase in the number of clinics. Longer clinic appointments are now available so that patients have time to discuss their concerns with the clinicians without feeling hurried.

- We received a complaint about poor patient experience at discharge following day case surgery where insufficient pain medication had been supplied. As a result of this complaint, the 'pain score' is now recorded for all patients admitted as a day case and they are not discharged unless the pain score is below 3/10.

- We have introduced a red flag system in the surgical division for clinic letters to be typed urgently where a patient needs imaging prior to a scheduled appointment or procedure. This has meant that patient experience is improved, delays prevented, and avoids waste of NHS resources.

Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. The top themes of complaints related to clinical treatment, delays, communication and attitude of staff.

In 2016/17 all complaints were thoroughly investigated by the General Manager for the appropriate division and a full and honest response was sent to the complainant.

The majority of complaints were resolved at local resolution level, with 8 complainants requesting the Parliamentary and Health Service Ombudsman (PHSO) review their complaints. Of these 8 cases the PHSO investigated 7. Five complaints were 'not upheld' and 2 complaints were 'partly upheld'.

In 2017/18 we also aim to:

- Promote informal and prompt resolution of concerns at a local level thereby reducing the number of formal complaints and improving patient experience
- Raise the profile of complaints within the Trust via newsletters and training
- Where investigators are having difficulty completing investigations due to circumstances outside their control they will be asked to work closely with the Patient Affairs Team to keep complainants updated and negotiate extensions where appropriate

Compliments

During the reporting period over **6,500 compliments** were received about our staff and our services.

Below are some extracts taken from the compliments we received:

'The reason that I am writing to you is to bring to your attention the wonderful treatment that I recently received when I attended for a breast screening assessment in January 2017.

I had a recall from a mammogram. This was obviously a very anxious time for me waiting for my second assessment.

I arrived early for my assessment and was seen very promptly. The nurse was delightful and so very reassuring. An assessment was carried out by the doctor who was absolutely wonderful, making me feel calm and relaxed. It was a real pleasure to meet such a professional and caring team of people.'

'Please pass on my thanks for the excellent treatment I have received. From first appointment to follow up appointment I've had very respectful treatment. I also like the fact that I had a 19.00 hours appointment. This was very convenient for me as it meant no time off work. Thank you.'

'I just wanted to say a huge thank you to everyone who was involved in my 11 year olds care last night and this morning. He had to have emergency surgery in the early hours of this morning and my husband said everyone involved was fantastic, caring and informative - so thank you, you all do such an amazing job and we are very lucky to have you all and the NHS!'

'I was admitted through A&E in January 2017 and wanted to say how excellent the care and treatment I received was. I could not have asked for more. I was seen immediately, and had lots of tests but every step was explained to me, the nursing staff hardly left me but if they did someone was always checking I was ok. I want to say thank you. In this difficult time for the NHS I could not have asked for more and wanted to pass on my thanks.'

5.6 Performance against Key National Priorities 2016/17

		2013/14	2014/15	2015/16	2016/17	Target 16/17
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	19	10	11	8	6
MRSA	To achieve contracted level of 0 cases per annum	3	3*	1	1	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	99.8%	100%	100%	99.9%*	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	91.5%	91%	88.4%	88.6%*	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.7%	95.5%	95.8%	96.4*	93%

		2013/14	2014/15	2015/16	2016/17	Target 16/17
Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	100%	98.9%	98.6%	100%*	94%
	Anti-cancer Drugs	100%	100%	99.8%	100%*	98%
Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	96.5%	96.9%	96.3%	93.2%	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.4	98.6%	98.6%	98.8%	95%
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	N/A	N/A	N/A	0.7%	<1%

* Public Health England Healthcare Acquired Infection Surveillance Group identifies the number of MRSA bacteraemia "allocated" to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
** currently to February 2017 – March data to be added in May 2016

5.7 Performance against Core Indicators 2016/17

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

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time, divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality; however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. The L&D is a provider of level 3 Neo-natal 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. Other benchmarking data is used to provide assurance on performance and data is also subject to on-going review. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' rather than the numerical codes which correspond to these bandings

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
Value and banding of the SHMI indicator	Published Apr 13 (Oct 11 -Sep 12)	As expected	As expected	Not Avail	Not Avail	2
	Published Jul 13 (Jan 12 - Dec 12)	As expected	As expected	Not Avail	Not Avail	2
	Published Oct 13 (Apr 12 -Mar 13)	As expected	As expected	Not Avail	Not Avail	2
	Published Jan 14 (Jul 12 - Jun 13)	As expected	As expected	Not Avail	Not Avail	2
	Published Oct 14 (Apr 13 -Mar 14)	As expected	As expected	Not Avail	Not Avail	2
	Published Jan 15 (Jul 13 - Jun 14)	As expected	As expected	Not Avail	Not Avail	2
	Published Mar 16 (Sep 14 -Sep 15)	As expected	As expected	Not Avail	Not Avail	2

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level (The palliative care indicator is a contextual indicator	Published Mar 17 (Sep 15 -Sep 16)	As expected	As expected			2
	Published Apr 13 (Oct 11 -Sep 12)	12.4%	19.2%	0.2%	43.3%	***N/A***
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 -Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 - Jun 13)	12.6%	20.6%	0%	44.1%	N/A
	Published Oct 14 (Apr 13 -Mar 14)	13.7%	23.9%	0%	48.5%	N/A
	Published Jan 15 (Jul 13 - Jun 14)	14.7%	24.8%	0%	49%	N/A
	Published Mar 16 (Sep 14 -Sep 15)	13.8%	26.7%	0%	53.5%	N/A
	Published Mar 17 (Sep 15 -Sep 16)	26.2%	29.6%	0.4%	56.3%	N/A

The Luton and Dunstable University Hospital considers that this data is as described for the following reason:

- This is based upon clinical coding and the Trust is audited annually.
- The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- Mortality rates remain as expected and other benchmarking, including HSMR remains one of the Trust quality priorities for 2016/17 and the Mortality Board maintains ongoing oversight of any indicators that flag as an outlier.

Indicator: Readmission rates

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 the Trust during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 - 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2010/11	10.16	11.17	13.00	0.0%
	2011/12	10.64	11.26	13.50	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:

- This is based upon clinical coding and the Trust is audited annually.
- The Trust does not routinely gather data on 28 day readmission rates
- The Luton and Dunstable University Hospital has taken the following actions to improve this percentage, and so the quality of its services, by:
- We will continue to work with our commissioners to prevent unnecessary readmissions to hospital through admission avoidance services available for patients to access. These include Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team, the Hospital at Home service, provider support in the Emergency Department and the integrated models of care

*The most recent available data on The Information Centre for Health and Social Care is 2011/12 uploaded in December 2013.

Indicator: Patient Reported Outcome Measures (PROMs) scores

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.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Groin hernia surgery	2010/11	0.110	0.085	0.156	-0.020
	2011/12	0.12	0.087	0.143	-0.002
	2012/13	0.09	0.085	0.157	0.014
	2013/14	0.079	0.085	0.139	0.008
	2014/15	0.088	0.081	0.125	0.009
	2015/16	**	0.088	0.13	0.08
	2016/17*	0.079	0.089	0.161	0.016
Varicose vein surgery	2010/11	**	0.091	0.155	-0.007
	2011/12	**	0.095	0.167	0.049
	2012/13	**	0.093	0.175	0.023
	2013/14	**	0.093	0.15	0.023
	2014/15	**	0.1	0.142	0.054
	2015/16	**	0.1	0.13	0.037
	2016/17*	**	0.099	0.152	0.016
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14	0.369	0.436	0.545	0.342
	2014/15	**	0.442	0.51	0.35
	2015/16	**	0.45	0.52	0.36
	2016/17*	**	0.449	0.522	0.329
Knee replacement surgery	2010/11	0.325	0.299	0.407	0.176
	2011/12	0.313	0.302	0.385	0.181
	2012/13	0.321	0.319	0.409	0.194
	2013/14	0.297	0.323	0.416	0.215
	2014/15	**	0.328	0.394	0.249
	2015/16	**	0.334	0.412	0.207
	2016/17*	0.29	0.337	0.430	0.260

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- Results are monitored by the Clinical Audit and Effectiveness Group
- Results are monitored and reviewed within the surgical division

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:
- Reviewing these results in both high level committees and within the surgical division.
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings.
- Patient level data is scrutinised and surgical team performance reviewed. The Trust completed a review in April 2015 that identified no concerns at the patient level.
- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

* Relates to April to September 2016 (most recent data published in February 2017 by HSCIC)
** Score not available due to low returns

Indicator: Responsiveness to the personal needs of patients during the reporting period

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	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Responsiveness to the personal needs of patients.					
	2010/11	65.6	67.3	82.6	56.7
	2011/12	64	67.4	85	56.5
	2012/13	67.5	68.1	84.4	57.4
	2013/14	65.6	68.7	84.2	54.4
	2014/15	66	68.9	86.1	59.1
	2015/16	74.2	77.3	88	70.6
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- The source of the data is the National In-Patient Survey.

The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- Continued implementation of Electronic Prescribing system and that has improved timeliness of available medications for patients to take home
- On-going refurbishment programme to assess the high risk environmental areas that need attention particularly toilets and bathrooms
- On-going monitoring of patient feedback from the Patient Experience Call Centre and Friends and Family feedback

*The most recent available data on The Information Centre for Health and Social Care is 2015/16

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	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of staff who would recommend the Trust as a provider of care to family and friends when compared to other acute providers.	2010/11	57%	66%	95%	38%
	2011/12	57%	65%	96%	33%
	2012/13	61.5%	63%	94%	35%
	2013/14	67%	67%	89%	38%
	2014/15	67%	65%	89%	38%
	2015/16	72%	70%	*	*
	2016/17	77%	70%	95%	45%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- The source of the data is the National Staff Survey.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:
- The hospital runs with a clinically led, operating structure.
- The Chairman and Non-Executive Directors have a programme of clinical visits and the experiences of each visit is reported to the Clinical Outcomes, Safety and Quality Committee.
- Transforming Quality Leadership Group in place and supports areas across the Trust through a 'buddy' process.

* Not available on the HSCIC website

Indicator: Risk assessment for venous thromboembolism (VTE)

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of patients who were admitted to hospital and who were risk assessed for VTE.					
	2010/11 – Q4	90.3%	80.8%	100%	11.1%
	2011/12 - Q4	96.1%	92.5%	100%	69.8%
	2012/13 – Q4	95.3%	94.2%	100%	87.9%
	2013/14 – Q4	95.1%	96.1%	100%	74.6%
	2014/15 – Q4	95%	96%	100%	74%
	2015/16 – Q3	95.7%	95.5%	100%	94.1%
	2016/17 – Q3	95.74%	95.64%	100%	76.48%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- There is a robust process for capturing the evidence of completion

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:
- The hospital has and will continue to ensure that all clinical staff are aware of the importance of timely VTE risk assessment of patients. This is undertaken at induction and through clinical bedside teaching.
- There is daily clinical review and for any patient that have not been risk assessed, there is a follow up action to ensure that this is undertaken; this has resulted in achieving 95% and above throughout 2016/17.
- We have implemented an electronic solution to the risk assessment process.
- We undertake root cause analysis on all patients who develop a VTE.

