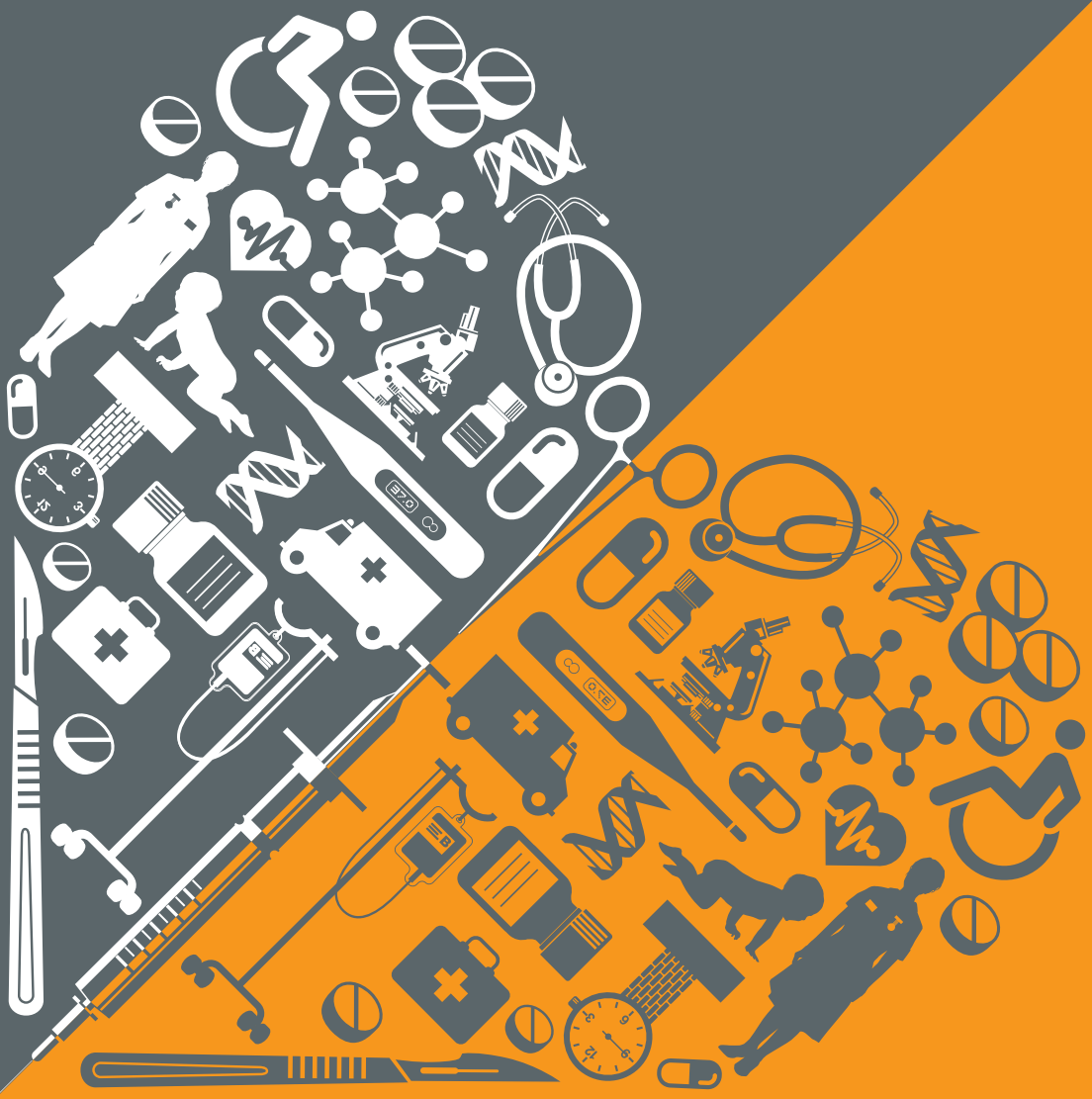
LUTON & DUNSTABLE UNIVERSITY HOSPITAL

Quality Account

for the period April 2016 to March 2017



Luton and Dunstable University Hospital
NHS Foundation Trust

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.