Indicator: Clostridium difficile infection rate

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

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Rate for 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	5.1	15.1	62.2	0
	2015/16	5.4	14.9	66	0
	2016/17	3.5+	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The accuracy of the data is checked prior to submission. The data is also cross checked with laboratory data and verified before reporting to the Board.
- The Trust had 8 C.difficile for 2016/17 and this figure is one of the lowest numbers in the country.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- maintaining C.difficile high on the training agenda for all healthcare staff
- rigorously investigating all cases of C.difficile through the RCA mechanism and actioning all learning points identified
- assessing all patients suspected of C.difficile infection when alerted
- uncompromisingly isolating suspected cases of C.difficile when first identified
- attending the CCG Infection Control Network with its potential for shared learning
- monitoring high standards of environmental cleaning (including equipment) and exploring other mechanisms of reducing C.difficile contamination further

*Data not available on Health and Social Care Information Centre
+ Local Data

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	L&D Score	National Average	Lowest score (worst)	Highest score (best)
Total number and rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute trusts	2010/11	**	**	**	**
	2011/12	**	**	**	**
	2012/13	**	**	**	**
	2013/14	**	**	**	**
	2014/15	37.52	35.1	17	72
	2015/16	32.2	39.6	14.8	75.9
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*

Total number and rate of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2010/11	0.03	0.04	0.17	0
	2011/12	0.03	0.05	0.31	0
	2012/13	0.03	0.05	0.26	0
	2013/14	0.03	0.05	0.38	0
	2014/15	0.25	0.19	1.53	0.02
	2015/16	0.09	0.16	0.97	0
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The hospital reports incident data and level of harm monthly to the National Reporting and Learning System
- 22 Serious Incidents were reported in 2016/17 compared with 32 in 2015/16, 46 in 2014/15 and 36 in 2013/14 (excluding pressure ulcers). One incident was downgraded in 2016/17 by the CCG on receipt of the investigation findings which identified that there were no acts or omissions in care that contributed to the outcome for the patient.
- The Trust reported 2 Never Events in 2016/17 under the following Department of Health criteria - a wrong implant/ prosthesis, a wrong site surgery.
- The Trust is contractually required to notify its Commissioners of a Serious Incident within 2 working days of identification – in 2016/17 this target was met in 18 out of 22 cases (82%) compared to 21 out of 32 cases (66%) in 2015/16.
- The Trust is also contractually required to submit an investigation report for all Serious Incidents within 60 working days of the notification. During 2016/17 this target was met in 17 out of 19 cases (89%) compared to 20 out of 26 cases (77%) in 2015/16. Three incidents were still under investigation at the time of data collection but it is anticipated that these will all meet their deadlines for submission.
- The Trust continues to review its systems and processes to ensure it can meet the contractual requirements going forward.
- The Trust was 100% compliant with the Duty of Candour contracted requirements.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- The hospital has a low level of serious harm or death, however strives to continue to improve this through improved falls prevention, pressure ulcer avoidance mechanisms and improved learning from serious incidents.
- The hospital is a high reporting organisation and this demonstrates a culture of patient safety and openness. The hospital continues to ensure that patient safety is a quality priority and will continue to drive improvements.
- Learning from incidents is shared through Divisional Governance, Grand Rounds and Safety Briefings. Patient Safety Newsletters are issued to all staff each quarter and include a focus on learning from Serious Incidents. Examples of learning:
  - We have put in place closer monitoring of skin checks by Senior Nursing Staff
  - We have introduced Paediatric High Dependency training days with skills stations
  - We have introduced an intubation check list to introduced for Paediatric Emergency Intubation
  - We have increased the level of support offered to new consultants in surgical specialties
  - We have updated the WHO safer surgery checklist for cataract surgery to include a documented intraocular lens power
  - We have introduced a multi-factorial falls risk assessment
  - We have raised awareness of the early recognition and treatment of sepsis using agreed standards and protocols

*Data not available on Health and Social Care Information Centre
** NRLS amended their calculation from per 100 bed days to per 1000 bed days in 2013 so no comparable historical data available

5.9 Embedding Quality – Workforce factors

Our success is delivered through our people and as such our staff continue to be our most valuable asset when it comes to delivering clinical excellence, quality and safety to our patients. We strive to achieve this through many different routes, including delivery of learning and development; good leadership and good communication. This journey starts from the point that an individual applies for a post with us and continues through their employment with the Trust.

Recruitment and Resourcing

Assistant Practitioners
As a Trust we recognise that there are national challenges in recruiting to band 5 Registered Nurse positions. As per Carter (2016) recommendations, we are trying to make best use of resources and develop new ways of working to address this. One initiative that we have firmly embedded is the use of band 4 Assistant Nurse Practitioners (ANP). Currently we have 31 WTE ANPs employed in the Trust. They can be seen working in areas such as Medicine, Surgery and Paediatrics. These staff are vital in supporting our registered nursing staff to deliver safe, quality patient care. Following our success with this, we will be the 'fast followers' for the NMC band 4 implementation programme. It is envisaged that these staff will be supported to move through the registered nurse training pathway. As such this will help us 'grow our own' and go some way towards reducing our vacancies. This is a great opportunity for us to support our local community members who wish to become nurses, but may not be able to do so as a result of the removal of the nurse training bursary.

Role of the Workforce Nurse
In April 2016 we introduced a corporate nursing role; Nurse Lead for Workforce. This role has been active in helping the Recruitment team deliver the vision of the right staff, in the right place, with the right skills at the right time. The role has seen changes to the recruitment process of clinical staff, competency monitoring, revalidation compliance and robust management of the temporary workforce. The role has been pivotal in ensuring communication between the Recruitment and Resourcing, E-Rostering and Corporate Nursing teams.

Registered Nurse Recruitment
We continue to face a challenge when recruiting to band 5 registered nurse posts in particular. This is due to national shortages and changes in service requirements in order to deliver safe care in our acute hospital.

Numerous approaches are being undertaken to try and address this situation. These include the use of local and national advertising, social media, overseas recruitment and the promotion of nursing careers at local career fairs at schools, colleges and universities.

Proactive recruitment activity continues with both targeted and expedient campaigns running monthly. The Trusts overseas recruitment programme saw events held in Italy, Singapore, Spain and Portugal. However, the high International English Languages Test (IELTs) and Objective Structured Clinical Examination (OSCE) requirements remain a challenge. Subsequently the length of time for these nurses to commence in post remains protracted due to the amount of time it takes the for all the stages to be completed and for the Nursing and Midwifery Council to process the applications for registration.

New starter questionnaires
In order to understand new staff members experiences better and to assist the Trust to improve staff experience a new starter questionnaire was introduced. All new staff are asked to complete a questionnaire commenting on their findings of both the recruitment process as well as their experiences during their first weeks at the Trust. This information is then reviewed to consider what improvement could be made to the recruitment/ induction process.

Health Care Assistants (HCA's)
The Trust has continued with bi-monthly Healthcare Assistant campaigns. These have been very successful and have resulted in the majority of vacancies being filled. At present we are continuing these campaigns to allow for attrition and changes in services.

In order to support the Trust's vision to meet the apprenticeship requirements, and to deliver an alternative route for staff into nursing, we have introduced a literacy and numeracy assessment for all potential HCA candidates. The shortlisting criteria have been revised and we have implemented strength based interviewing which has resulted in an increase in the calibre of HCAs recruited.

Agency Collaboration
Since the implementation of the national NHS Improvement (NHSI) agency rules the Trust has been working collaboratively with trusts across Bedfordshire on joint tendering and common processes to ensure best value without risks to patient safety. Since inception this project has delivered savings of £2m to the trust

and was recognised with a highly commended award in the 'collaboration' category at the Healthcare Supply Association Awards in November 2016.

Consultant Job Planning

The Trust recognises the importance of ensuring alignment between meeting patient demand and the availability of senior medical staff. Following a refresh of the Trust's Job Planning Principles and Guidance, the Trust has embarked on a project to ensure all consultant job plans are up-to-date and representative of service needs 7 day a week, 365 day a year. Dedicated project support has been procured to ensure due focus on completion of the project. To provide a clean baseline for future timetable adjustments, and to ensure clinical leaders and general managers are fully equipped to manage the on-going job planning process, and to make best use of the Health Medics / Allocate job planning software. The Trust's Job Planning Assurance Group meets monthly to provide oversight and scrutiny of all job plans and a final approval process which has been designed to ensure a fair and consistent approach across the Trust.

Junior Doctor Contract

During 2016 the roll out of the new Junior Doctors Contract commenced and this will continue during 2017, with phased transition for all trainees in line with NHS Employer's timeline. The Trust appointed a Guardian of Safe Working and also established a Junior Doctors Implementation group that includes the Guardian of Safe Working, Director of Medical Education , Junior Doctors, General Managers, Finance and HR. The focus of the group is to ensure a smooth transition to the new contract by engaging with and listening to our Junior Doctors. The group also ensure that all actions are communicated to relevant staff who may be directly impacted by new contract. The Medical Workforce team regularly attend the Regional Medical Personnel Specialist group meetings to ensure there is parity and shared practice with other local Trusts.

Managing Absence

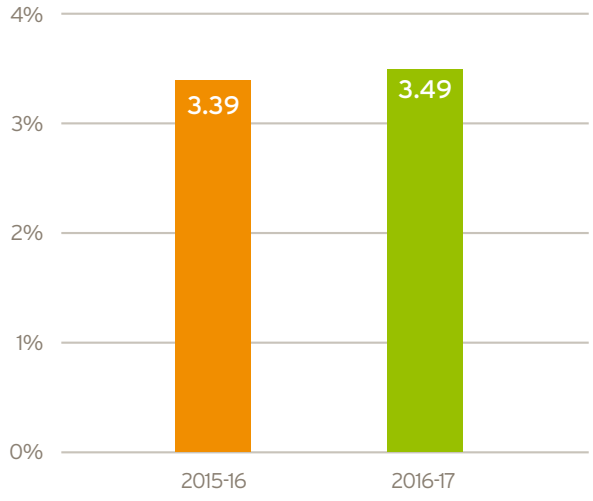
In October 2016, the Trust reduced the Bradford Score trigger point from 200 to 150 as a way of managing employee attendance more effectively through providing earlier formal support and continuing to deliver against the Trust's operational requirements.

Since the introduction of the sickness absence project the Trust has seen a reduction in staff with a Bradford Score of >200 from approx. 540 (in 2013) to a figure of between 325 and 350 cases. The focus on managing absence has also led to a considerable change in mind-sets and behaviours; an increase in the number of stage 2 formal sickness absence meetings has increased from 27% in 2013 to approx. 70% meetings being held in 2016 and an improved use of return to work interviews. With the recent reduction in the Bradford score trigger point, it is anticipated that the continued benefits of this will include:

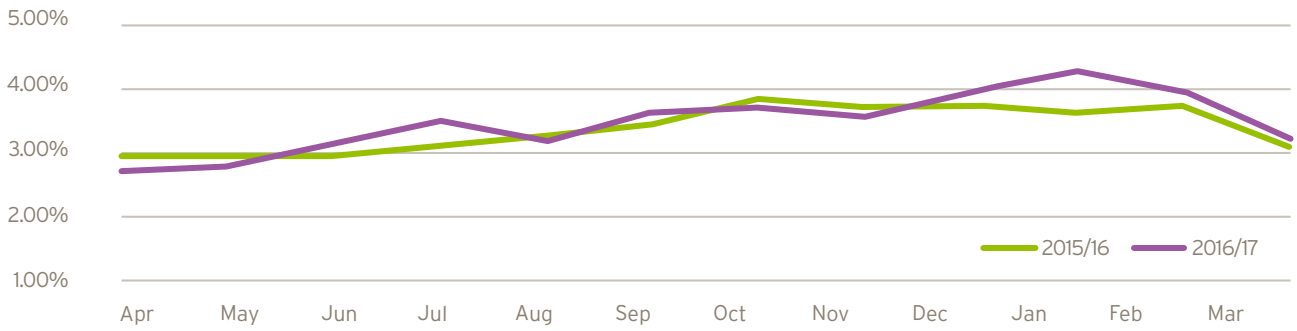
- Suitable support mechanisms and appropriate, reasonable adjustments implemented at an earlier stage, allowing employees to achieve and maintain maximum attendance;
- A reduced absence rate resulting in alleviating staffing pressures on wards and departments;
- A reduction in costs associated with sickness absence and subsequent bank and agency usage, with this money being reinvested back into patient care;
- Earlier intervention in sickness absence cases with less progressing to a formal hearing stage.

As a result of this focus, the Trust continues to have one of the lowest sickness absence rates of any acute Trust in the East of England and one of the leading Acute Trusts across NHS England when it comes to sickness absence rates.

Full Year Sickness Absence Rates 15/16 vs 16/17



% Sickness absence rates



Staff Engagement and Consultation
The L&D takes pride in having a healthy and productive relationship with staff and this is reflected in the staff engagement scores in the Staff Opinion Survey, where this year was again higher than the national average, with our overall staff engagement scores placing us in the top 20% of Trusts.

The feedback for recognition and value of staff by managers and the organisation, Staff motivation at work and the organisation and management interest in and action on health and wellbeing also placed the L&D in the top 20% of Trusts.

Partnership working is demonstrated in many ways, for example:

Staff Involvement Group
This focus of this group is on developing a culture of staff involvement, open communication and partnership working with factors that have a real impact on staff such as reward and recognition, security, health and wellbeing. The membership of the group is diverse and members are active in taking forward themes from the staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.

Staff Recognition
There have been a number of opportunities over the year to thank staff and volunteers for their contributions. In particular:

- In recognition of their long service, staff are invited to an awards event at Luton Hoo Hotel bi-annually. This is the Trust Board's way of thanking staff who made a significant contribution to the Trust over the last 25 or 40 years. The event continues to be supported by the Charitable Funds
- During National Volunteers week which is held in June 2016, we arranged a picnic in the park for our volunteers, which was a very enjoyable day. A further event was held in January 2016 where 80 volunteers enjoyed an afternoon of Pantomime at a local theatre.

Communicating and engaging with our staff
The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2016 Staff Survey showed that the Trust scored above average for its overall staff engagement score. Similarly, we scored above average for the percentage of staff reporting good communication between senior management and staff.

Having a committed and engaged workforce contributes directly to the quality of the care we provide to our patients. Messages are delivered in a variety of ways both within individual teams and department and across the Trust as a whole.

Examples of staff communications and engagement include:

- Regular face-to-face staff briefings are led by our Executive Team, where we share information on key operational issues
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our

clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets quarterly with our Council of Governors, which includes nine elected staff governors
- Quarterly public Trust Board meetings
- Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust
- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

Staff Involvement Group Newsletter
The newsletter is produced every two months and is full of news and stories for staff, by staff and about staff. The aim is for staff to be involved in something that is purely for them, and is a method for individuals to share their stories such personal achievements, smoking cessation, weight loss, hobbies/interests or a new fitness regime that could inspire others to take action to live healthier lifestyles.

Engagement events 2016
Our third 'Good, Better, Best'' staff engagement event was a great success. More than 80% of our staff participated during the week of 11 July 2016. The focus of the event was Patient Safety and Patient Experience. We worked with a specialist training provider who used theatre to 'bring training to life' with professional actors simulating a patient safety situation. The event enabled us to brief on the forthcoming comprehensive patient safety review which will be led by the Institute for Healthcare Improvement (IHI).

During the week we were also able to thank our staff for the tremendous work for the year. The finale to the event was a Keynote Address given by Sir Bruce Keogh attended by staff. The event was funded from Charitable Funds and commercial sponsorship.

The fourth Good, Better, Best Christmas staff engagement event was held in the week of 12 December with more than 2000 members of staff attending the sessions. Themes this Christmas included presentations on Patient Safety, the L&D's new Freedom to Speak Up Guardian, and an update on the Bedford, Luton and Milton Keynes Sustainability and Transformation Plan (STP).

Our Volunteers
We currently have 264 volunteers working closely with our staff in a variety of different roles within the Trust. Our volunteers are a vital part of our organisation and provide an invaluable helping hand to complement our workforce. Alongside our own volunteers, Carers in Bedfordshire and Hospital Radio provide important services not only for patients and visitors, but also staff. The Royal Voluntary Service has a shop in the Maternity Unit and a Ward Trolley Service and each year they donate several thousand pounds to the Trust. The League of Friends raises funds for new medical equipment and extra facilities and comforts for those using our hospital.

All volunteer recruitment is aligned to that of a paid member of staff and external organisations working with us sign up to an agreement to ensure consistency. All new volunteers attend a comprehensive induction and undertake training to be able to carry out their roles safely and effectively.

The highest percentage of our Trust volunteer base fall within the 66-79 age category:

Age (years)	% of volunteers
80 and over	5.88
66 - 79	47.35
50 - 65	21.59
25 – 49	17.61
18 - 24	7.58

Generally, those in the 18 – 24 age category use their volunteering experience to help them gain an insight into healthcare which in turn support their applications for health related courses.

25.37% per cent are from a BME background, which is slightly under representative of our local community. Plans are in place to work with our local Imam to discuss how we can encourage out local Muslim population to engage with the hospital.

During 2016/2017:
- Our Trust volunteers gave us a total of over 22500 hours, which is the equivalent to 11.5 full time band 2 staff.
- 87 new volunteers were recruited and there were a total of 85 Leavers. Of the other volunteers who left during this period, 4 returned as University of Bedfordshire Nursing and Midwifery students.
- 3 former volunteers have secured permanent or bank employment within the Trust.

National Volunteers Week is held during the first week of June each year. The Grove Theatre in Dunstable hosted the 'Cheering Volunteering Awards' which were organised by Central Bedfordshire Council. David McDonald one of our own Main Reception volunteers was the proud recipient of an 'Outstanding Contribution' award for his professionalism and for the average 375 hours he gives us each year.

In November we worked with Nationwide Building Society who provided their support as part of their Employee Community Volunteering Programme. They transformed the garden area of our NICU parents bungalow and the balcony outside the Chemotherapy Unit. Their visit was a huge success and provided an excellent opportunity for positive publicity, they will be returning once again in May this year.

New roles this year include assisting Medical Education with the Junior Doctors mock OSCE exams by acting as patients and volunteers are now assisting with PLACE assessments. We have also extended volunteer cover to include weekend Pharmacy TTA deliveries.
We held our annual Long Service awards event in December which was attended by 100 Volunteers .The awards were, presented by the Trust Chairman and included a special award presented by the Trusts very first Voluntary Services Manager , Rhona Harvey to Jill Wills who had dedicated over 50 years Voluntary Service to the Hospital.

Health and Wellbeing / Occupational Health
We offer a full range of Occupational Health and Wellbeing Services which contribute to increasing the effectiveness of the organisation, by enhancing staff performance and morale through reducing ill-health, absence and accidents.

During 2016/17 the Trust has continued with, and also introduced new, initiatives, to promote opportunities for staff to adopt a healthier lifestyle either onsite or by promoting external facilities that are conducive to good health.

We had a company visit in order to provide free eye testing to staff, and 574 member of staff were seen over a five week period.

The Occupational Health and wellbeing Service has focussed on providing information on health promotion topics and activities, by acting as a signpost for staff to obtain information and advice on a variety of health and fitness related initiatives. This has been achieved through the continued development of a health and wellbeing section on the staff intranet, various electronic communications, newsletters, and awareness raising events.

In June 2016, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place, which proved to be very popular. Awareness raising stands and activities included: - smoking cessation, Livewell Luton promoted personal health plans, smoothie bikes, Heights/weights and Body Mass Index, healthy eating, a nutritionist performing health snacks demonstrations, Active Luton conducted chair exercise classes and Team beds and Luton workplace challenge promoted table tennis and a skipping challenge, amongst other initiatives. There was also a stand raising awareness around prevention of bullying and harassing with staff being encouraged to make pledges in support of good behavior at work. A similar event is currently being planned for 2017.

Team Beds and Luton activities such as paddle boarding and Dodge ball, took place with those staff taking part reporting back via the Staff involvement group newsletter
This year, 71.4% of our frontline staff were vaccinated against flu, which was a higher uptake than the national average amongst other NHS Acute Trusts.

The Wednesday walking activity (30 minutes of a brisk walk) that first started in 2009 continued, and was pepped up a little with the help of Active Luton, offering incentives to regular walkers.

The Occupational Health team were successful in retaining their accreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the Faculty of Occupational Medicine.

SEQOHS accreditation is the formal recognition that an Occupational Health Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

The Trust continues to employ the services of an Employee Assistance Programme, which is available to all staff. This provides access to an independent, free and confidential telephone advice service, staffed by highly experienced counsellors who can provide practical and emotional support with work or personal issues. The Advice Service is available 24 hours a day, 365 days of

the year. The provision of this support during the past four years has proved to be valued greatly by staff with an excellent utilisation rate. Monthly help/awareness raising sheets are also provided, which not only remind our staff of the availability of this important support but also give information about a number of health/life issues.

Health Checks for staff
The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. Live Well Luton is a company commissioned by Luton Borough Council and they provide free health checks to those over the age of 40 and up to the age of 74. Whilst this is national scheme we have been able to continue to secure dates for this service to be brought on site to our staff. Since October 2013 sessions have been available on a monthly basis with over 470 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary referrals made.

Fruit and Vegetable Market Stall
Following on from a staff suggestion, a fruit and vegetable vendor was asked to set up a stall in an effort to promote healthy eating primarily to staff, but this has also been welcomed by patients and visitors to the Trust alike.

The stall first commenced in September 2015, and has been on site one day a week.
In April we introduced a new activity entitled' Apples and Pears to take the stairs', this was in order to encourage staff to use the stairs more to assist in increasing levels of fitness and also to raise awareness regards the fruit and veg stall.

Staff Health and Wellbeing questionnaire
During the 2016 Christmas Good, Better, Best staff engagement event, we took the opportunity to ask staff what health and wellbeing activities they had accessed, and what they would like to see more of.
From the 29 listed activities, the top five were
- Occupational Health Department services
- Health and wellbeing emails
- Free on site eye tests
- Fruit and Veg Stall
- NHS Discounts

Staff asked for Health checks for those who did not qualify for the over 40 health checks, and these commenced in February.

2016 National staff survey summary of results and action plan

1. Introduction

The thirteenth National Staff Survey was undertaken between September and December 2016. All Trusts are required to participate in the survey using a random sample of staff and the data from which is used by the CQC for the Benchmark reports across all NHS Acute Trusts.

The feedback reports produced for each organisation focus on 32 key areas (known as key findings)

The key findings are presented in the feedback reports under the following nine themes:
- Appraisals & support for development
- Equality and diversity
- Errors and Incidents
- Health and wellbeing
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying
- Working patterns

This year the Trust opted to survey a sample survey of 1250 staff. Questionnaires were distributed in paper format only.

Completed questionnaires were sent directly to the Trust's independent survey contractor, Quality Health, for analysis by age, staff groups and work and demographic profile.

This report gives a high level overview of the survey findings. A summary report of the complete results will be made available on the Trust intranet.

The survey report provides vital feedback from staff about working in the Trust.
As in previous years, there are two types of key finding:
- Percentage scores, i.e., percentage of staff giving a particular response to one, or a series of survey questions.
- Scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these summary scores, the minimum score is always 1 (Strongly disagree) and the maximum score is 5 (Strongly agree)

2. Response Rates

2016 National NHS Staff Survey		2015 National NHS Staff Survey		Trust Deterioration
Trust	National Average*	Trust	National Average*	
43%	43%	49%	41%	6%

* Acute Trusts

The official sample size for our Trust was 1250, and we had 516 members of staff take part.