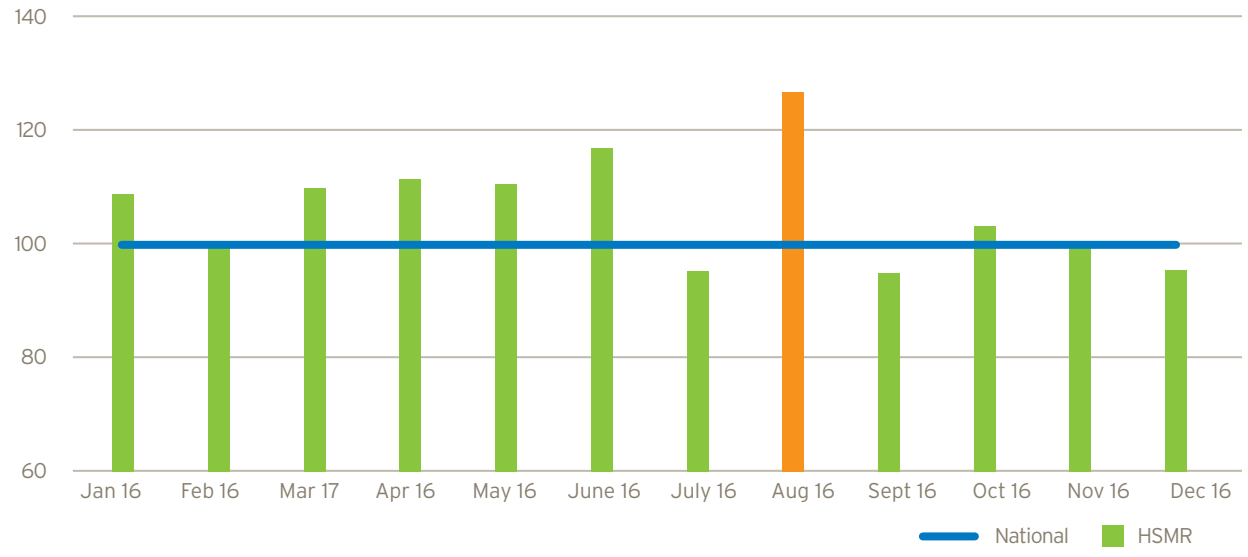
What did we do?

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.

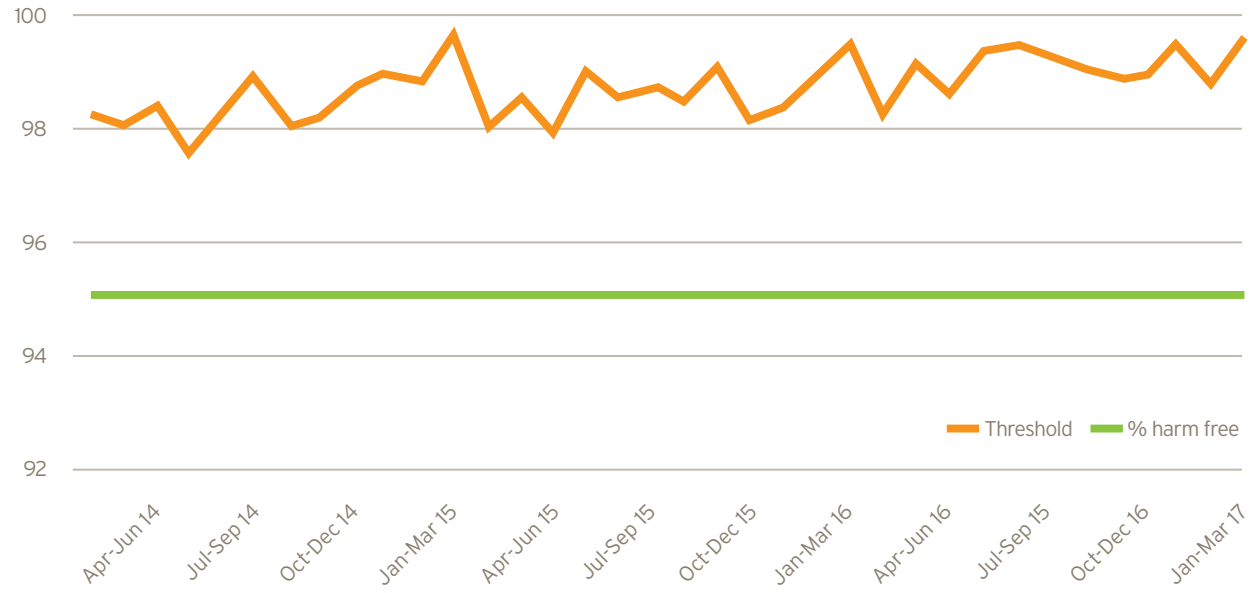
What did we do?