3. Staff Engagement

The survey measures overall Staff Engagement and the Trust scores are detailed as follows:

	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
Overall Staff Engagement	3.90	3.81	3.84	3.79	No significant change	Highest (best) 20%
KF 1 Staff recommendation of the Trust as a place to work or receive treatment	3.88	3.76	3.81	3.76	No significant change	Above (better than) average
KF 4 Staff motivation at work	4.01	3.94	3.94	3.94	No significant change	Highest (best) 20%
KF 7 Staff ability to contribute towards improvements at work	75%	70%	73%	69%	No significant change	Highest (best) 20%

4. Key Findings

A summary of the key findings from the 2016 National NHS Staff Survey are outlined in the following sections:

4.1 Top Ranking Scores

Top 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 7 % of staff able to contribute towards improvements at work	75%	70%	73%	69%	No significant change	Highest (best) 20%
KF9 Effective Team working	3.84	3.75	3.79	3.73	No significant change	Highest (best) 20%
KF 12 Quality of appraisals	3.40	3.11	3.31	3.05	No significant change	Highest (best) 20%
KF 19 Organisation and management interest in and action on health and wellbeing	3.75	3.61	3.56	3.57	Increase (better than)	Highest (best) 20%
KF 27 Percentage of staff/ colleagues reporting most recent experience of harassment, bullying or abuse	54%	45%	36%	37%	Increase (better than)	Highest (best) 20%

Other Key Findings that scored above or below (better than) average

- KF1 – Staff recommendation of the Trust as a place to work or receive treatment
- KF2 - Staff satisfaction with the quality of work and care they are able to deliver
- KF3 - %agreeing that their role makes a difference to patients/service users
- KF4 - Staff motivation at work - highest (best) 20%
- KF5 - Recognition and value of staff by managers and the organisation - highest (best) 20%
- KF6 - %reporting good communication between senior management and staff
- KF8 - Staff satisfaction with the overall responsibility and involvement –highest (best) 20%
- KF10 - Support from immediate managers
- KF13 - Quality of non-mandatory training, learning or development
- KF14 - Staff satisfaction with resourcing and support
- KF24 - % reporting most recent experience of violence - highest (best) 20%

4.2 Bottom Ranking Scores

Bottom 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 16 % of staff working extra hours***	79%	72%	75%	72%	No significant change	Highest (worst) 20%
KF 20 % of staff experiencing discrimination at work in the last 12 months	15%	11%	12%	10%	No significant change	Highest (worst) 20%
KF 22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	15%	15%	14%	No significant change	Highest (worst) 20%
KF 25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%	27%	30%	28%	No significant change	Highest (worst) 20%
KF 32 Effective use of patient/ service user feedback	3.62	3.72	3.65	3.70	No significant change	Lowest (worst) 20%

Of the total 32 reported key findings, all 32 can be compared to 2015 and these are as follows:

- No real statistical change = 28
- Improvements = 4
- Deteriorated = 0

5.10 Improving the quality of our environment

The Trust actively engages with patients through the Patient Led Assessment of the Care Environment (PLACE) initiative.

An annual inspection, led by a nominated patient representative, is undertaken as directed by the Department of Health. In addition to the annual inspection, monthly inspections are undertaken, again led by a patient representative and supported by Non-Executive Directors of the Trust. Information received from inspections is used to improve the patient environment and patient experience.
Improvements have been made to car parking with extra spaces now available for our patients and visitors.

In the year, a number of schemes of work have been undertaken to improve facilities for our patients, this includes:-

- Creating additional side rooms on wards
- Conversion of outpatient areas into new inpatient accommodation
- Refurbishment of existing chapel to create new multi faith place of worship
- Conversion of existing delivery suite room to include birthing pool

Looking forward into 2017/18, the Trust already has advanced plans to make further improvements to the hospital estate with:-

- Improvement to the existing Neo Natal accommodation
- Refurbishment of outpatient areas
- Expansion of endoscopy services
- Expansion of maxillofacial department

In the coming year, a number of schemes of work for the hospital estate are planned to take place. The works underpin our commitment to keep patients safe at all times; these works include the replacement of the automatic fire detection system, reinforcement works to power supplies and replacement of old heating systems.

5.11 Quality and Business Strategy

One of our key approaches to delivering high quality sustainable care is our Reengineering programme focussed on delivering care more efficiently and effectively. This is a formal programme to resolve the fact that overall systems and processes are not functioning to a maximum level of efficiency and that potential improvements represent a key opportunity to improve both quality and efficiency.

The overarching governance is through monthly dedicated Executive Board, and at Board Committee level through the Finance, Investment and Performance Committee. The Trust has a dedicated Executive Director to ensure delivery.

We have also continued to market its services to GP's and held a range of events to promote our services, where expert speakers have drawn consistently good attendances. These will continue, but will take place on the margin of our traditional catchment areas. We have worked hard to ensure we are the easiest place to refer to clinically, the quickest place to see patients, and can clearly evidence and promote the quality of our services. This will involve enhanced investment in marketing materials, but will require careful alignment with capacity released by re-engineering our processes. We have launched a strategically important maternity hub in Leighton Buzzard including the delivery of antenatal imaging conveniently located for local appointments. We have also been successful in securing a contract to deliver an innovative modern Sexual Health service for the area of Luton.

5.12 Review of Quality Performance - how the Trust identifies local improvement priorities

The hospital agreed the Corporate Objectives for 2014 – 2016, and these include the quality objectives. The Trust Governors, that include staff and public representatives, were engaged with the development of these objectives. This is through the Council of Governors meetings and their selection of the indicator to review annually. The Advancing Quality Strategy was also part of the Engagement Event in December 2016 to receive feedback from staff regarding the priorities and activities outlined.

The list of clinical indicators which were developed and added to in previous years remain included. People identified those indicators most important to them and also stated the elements of care that they would want the Trust to concentrate on improving.

Amendments to the quality priorities have been considered by staff in management executive based on performance and improvement needs.

Quality is discussed and monitored at quarterly monitoring meetings with our local Clinical Commissioning Groups. There remains a high level of agreement among the various groups of people that have contributed to determining priorities.

6. Statement of Directors' responsibilities in respect of the Quality Report

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.

Monitor 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 2016/17 and supporting guidance;
- 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 2016 to March 2017
  - papers relating to Quality reported to the board over the period April 2016 to May 2017
  - feedback from commissioners dated 23/5/2017
  - feedback from governors dated 15/02/2017
  - feedback from Healthwatch Luton received 23/5/2017
  - feedback from Luton Overview and Scrutiny Committee – they will not be providing a response for 2016/17
  - feedback from Central Bedfordshire Social Care Health and Housing Overview and Scrutiny Committee received 23/5/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26/7/2016, 27/10/2016, 9/2/2017 and 2/5/2017
  - the 2016 national patient survey [not received at time of signing]
  - the 2016 national staff survey 7/3/2017
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 17/5/2017
  - CQC Intelligent Monitoring Report dated May 2015

- 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; We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

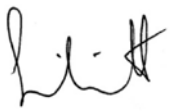
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- 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; and

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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



Chairman
24th May 2017

Chief Executive
24th May 2017

Note: An Equality Analysis has been undertaken in relation to this Quality Account.

7. Comments from stakeholders

NHS
Bedfordshire
Clinical Commissioning Group

Statement from Luton Clinical Commissioning Group (LCCG) and Bedfordshire Clinical Commissioning Group (BCCG) to Luton & Dunstable University NHS Foundation Trust (L&D) on Quality Account 2016 – 2017

Luton Clinical Commissioning Group (LCCG) continued to working closely with the Luton and Dunstable University Hospital NHS Foundation Trust (L&D) L&D throughout the year, and has received assurance on the delivery of safe, caring and effective services. In line with the NHS (Quality Accounts) Regulations 2011, the CCGs have reviewed the information contained within the L&D annual account and checked this against data sources, where this is available to us as part of our existing monitoring discussions, and confirm this account to be accurate. The Quality Account was shared with Non-Executive Directors (lead for patient safety), Executive Directors, Performance, and Quality Teams. The Quality Account and Response from the CCG's will be shared for the attention of the respective Boards. The LCCG Patient and Safety Quality Committee (PSQC) and Beds CCG Integrated Commissioning and Quality Committee (ICQC) will review the account to enable development of our commissioning statement

In reviewing the Trusts quality accounts from 16/17 and the associated priorities, LCCG working closely with BCCG and the L&D and are aware of how these priorities were formed to align with National and local quality priorities and areas requiring improvement from patient safety to specific clinical outcomes. As commissioners we are aware of the Trusts ongoing work in these key areas. We know the Trust has continued to work on delivering good clinical outcomes for patients following improved delivery in areas such as Sepsis management, appropriate use of antibiotics to patients and, management of the deteriorating patients (patients who become suddenly critically ill). We will continue to work with L&D on assurances of delivery and ongoing learning for all key priorities.

LCCG are assured by the outcomes of the clinical priorities of 2016/2017;

1. Continued work by the L&D has seen improvement in the treatment of patients with Acute Kidney Injury (AKI), with initiatives implemented resulting in 92% of episodes of Acute Kidney Injury being treated within six hours. Work to increase the long term health outcomes of patients with AKI extends to work with our local GP's through the establishment of a 'plan of care' to optimise and monitor long term recovery.

2. L&D priorities for 2016/17 included a high level of focus and clinical prioritisation of patients presenting with Sepsis both in the Emergency Department and in-patient wards. We commend the Trust on the initiative to introduce Sepsis champions. The focus on Sepsis identification and treatment has shown a success of 90% when measured by audit in all clinical areas and is equally identified as a National priority in CQUIN Indicators for Acute Trusts.

3. We are reassured to see a continued focus on reducing mortality rates and has been pleased to be invited to be a substantive member of the Mortality Review Panel. Over course of 16/17 the L&DU Trust did see variation in the Hospital standardised mortality ratio (HSMR). This is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than expected. We are aware of the Trusts response and the Trusts commissioned independent review. As collective CCGs we acknowledge their recent improvement in the indicator for L&D. We are also aware on the ongoing work with the daily screening and wider discussion of all deaths at the Trusts Mortality board and will continue to work with the Trust in understanding the ongoing performance and service improvement work in this area.

4. A strong focus within the Trust has been the national quality initiative to reduce the antibiotic consumption work which continues and is subject to monthly audit.

The National Initiative to reduce avoidable harm from incidents of pressure sores, falls, catheter infections and venous embolism is measured through a national tool and it is reassuring to note that the L&D achieved over 98% Harm Free Care for their patients. All incidents of avoidable harm occurring within the care of the hospital are investigated and shared transparently with the CCG as Serious Incidents. Throughout 16/17 the Trust has demonstrated significant improvement in areas regarding patient safety. Specifically the Trust improvement in the management of patient falls in hospital. For all patients at risk of falls the Trust will conduct a risk assessment and although not all falls are completely avoidable, the Trust has worked to reduce the proportion of people who come to harm from result of a fall. Over 16/17 this reduced by almost 50%.

The CCG recognises the continued improvement and efforts that the Trust has made to ensure that majority of serious incident reports are completed within nationally prescribed time frames and acknowledge that the quality of the reports have improved to a high standard. The L&D is able to evidence its compliance with the duty of candour in its openness and transparency with patients, families and staff.