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

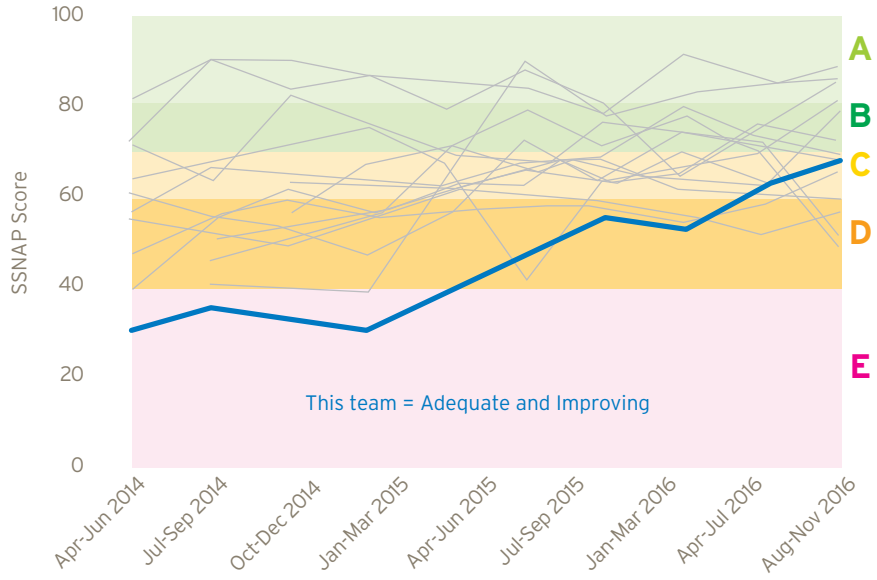
New Consultant Posts

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

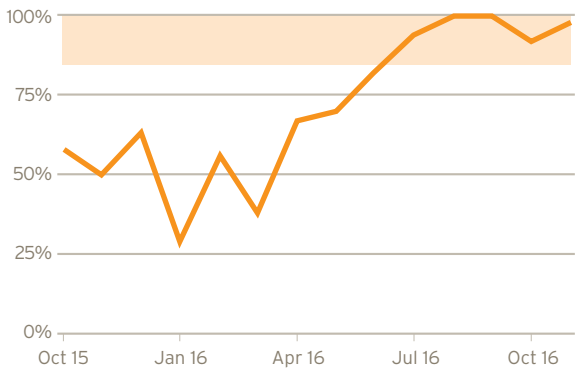
Luton and Dunstable Hos ital - SSNAP Executive Summary			
Activity and length of stay			
In August-November 2016 this hospital treated 260 patients, of which:			
256 patients were first admitted to this hospital		4 patients v1ere transferred in from another hospital	
leneth of stay:	For all routinely 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).

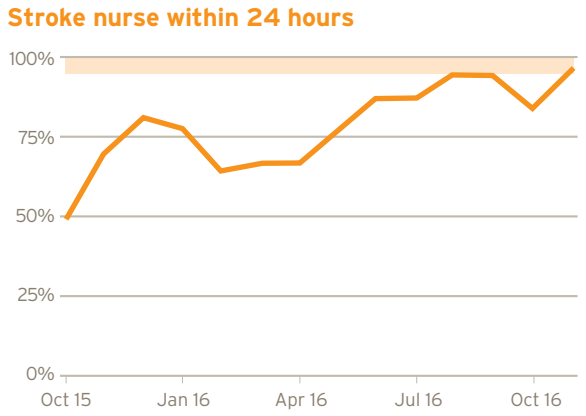
Figure 1

Swallow screen within 4 hours



Source SSNAP Aug-Nov 2016
Team centred results at team level for Key Indicator 4.5B (Team 185)