In spring/summer 2016/17 strategic changes to the pathway for how stroke services are delivered across Bedfordshire has meant a significant change to how care for stroke patients was provided over the course of 16/17. L&D demonstrated a strong commitment to working positively with Bedfordshire commissioners and other relevant stakeholders to assure safety and outcomes were consistent for all stroke patients who are managed in their care. Patients requiring essential stroke specialist care in the first hours of stroke presentation are managed in L&D for all of Bedfordshire. It has been encouraging to see L&D demonstrate significant improvement in their SSNAP audit performance from E-C (SSNAP audit provides detailed information about individuals who have strokes, the processes of care they receive and their eventual outcome).

The Trust's commitment to participation in national and local audits is to be commended and LCCG commit to supporting the Trust in ensuring that their services improvements are reflective of the outcomes of audits and achieve sustainable quality improvements.

The ongoing work to date is acknowledged regarding improving the safety and experience of those accessing maternity services at L&D. The CCG and its associates are sighted on the extensive action plan and progress that the Trust has made against this plan and we will continue to work with L&D on the assurances of this plan with regard to safety and outcomes.

The Trusts Efforts and leadership to achieve the CQCs 'good overall' rating is recognised by the CCG. All areas requiring attention to improve are reflected within theL&D clinical priorities for 2016 /17.

Patient experience improvement work in L&D Outpatients with Partial-booking has been successful in enhancing patient access in outpatients over 16/17. (Partial booking enables patients to choose a convenient outpatient appointment date, reducing some long waits and potential for cancellation or patients unable to attend).

Luton CCG and other associate CCGs support the Trust's quality priorities and indicators for 2017/18 as set out in the annual account and Luton CCG will monitor the progress of the Trust in driving forward the 2017-18 initiatives and improvements to ensure high quality healthcare and outcomes for the population of Luton and Bedfordshire.

Luton Clinical Commissioning Group

*It should be noted that these comments were made on an early draft of the L&D Quality Account received April 2017.

Colin Thompson
Accountable Officer
Luton Clinical Commissioning Group

Matthew Tait
Accountable Officer
Bedfordshire Clinical Commissioning Group

Central Bedfordshire comment on the Luton and Dunstable University Hospital NHS Trust

QUALITY ACCOUNT 2016/17

At the Social Care Health and Housing Overview and Scrutiny Committee meeting held on Monday 15 May 2017, the Committee considered the Luton and Dunstable Hospital Quality Account 2016/17.

A concern was expressed about the percentage of staff who felt they were bullied/harassed and the level of confidence that staff appeared to show when asked if they would recommend the hospital to their family/friends as opposed to the greater confidence patients seemed to have in the hospital.

The Committee praised the outstanding work undertaken by the Hospital's volunteers and complimented the Memorial Service that had been introduced and was helping many families in the grieving process. Members also commented on the introduction of listening events to capture views and concerns of staff.

Members thanked the Director and Company Secretary present and were reassured that the Trust had provided good quality services with the right interventions in place and had listened and responded to patients' needs and the views of their staff.

Comments from Luton Borough Council Health and Social Care Review Group

L&D Hospital NHS Foundation Trust Quality Accounts 2016-17

Luton Borough Council Health and Social Care Review Group have agreed not to comment on the Quality Account for 2016/17.

Comments received from the Trust Stakeholders

Comment	Response
There is no commentary on the stroke services moving from Bedford Hospital to the L&D.	Added a reference under the quality priorities.
Clarity requested on involvement of staff and patients in the priorities.	Further explanation added.
Some of the acronyms are not in the glossary.	Updated the glossary.
Concern raised over the staff survey scores for Bullying and Harassment.	Noted by the Trust. This is an improving score although it is recognised that further work is being undertaken.

Healthwatch Luton response to the Quality Account/Report for 2017 for Luton and Dunstable NHS Foundation Trust

Healthwatch Luton are happy to respond to the Luton and Dunstable Hospital Quality Accounts for 2017. Generally, Healthwatch Luton report effective relationships with the Trust and its staff. Healthwatch Luton can feedback their patient feedback to a direct contact (Director of Nursing) and maintain an established relationship with the PALS department. Healthwatch Luton provide a Provider Feedback report on feedback gathered on all areas of the hospital to L&D on regular intervals.

It is recognised that the Trust is proactive in gathering the view of patients via patient surveys, Friends and Family Tests and interviews, and the number of compliments they receive is to its credit. Learning from complaints and incidents is evident, and it would be suggested patient stories are an effective way to reflect these views, although not used in this report.

The report is written well and in plain English for the most part. The layout is good and the tables are easy to read. The Trust could however pay greater attention to the use of technical and specialist language in the report which for some public may be confusing. A glossary of terms may make the report more accessible to a wider range of audiences.

Progress against the key priorities is reported in detail and shows positive achievements, and it is recognised that the Trust's Care Quality Commission rating identifies areas for improvement as well as where the Trust fairs well.

It is encouraging to see stepped priorities for areas such as end of life, dementia and stroke patients.

Patient experience

The Quality Account reflects Healthwatch Luton's (HWL) views of the hospital and in particular around patient experience. HWL have received nearly 100 feedbacks from patients without targeting the hospital as a venue to gather feedback from, and this is mainly positive. The main positive areas highlighted from our feedback relevant to the QA are effective treatment and care when you arrive at the hospital, positive staffing attitudes, and generally good diagnosis and assessments.
HWL agree with Priority 3: Patient Experience around stroke, dementia and partial bookings and think these areas represent the public's views of the hospital. Addressing areas such as safe discharge was also positive to see and reflected HWL's feedback from 2016.

HWL have feedback from the NHS Friends and Family Test which shows most people attending the hospital are 'likely' or 'extremely likely' to recommend the hospital. The principal areas of concern from our feedback were:

- Treatment and care, in particular with effectiveness, safety of care and treatment explanation. This was mainly in the ward settings.
- Access – around waiting times (for referrals or being seen) and being discharged
- Staffing – there were some issues around staffing capacity levels and training and development. These issues have been fed through the PALS department
- Facilities – in particular around car parking and food and hydration
- Discharge –around timing and safety although we have also received many positive experiences of discharge
- Treatment and care, particularly from A&E but also Pediatrics was rated very highly in our feedback and we thought it worth mentioning. Some areas such as referrals (particularly from department to department) seemed to be experienced fairly negatively.

It is positive to read the QA is highlighting areas around Dementia (and in particular around staffing capacity which we have received feedback on), discharge (and linking with community care) and facilities (mainly around the lack of parking for staff and patients).

HWL would offer to add HWL feedback into how areas will be improved, measured and reported. Whilst not targeted feedback on a particular area within the hospital, it would be encouraging to see more patient voice influencing priorities moving forward.

Healthwatch Luton would like to take this opportunity to thank all staff at the hospital for all their committed hard work, and ensuring patients are at the heart of their decision making and procedures.

8. Independent Auditor's Assurance Report

Independent auditor's report to the council of governors of luton and dunstable university hospital nhs foundation trust on the quality report

We have been engaged by the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Luton and Dunstable University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge. We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the
- Detailed requirements for quality reports for foundation trusts 2016117 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.
We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 23 May 2017;
- feedback from governors, dated 15 February 2017;
-
- feedback from local Healthwatch organisations, dated 23 May 2017;
- feedback from Overview and Scrutiny Committee, dated 24 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national staff survey, dated 7 March 2017;
- Care Quality Commission Inspection, dated 3 June 2016;
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated 17 May 2017; and
- any other information included in our review.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales {ICAEW)

Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.
This report, including the conclusion, has been prepared solely for the Council of Governors of Luton and D_unstable University Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Luton and Dunstable University Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non mandated indicator, which was determined locally by Luton and Dunstable University Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants London
26 May 2017

9. Glossary of Terms

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
Anticoagulation	A substance that prevents/stops blood from clotting
Antimicrobial	An agent that kills microorganisms or stop their growth
Arrhythmia	Irregular Heartbeat
Aseptic Technique	Procedure performed under sterile condition
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
CAUTI	Catheter Acquired Urinary Tract Infection – this is where the patient develops and infection through the use of a catheter
CCG	Clinical Commissioning Group.
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 targets set by the CCG where the Trust receives a financial incentive if it achieves these quality targets.
DME	Division of Medicine for the Elderly
Elective	Scheduled in advance (Planned)
EOL	End of Life
Epilepsy	Recurrent disorder characterised by seizures.
EPMA	Electronic Prescribing and Monitoring Administration system in place.
Grand Round	A lunch time weekly meeting with consultants and junior medical staff to communication key issues and learning.
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow.
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
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.
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
Meningococcal	Infection caused by the meningococcus bacterium
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures

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
MUST	Malnutrition Universal Screening Tool is a nutritional assessment that is carried out on inpatients to ensure that they are maintaining their body weight
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Myringotomy	A surgical procedure of the eardrum which alleviates pressure caused by the build up of fluid
Neonatal	Newborn – includes the first six weeks after birth
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
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
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
Prevalence	The proportion of patients who have a specific characteristic in a given time period
Red and Green	The Red:Green Bed day is a visual management system to assist in the identification of wasted time in a patients journey. If it is red, the patient has not progressed, green they have.
Safety Thermometer/Harm Free Care	Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
SEPT	South Essex Partnership University NHS Foundation Trust
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
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.
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply
Syncope	Medical term for fainting and transient loss of consciousness
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
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins

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.

Appendix A - Local Clinical Audits

Title/Topic
Audit Of Pregabalin & Oxycodone Use In Patients Reviewed By Pain Service
N = 21

Specialty
Anaesthetics

Completed
April 2016

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Examine prescriptions/suggestions made by pain service related to pregabalin and oxycodone
- Examine the presenting complaint and appropriateness of the prescription
- Examine the reason for prescribing the drug
- Examine if first line analgesic had been used prior to prescribing prgabalin or oxycodone

Findings:
- The predominant presenting complaint that resulted in prescription of either pregabalin/oxycodone was neuropathic/chronic pain condition (66%). 33% were acute pain or post-operative pain. This is appropriate and in line with primary care guidance
- All patients had tried other opioid analgesics or anti neuropathic agents before switching to oxycodone or pregabalin
- The doses prescribed or suggested by the pain service were in line with current guidance related to safe opioid prescribing

Key Recommendations/Actions:
- No risks identified

Title/Topic
Pre-Operative Fasting In Adults
N= 31

Specialty
Anaesthetics

Completed
May 2016

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Assess compliance with national guidance on pre-operative fasting in adults
- Identify areas of good compliance
- Identify areas of poor practice with a view to making improvements

The proposed standards from the Royal College of Anaesthetist, for best practice, that were taken into consideration were:
- 100% of healthy elective adult patients should be permitted to drink water or other clear fluids until 2 hours before the induction of anaesthesia. Patients should be encouraged to drink clear fluids up until 2 hours before elective surgery

Findings:
- Ninety four percent of patients stated the time of last fluid intake was more than 2 hours prior to surgery
- Fifty five percent of patients felt they were thirsty/ dehydrated before their operation
- Fifty eight percent of patients were unaware they could drink until 2 hours before surgery
- Eighty four percent of patients were an ASA grade of I & II, the remaining 16% had a ASA grade of III or above

Key Recommendations/Actions:
- To raise patients' awareness by improving communication with them.
- To inform patients promptly when a delay happens to keep themselves rehydrated.
- To find a sample letter sent to patients containing fasting instructions and adjust accordingly, if necessary. Action: Communication with waiting list manager, Fyne Brenda to see pre-assesment letter sent to patients and amend it if needed.