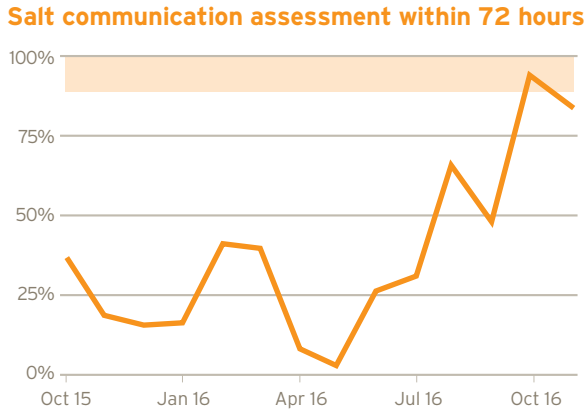
Figure 2



Source SSNAP Aug-Nov 2016
Team centred results at team level for Key Indicator 4.3B (Team 185)

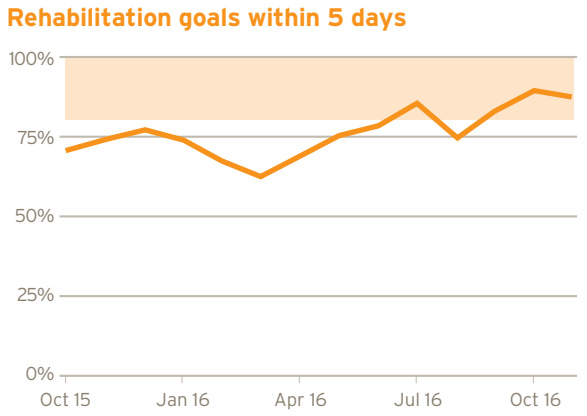
There has also been a stroke therapy service manager appointed who has been responsible for improving: Physiotherapy; Occupational Therapy; Speech and Language Therapy; and Dietetics. Physiotherapy and Occupational Therapy for the unit continues to be rated as Excellent (OT) and Good (PT). Locum SLT 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)

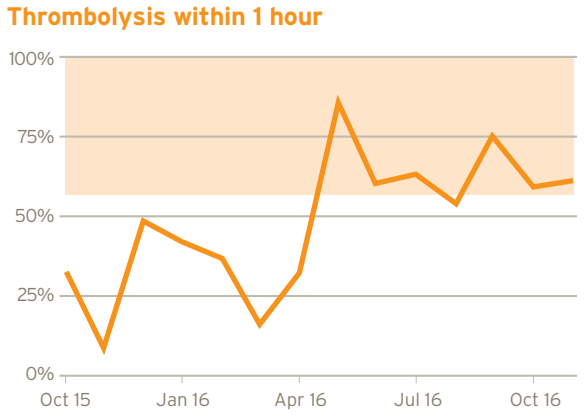
Figure 4



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.