Title/Topic

Record Keeping Audit 2015 – Gynaecology
N = 20

Specialty

O&G

Completed

May 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

- To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings

Findings:

- 47% of standards fully compliant
- 14% of standards with high compliance
- 16% of standards with moderate compliance
- 23% of standards with low compliance

Key Recommendations/Actions:

- The use of patient specific EVOLVE in patient sheets.
- Staff need to be aware that whoever makes the first written entry is responsible for completing these details.
- Use of stamps
- The importance of clear handwriting to be fed back to staff

Title/Topic

Venous Thromboembolism Re-Audit Of Nice Cg 92 General Surgery
N = 121

Specialty

General Surgery

Completed

May 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

Overall purpose to re-measure compliance with the standards identified in NICE CG 92. Specifically to:

- Identify improvements following the audit completed in 2013
- Identify whether L&D are adhering to NICE guidance
- Identify areas where compliance with the recommendations made by NICE need to be improved
- Identify areas of good practice

Findings:

High compliance with 3 standards; suboptimal compliance (<74%) compliance with 3 standards. Areas of por compliance include: assessing patients on admission to identify those who are at high risk of VTE; assessment of risk of bleeding and VTE within 24 hours of admission and whenever clinical situation changes; encouraging patients to mobilise as soon as possible.

Key Recommendations/Actions:

Thought likely that these results reflect a problem with data capture (poor record keeping) rather than an omission in clinical care. It was agreed that changes could be made to the surgical admissions proforma to make it easier to record assessments and advice to mobilise. Dr Taylor will liaise with Miss Brown regarding changes to the proforma

Title/Topic

Audit Of The Use Of PCA Post-Operatively For Laparoscopic Hysterectomies
N = 21

Specialty

Anaesthetics

Completed

June 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

- To review the current practice of anaesthetic management of patients undergoing laparoscopic hysterectomy in our trust.
- To identify the key elements essential in establishing a successful ER program after laparoscopic Hysterectomies in our trust.
- To suggest practical recommendations on the peri-operative anaesthetic policies for an ERAS pathway in gynaecological surgeries.

Findings:

- The majority (72%) of the patients included in this audit were classified as ASA grade 2 and only 28% were written as ASA grade 1.
- 85% of the patients had a consultant grade anaesthetist delivering the peri-operative anaesthetic care.
- We found that the average length of stay for these patients undergoing laparoscopic hysterectomies were 2.7 days. However, the maximum number of days any patient stayed in the hospital after laparoscopic hysterectomies was found to be 7 days. We didn't probe into the reasons for this delayed discharge but post-operative ileus, PONV and inadequate pain relief could have been a few possible causes.
- Looking at the intra-operative analgesia given in these patient we found that almost all of the patients received paracetamol (91%), fentanyl (81%) and intermittent morphine(81%).There was a relatively small percentage of patients receiving NSAIDS (33%).We did notice a small but striking number of patients receiving short acting opioids infusion (29%) intraoperatively. Only one patient was reported to have received combined spinal anaesthesia (CSE).
- The results from the post-operative analgesia prescribing demonstrated that a large majority of the patients had regular Paracetamol prescribed (91%). We found that more than half of the patients (62%) had a PCA morphine written up for post-operative pain relief and the remaining 38% patients had intermittent morphine prescribed. One patient had a PCA oxycodone setup for pain relief. Again there were a relatively small number of patients who were prescribed NSAIDS (48%) post-operatively.
- We recorded the pain scores in all these patients in the immediate post-operative period and at different time intervals (6hrs, 12hrs, 24hrs, 3 days and at discharge).
- We found that in the immediate postop period 52% patients had a pain score of zero.19% of the patients were having moderate pain and in 23% patients pain was recorded as severe pain.
- Based on post-operative analgesia prescribing we broadly grouped the patients into one who received a PCA (patient controlled analgesia e.g morphine and oxycodone) and the other without a PCA. We then compared the pain scores in these two groups at different time intervals. We found that the pain scores at various time intervals in both the groups were more or less the same, hence suggesting that the group with PCA analgesia were not getting any added benefits in terms of pain relief. Thus helping us draw a conclusion that PCA for laparoscopic hysterectomies in not essential.

Recommendations/Actions:

- STANDARDISED ANAESTHETIC PROTOCOL (SAP) for Enhanced Recovery in laparoscopic hysterectomies
- Liaise with the Enhanced recovery team of our trust to help in implementation of the Enhanced recovery protocol (anaesthetic component) for gynaecological surgeries.
- Disseminate the information
- Auditing Compliance post-ERAS protocol for gynaecology surgery

Key Recommendations/Actions:

- STANDARDISED ANAESTHETIC PROTOCOL (SAP) for Enhanced Recovery in laparoscopic hysterectomies
- Liaise with the Enhanced recovery team of our trust to help in implementation of the Enhanced recovery protocol (anaesthetic component) for gynaecological surgeries.
- Disseminate the information
- Auditing Compliance post-ERAS protocol for gynaecology surgery

Title/Topic

Ophthalmology Internal Health Record Keeping Audit 2015/2016
N = 30

Specialty

Ophthalmology

Completed

June 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

- To measure compliance with standards set out by NHSLA, CQC and local guidelines.

Findings:

- Standard Fully Compliant (100%) = 90%
- High Compliance (91 – 99%) = 3%
- Moderate Compliance (75 – 90%) = 2%
- Low Compliance (<75%) = 5%

Key Recommendations/Actions:

- Poor compliance with documentation on Consent Form (patient dating form and printing names): Ensure this is fully completed by the patients
- Poor compliance with documentation of initial patient history: To be fully completed by health care professional
- Availability of prescription chart or ePMA: This is a must for all patients

Title/Topic

Re-Audit Of 'Safe Paediatric Intubation In A&E And Paediatric Wards
(Paediatric Emergency Intubations)'
N = 20

Specialty

Anaesthetics

Completed

July 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

- To have an initial assessment of the resources available for remote site paediatric emergency airway management
- To identify the key components essential in establishing a standardised airway resource (equipment and monitors) for out of theatre paediatric intubations in our Trust
- Endorse a multi-disciplinary approach to improve resources, bring about changes in practice to ensure safe airway management and maintain the standards set out by the AAGBI and RCoA.

Findings:

- In forty five percent of the paediatric emergency intubations the paediatric registrar was not present. **(LOW COMPLIANCE)**
- In thirty five percent of the paediatric emergency intubations an ODP (operating department practitioner) was not present. **(LOW COMPLIANCE)**
- In all 20 cases there was a Bag-valve-mask apparatus available (100%). **(FULLY COMPLIANT)**
- In 19 cases there were laryngoscope, bougie and endotracheal tubes available (95%) **(HIGH COMPLIANCE).**
- In all 20 cases there was an end-tidal CO2 monitor available (100%) **(FULLY COMPLIANT).**
- In all 20 cases a pulse oximeter, non-invasive blood pressure monitor and ECG monitor were available (100%) **(FULLY COMPLIANT).**
- Eighty five percent of the paediatric emergency intubations were supervised by a consultant Anaesthetist, seventy percent were attended by a paediatric consultant and a hundred percent emergency intubations were attended by a Neonatal Consultant (LOW TO MODERATE COMPLIANCE).

Key Recommendations/Actions:

- A dedicated 'Paediatric Airway Trolley' to be positioned in these areas. This Paediatric airway trolley should be the gold standard of resource provision for increasing the safety of emergency paediatric airway management.
- Regular maintenance of the Airway Trolley in the form of keeping a checklist.
- ODP to be included in the **'Paediatric Emergency Airway'** call alerts/fast bleeps.
- Paediatric Resus bag to be moved from theatres (A-D) to paediatric ward.

Title/Topic

Audit Of The Administration Of Intravitreal Injections In Ophthalmology
N = 15

Specialty

Ophthalmology

Completed

July 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

- The overall purpose of the audit is to measure compliance with the revised protocol of administration of intravitreal injections. Specifically to:
- Identify whether the Ophthalmology Department are adhering to the revised protocol
- Identify areas where compliance with the protocol need to be improved
- Identify areas of good practice

Findings:
100% compliance with all standards identified

Key Recommendations/Actions:
No risks identified. 100% compliance achieved with all standards.

Title/Topic

Essence Of Care Respect & Dignity Trustwide Audit 2015
Patient Survey N = 183
Data Collector N = 55

Specialty

Corporate

Completed

August 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:
The survey aims to provide information about patients' experiences of respect and dignity during their stay or visit. It also aims to identify compliance with the benchmark and local guidance, and then highlight any problems as well as areas of good practice with a view to making improvements

Findings:

- 99%of patients felt they had enough privacy when being examined and treated always, and 3% felt this was the case sometimes.
- 99% of patients felt curtains were well fitting and long enough to provide adequate privacy.
- 83% of patients stated staff always knock/ask before entering their bed area/room. A further 15% stated staff sometimes knock/ask before entering.
- 92% of patients felt they always had enough privacy when using the commode or toilet. Ninety three percent of patients felt they always had enough privacy when washing by their bed.
- 88% of patients always felt their personal space/bed area was respected and protected.
- Only 75% of patients stated that staff always introduced themselves on initial contact, and 76% stated that staff discussed what name they would like to be called by.
- 89% of patients felt they were always given enough privacy when discussing their condition or treatment. A further 8% felt this was the case sometimes
- 22% of patients felt that information about them was shared inappropriately, i.e. in a way that could be overheard or overseen.

- Most patients were either always (88%) or sometimes (12%) happy with the way in which staff communicated with them.
- 97% of patients felt they have been supported by staff to maintain confidence and a positive self esteem.
- 95% of patients felt they have been listened to and have been supported to express their wants and needs.
- All patients felt their modesty was maintained when moving between wards/departments.
- 98% of patients felt they have been treated with dignity and respect throughout their time in hospital, and 99% of patients were overall satisfied with their experience with regards to respect and dignity.
- 61% of wards/areas were divided into male/female sides/ends.
- 86% of areas stated their patients were in single sex bays
- 59% of areas stated their toilets/washrooms were single sex
- Most toilets/bathrooms were lockable.
- 87% of areas had a nurse call bell in place in toilets/ washrooms which patients could access in case of an emergency.
- 85% of areas felt their toilets/washrooms were well maintained and cleaned regularly.
- For 6% of areas confidential information about patients is on display.
- Only 63% of areas had a room for patients and relatives where discussions could be carried out in private.
- 47% of areas do not have privacy signs on bed curtains.
- 31% of areas stated they do not have sufficient supplies of night clothes on their ward
- In 63% of areas all staff were aware of respect and dignity guidelines and in 37% some staff were aware of the guidelines.

Key Recommendations/Actions:

- Reinvigorate the 'hello my name is' campaign
- Include in daily safety briefing for 2 weeks (preferred name to be documented in handover and on the patients board above the bed/chair)
- All nurses to have a whiteboard marker in their pocket to facilitate them writing their name on the patient status board – to be checked each morning by the nurse in charge
- Implement as part of new paperwork launch
- Distribute hospital gown guidance poster around the hospital (see breast screening guidance) – investigate potential of including this in the 'Nursing News'
- Review hospital dressing gown availability
- Liaise with communications team to ensure this is included in the new build signage plans
- Quote for costs to install signage across the hospital (bulk order)
- Trial new blue curtains with privacy embroidery

Title/Topic

Psoriasis: Assesment And Management Nice Clinical Guideline 153
N = 30

Specialty

Dermatology

Completed
July 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

- The overall purpose of this audit is to measure compliance with the standards identified in NICE Clinical Guideline 153. Specifically to:
  - Identify areas of good practice
  - Identify areas of practice which require improvement

Findings:

- Not 100% in recording of DLQI, PASI AND PEST.
- Not all patients with suspected psoriatic arthritis were referred to Rheumatology.
- Narrowband UVB offered appropriately except in 1 patient.
- Systemic treatment offered appropriately in all patients, except in 5 patients where no info available as they have been on systemics pre-2009.
- 5 patients in total managed appropriately on topicals only

Key Recommendations/Actions:

- To record DLQI, PASI and PEST at first visit, pre and post start of new treatments and then at least once a year. To get PEST form on evolve.
- Any patients with PEST 3 or more can be referred directly to Rheumatologists
- Undertake audit for phototherapy and relapse

Title/Topic

Re-Audit Of Safer Measurement And Administration Of Oral Liquid Medicines
N = 26

Specialty

Corporate

Completed

September 2016

Aims, Findings, Key Recommendations/Actions

Main Aims:

- Assess practice in all clinical areas against the standards for oral liquid medicine administration to enable improvements in practice where needed. The aim is to ensure we provide safe care to our patients

Findings:

- 100% compliance with all standards.

Key Recommendations/Actions:

- No risks identified

Title/Topic
OMFS Internal Health Record Keeping Audit 2015/2016
N = 20

Specialty
OMFS

Completed
November 2016

Aims, Findings, Key Recommendations/Actions
Main Aims:
- To measure compliance with standards set out by NHSLA, CQC and local guidelines.

Findings:
- Standard Fully Compliant (100%) = 57%
- High Compliance (91 – 99%) = 7%
- Moderate Compliance (75 – 90%) = 18%
- Low Compliance (<75%) = 18%

Key Recommendations/Actions:
- Ensure all entries made within patient notes are named, signed, dated, timed and legible. Findings of audit shared/presented to department to improve awareness
- Ensure all relevant information is included within electronic discharge letters. If no clinical information is required or a particular box on he discharge letter, it should be specified that it is not applicable to the patient as it cannot be assumed so. Findings o audit shared/presented to department to improve awareness
- Ensure all communication with patients/carers is documented within medical records

Title/Topic
Patient Identification Audit 2016
N:
Inpatient = 261
Outpatient = 80

Specialty
Corporate

Completed
December 2016

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure compliance with the Trust Policy on Patient Identification. Specifically to identify whether staff are adhering to the policy; identify areas where compliance with the policy need to be improved; identify areas of good practice

Findings:
- Inpatients: The most significant finding that poses a risk to the safety of our most vulnerable patients is that patients with diminished capacity appear not to have the ward identifier written onto their name bands routinely. Patients who are most likely to wander off the wards must be kept safe by enabling their early return to the safest place for their care to continue.
- Outpatients: In the past year, one never event and one near miss event occurred whereby patients responded to a call for a different patient. An elderly lady received an injection into her eye intended for a different patient and a child had blood taken by a phlebotomist who had called a different patient. It is vital that action is taken to ensure that patients are appropriately identified in the outpatient setting.

Key Recommendations/Actions:
33% of patients with diminished mental capacity or may pose a risk to themselves by wandering off the ward, had had the ward identifier manually added to their wrist band. 100% of these patients should have the ward identifier written on.

Risk is that if the patient does wander off the ward, it will be more difficult to relocate them. In accordance with 2.2.5 of the patient ID policy, all patients with reduced mental capacity or may pose a risk by wandering off the ward/dept., pts. must have the ward / dept. written onto the name band.

1. Present audit finding and remind nursing teams through Matron's meeting

2. Send out a mini presentation with case study to all ward managers to share with their teams each handover for two weeks.

3. Article in Nursing News

4. Put a laminated mini SOP near the ID band printer by way of visual reminder

5. Present finding and actions at Sisters meetings (January)

6. Matrons to review name bands of patients with DoLS in place as these are the higher risk patients

7. Mini audit by end of February 2017.

8. Review the ID policy to make the action a 'must do' (rather than a 'may do')

Not all patients were checked for verbal identify in OPD (reception and upon being called into a consulting room) in accordance with the policy. There is a risk that patients will respond to someone else's name being called and this will not be picked up until it is too late (e.g. patient may have procedure or consultation which was intended for another patient). Actions include:

1. Review the patient ID policy to ensure that OPD checks for ID are in line with best practice and meet confidentiality requirements.

2. Incorporate ID checking procedure into customer care training for OPD admin staff.

3. Prepare mini presentation using case studies and action points

4. Incorporate patient ID checks into LOCSSIPS (as part of NatSSIPs programme)

5. Cascade information for consultants via Clinical Directors

6. Cascade information via Nisha Nathwani for Junior Doctors

7. Use team meetings to discuss and raise awareness

8. Local audits broken down by speciality in OPD to review practice

9. Exit interviews with patients to explore their experience of identity checks.

Not all staff have read the updated patient ID policy (61% had read it). Actions include:

1. To produce a summary of the key, most important elements in the Nursing News.

2. To produce a summary of the key most important elements relevant to groups other than nursing, for the patient safety news

3. Cascade key messages via CDs, MD for med education, Matrons, Sisters and admin management teams

Title/Topic

Ward Audit 2016 - Are Drinks Thickened To The Correct Consistency?
N = 35

Specialty

Therapies

Completed

February 2017

Aims, Findings, Key Recommendations/Actions

Main Aims:

- Establish to what extent drinks are being thickened to the recommended consistency across the elderly and stroke wards
- To establish, if possible, reasons for drinks being the wrong consistency
- To create some learning points/ actions for improving adherence to recommended thickening of drinks

Findings:

- Out of the 35 cases audited, in 4 cases (11%) no drink was available to the Patient. There were 17 cases (49%) where the drink provided was an incorrect consistency. Only in 14 cases (40 %) out of the audited sample the drink provided was the right consistency.
- 47% (8/17) of the incorrect consistency drinks were served in Blue cup (250 ml) followed by red cup 29% (5/17), white plastic cup 18% (3/17) and white paper cup 6% (1/17).
- In summary, the main findings demonstrate that action is required to ensure that patients receive their drinks with the correct consistency and to improve availability of these fluids in order to keep patients safe. Though within the 4 cases where there was no drink available, it may have been that a patient had finished a drink, which was then replaced after the data was collected.
- 47% of the drinks prepared to the incorrect consistency were in the blue 250ml cup, followed by the red 200ml cup. There is a wide range of cups available to patients on the ward, and this therefore changes the amount of thickener needed to achieve the correct consistency drink, dependent on the volume of the cup used.
- Volumes are also not indicated on any of the cups available (though Speech and Language Therapy bed signage does explain how to thicken drinks within the white plastic 150ml cup). The variety of cups, and lack of labelling may have led to confusion for staff or patients when thickening drinks.
- Out of 17 drinks which were thickened to the incorrect consistency 11 were prepared by Unknown person representing 65 % (11/17), followed by 4 drinks prepared incorrectly by a Nurse 23% (4/17) and 2 drinks were prepared to the incorrect consistency by a Health Care assistant. (2/17) 12%. Please refer to the above tables for detailed analysis and breakdown.
- While additional training may be beneficial to ensuring drinks are correctly thickened by staff, a trust policy/ clinical guideline may also aid staff adherence to modified consistencies.
- It was also of note that on all occasions there was no further written instructions (apart from the bed signage given by Speech and Language Therapy) available to the patient or staff which described how to make a thickened drink to the advised consistency. Speech and Language Therapists could have left leaflets with further information on thickened consistencies to aid staff and patients in adhering to our recommendations.
- Additionally the audit so far gives statistical data, without indicating solutions to the problems highlighted, and therefore a follow up questionnaire will be sent to each ward to indicate what staff feel would be helpful in improving drinks being appropriately thickened.

Key Recommendations/Actions:

- The audit findings will be presented at Nutrition Steering Committee meeting 2017 and relevant Audit and Clinical Governance meetings
- Annual training to continue to be provided to nursing/ HCA staff by a Resource trainer
- Discuss with the wards how they would like information to be displayed (Resource manual, posters on trolleys, posters in kitchen?)
- Speech and Language Therapists to leave leaflets for each patient who requires thickened consistencies, which explain how to make a thickened drink.

Title/Topic

Mental Capacity Act Audit 2016
N:

Documentation Review = 41

Staff Survey = 37

Specialty

Corporate

Completed

February 2017

Aims, Findings, Key Recommendations/Actions

Mains Aims:
To receive feedback from Medical/Nursing staff to identify the current level of knowledge and awareness of procedures relating to mental capacity, and to identify gaps in education and training needs
To measure compliance with completion of Mental Capacity Act documentation

Findings:
Documentation Review
38/41 of clinical records reviewed evidenced the need for a Mental Capacity Assessment to be completed.
Of the 38 cases where the need for a Mental Capacity Assessment was identified, only 28 were completed. Of these 28 completed Mental Capacity Assessments, only 9 were completed fully with all domains filled and required information documented.

The key areas identified within this part of the Audit were:

- Missing signatures.
- No evidence that a Best interest decision was made as the section had no documentation or was incomplete.
- No evidence to support staff attempted various means of communication during the assessment period.

A best interest decision was deemed necessary in 31/38 of the cases reviewed which evidenced that in 6 cases a decision was made without a capacity assessment being completed.

A common theme was that the consent form 4 was completed in place of a Mental Capacity form.

Around 50% of the cases where a need was identified for family/advocacy to be involved showed no evidence of this occurring.

Only 15/24 reviews of a prior best interest decision took place. Examples of required reviews included a decision to treat cancer, reconsideration of the best means to obtain an MRI and several Deprivation of Liberty Safeguards.

In 72% of cases reviewed, there was no evidence of communication methods being adapted to meet the needs of the patient (e.g. simple language, pictures, interpreters). There was, on occasion, evidence of advice given from specialist teams on how this could be achieved.

Throughout this part of the audit there was a common theme that staff often worked on the assumption that a patient did not have capacity without formally assessing and fully evidencing how they came to that decision.

Staff Survey
Overall, the majority of staff understood the term mental capacity, however some thought that this was related to a patient's mental health, diagnosis or ability to care for him/herself (basic tasks). Some staff referred to a patient being able to make a "right" or "sensible" decision.

The majority of staff understood knew when a Mental Capacity Assessment should be completed, however several also stated that this should be done for every patient on admission or at each shift change rather than it being a time and decision specific task.

Many staff members answered that they would document capacity assessments and best interest decisions in medical notes, rather than on MCA paperwork.

The majority of staff understood when a Best Interest decision would be required, however the theme of assuming that a person didn't have capacity based on a diagnosis, with no evidence of assessing this, was present again.

The majority of staff clearly evidenced how to access advice/support in relation to Mental Capacity. Only 2/37 staff members were unsure of where to find advice and guidance on this subject.

Only 9 out of 41 staff members asked said that they would be confident to complete a capacity assessment, although a small number stated that they would with support / following training.

When asked, who is responsible for completing a Mental Capacity Assessment, most staff answered that they felt it was the responsibility of the medical/specialist teams.

Approximately 50% of people asked how they would assess someone's Mental Capacity gave a correct answer.

17/37 staff either did not know the answer or documented an answer evidencing a lack of understanding in what to do if they were informed a POA or Advanced decision existed. Out of the remaining staff questioned there was evidence to show they would either check the paperwork for authenticity or seek help from their peers/specialist teams.

Key Recommendations/Actions:

- The audit identified 2 key themes: a lack of knowledge and understanding of Mental Capacity Act processes amongst staff; a lack of confidence in assessing someone's mental capacity formally. **Action:** To introduce new Level 3 Adult Safeguarding Training Programme which will provide detailed learning on Mental Capacity Act and the completion of Mental Capacity Assessment forms. This will be aimed at particular clinical staff grades to ensure compliance with the MCA 2005

- A need for awareness of the MCA 2005 was identified in some key areas where mental capacity assessments are not commonly required and therefore not common practice. Staff felt they required further training to increase their confidence and knowledge ensuring they can identify/complete an assessment when required. **Action:** To complete a Mental Capacity Training Day – Perinatal Study Day

- Increase knowledge and awareness of the MCA 2005 and the legal implications. **Action:** Joint training day or clinical staff alongside the Trusts Legal Team on the Mental Capacity Act 2005

- For staff to have easy access to templates/examples that can assist them in the completion of a MC assessment. **Action:** Upload good examples of MC Assessments to the Trust's intranet to be used as guidance by staff members undertaking these assessments

- Feedback of findings. **Action:** To present the findings of the audit at the Medical Grand Round, NMB and Ward Sister's Meeting

Title/Topic

Re-Audit Of Aetiological Investigation Of Children With Permanent Hearing Impairment
N = 28

Specialty

ENT

Completed

February 2017

Aims, Findings, Key Recommendations/Actions

Main Aims:

- Assess efficiency of Joint Paediatric Audiology Clinic
- Establish current practice of aetiological investigations for PCHI at L&D Hospital in line with the guidelines produced by British Association of Audio vestibular Physicians and British Association of Paediatricians Audiology
- Identify improvements following the baseline audit
- Identify areas requiring further improvement

Findings:

- Only 18% of newly diagnosed children with permanent hearing loss were seen within 4 weeks of referral. This is a significant decline compared to the previous audit in 2014 where 65% were seen within 4 weeks of referral.
- Inappropriate referral rate has dropped to only 4%.
- The number of patients offered appropriate aetiological investigations has risen from 61% to 86%.
- MRI / CT scans of inner ear were performed in 64% of patients whereas only 20% of patients underwent this important investigation in 2014 audit cycle. No requests for MRI / CT scan were rejected by the Radiology Department.

Key Recommendations**/Action:**

- Number of newly diagnosed children seen within 4 weeks of referral dropped from 65% to 18T. **Action: ENT Managers to ensure that newly diagnosed children with hearing loss are seen in Joint Paediatric Audiology Clinic within 4 weeks**

Title/Topic
General Surgery/Urology
Record Keeping Audit 2016/17
N = 20

Specialty
General Surgery

Completed
March 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings

Findings:
- 54% of standards fully compliant
- 13% of standards with high compliance
- 27% of standards with moderate compliance
- 6% of standards with low compliance

Key Recommendations/Actions:
- Greater accuracy required in recording of information on electronic discharge summaries
- Need for timed entries in the record. **Action: To be shared with all staff at Clinical Governance Meeting**

Title/Topic
Learning Disabilities Audit
N:

Staff Survey = 127
Patient Survey = 33
Notes Review = 30

Specialty
Corporate

Completed
March 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
Obtain baseline information on specific arrangements currently in place at this Trust for patients who have a learning disability

Findings:
Organisational Snapshot Audit:
- Eighteen audit standards were identified. The position statement as at 01.09.16 identified the Trust is fully compliant with 50% of stadanrds, partially compliant with 44% of standards. The Trust is not compliant with 1 standard

Staff Survey:
- Forty seven percent of staff felt there was a patient care pathway in place for patients with a Learning Disability admitted as an emergency, 51% of staff were unsure and the remaining 2% of staff felt there was no pathway in place.
- Ninety percent of staff stated they had cared for a patient with a learning disability.
- Thirty five percent of staff stated they had attended a local training session on caring for the needs of patients with a learning disability. The main forms of training were through Induction and the Trust's Learning Disability Workshop.
- Sixty percent of staff felt the Trust has recognised processes in place to help staff be aware that a patient has a Learning Disability. Eight percent of staff disagreed with this statement whilst 32% of staff were unsure.

- Sixty five percent of staff felt they have access to information/resources in the hospital to help them identify the specific needs of patients with a Learning Disability. Eight percent of staff disagreed with this statement and the remaining 27% of staff were unsure.

- Eighty nine percent of staff felt patients with a Learning Disability have access to the same investigations and treatments as anyone else, whilst acknowledging and accommodating that they may need to be delivered differently to achieve the same outcome. Five percent of staff disagreed with this statement whilst 6% of staff were unsure

- Fifty nine percent of staff stated they would consider using the Learning Disability Liaison Nurse to help care for a patient with a learning disability.

- Twenty eight percent of staff stated they have been required to make a referral to the Learning Disability Liaison Nurse.

- Forty six percent of staff stated there were information/materials specifically available in their ward/department to help patients/carers with a Learning Disability during their visit/stay.

- Sixty one percent of staff felt Mental Capacity Act advice is easily available 24 hours a day

- Sixty one percent of staff stated they had received Mental Capacity Act Training

- Twenty three percent of staff felt they were very confident in applying the principles of mental capacity laws. Fifty seven percent felt somewhat confident and the remaining 20% were not confident at all with applying principles of mental capacity laws

- Thirty three percent of staff felt they would feel more anxious caring for a patient with a learning disability than with other patients.

- Seventy percent of respondents felt they have the necessary skills to care for patients with learning disabilities.

- Sixty four percent of staff felt confident evaluating the baseline health needs for patients with a learning disability.

- Sixty eight percent of staff felt able to respond appropriately to patients with a learning disability who are distressed.

- Sixty three percent of respondents felt there are processes in place within their ward/department that enables care to be adjusted to meet the needs of patients with a learning disability.

Patient Survey:

- All patients stated they had been told why they needed to come to the hospital.

- All patients felt they have always been able to ask questions about their stay.

- Ninety four percent of patients felt they are listened to by the hospital staff.

- All patients felt they were safe in the ward they were staying in.

- Ninety six percent of patients stated they felt involved in decisions about their care, whilst 4% of patients felt they were not involved in decisions.

- Fifty seven percent of patients stated they were not given any leaflets/additional written information whilst in the hospital.

- Forty four percent of patients stated hospital staff read their 'All About Me'

- Ninety three percent of patients stated they had seen a learning disability nurse during their visit/stay

- The majority of patients (90%) felt happy whilst in hospital, 3% felt unhappy and 7% of patients were unsure

Notes Review:

- High compliance with 2 standards; poor compliance with 7 standards

Key Recommendations/Actions:

- There was little evidence available to confirm that the Trust recognises people who have learning disabilities as a high risk group for deaths from respiratory problems. **Action:** Trust must ensure compliance with National Learning Disability Mortality Review (as of 01/04/17). Advice to Respiratory Leads around learning disability being a high risk group for respiratory related deaths

- Many staff did not seem to have an awareness of the available resources, care pathways etc. in place for patients who have a learning disability. **Action:** Update Learning Disability Resource Folder and disseminate across hospital

- Less than half of the staff who returned the survey had received any training around caring for patients who have a learning disability. Action: Begin to consider options to increase LD Awareness training uptake

- Less than a third of staff who returned the survey were confident in applying the principles of the Mental Capacity Act. **Action:** As per actions detailed within Trust Mental Capacity Act Audit (2017)

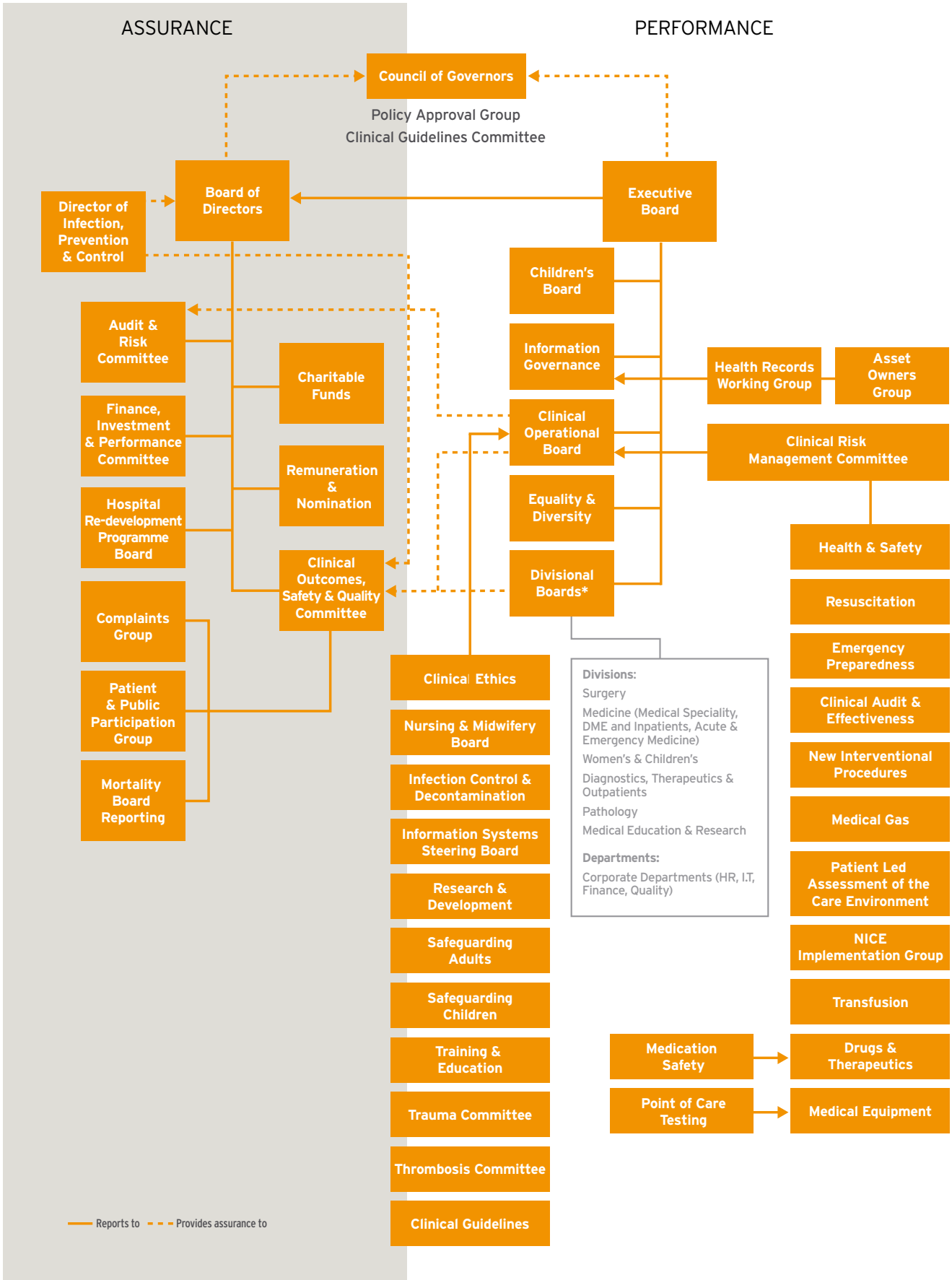
- There was little evidence to show that the All About Me document is being used by hospital staff. Action: Document is in the process of being updated using feedback from hospital staff Consider ways to promote this document (discuss with Communications)

- Very few patients who returned the survey received written information in a way that was accessible to them. **Action:** This will continue to be followed up / discussed as part of Accessible Information Standard. Discuss with Patient Experience Leads

- Less than half of the notes reviewed contained evidence that family members or carers where communicated with. Very few patients / carers felt that support made was available to carers. **Action:** Continue with the development of a welcome pack for those who have learning disabilities and their carers, and to include details of the Carers Lounge in this, with support from LD Liaison Nurses. Review the 'Guidelines for Support or Carers of Patients who have a Learning Disability with support from LD Liaison Nurses

Appendix B – Trust Committee Structure

Luton and Dunstable Hospital Governance and committee structure



* Divisional Board meeting include standard agenda items of Risk Management, Risk Registers, Incidents, Complaints and claims and information related to each of the relevant sub-committees of the Clinical Operational Board

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