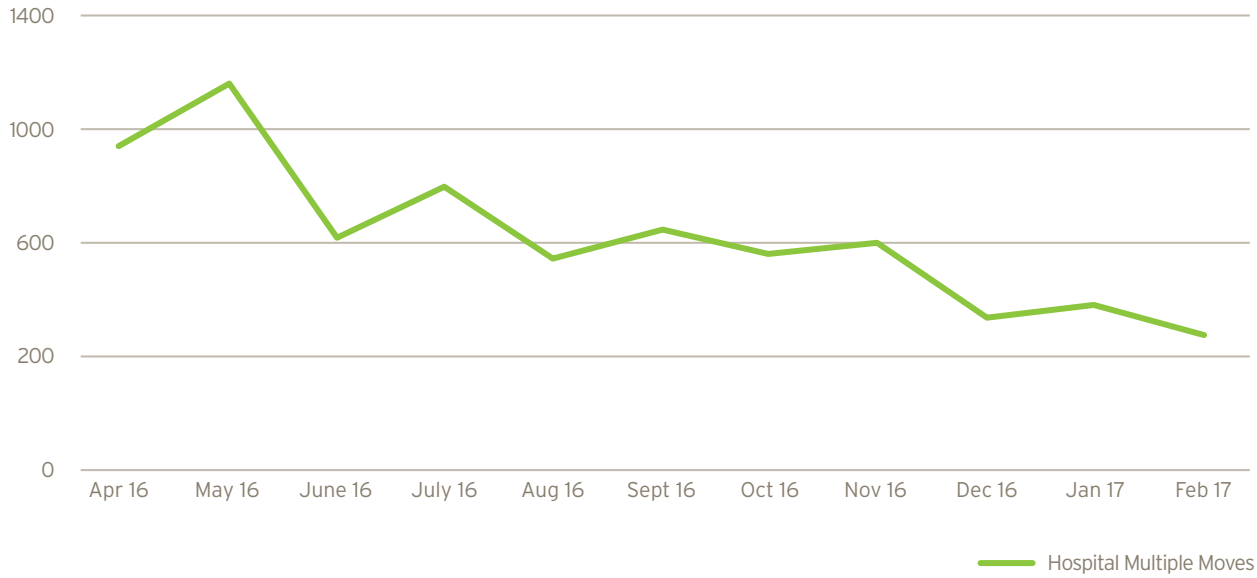
What did we do?

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.

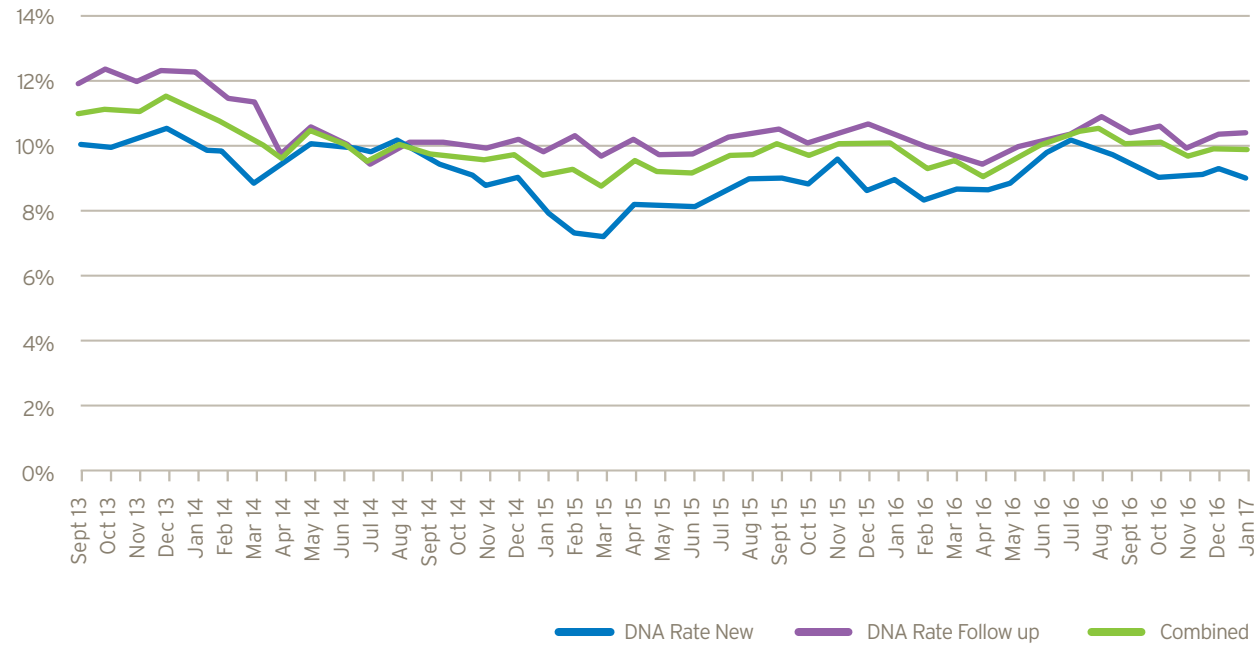
How did we perform?

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

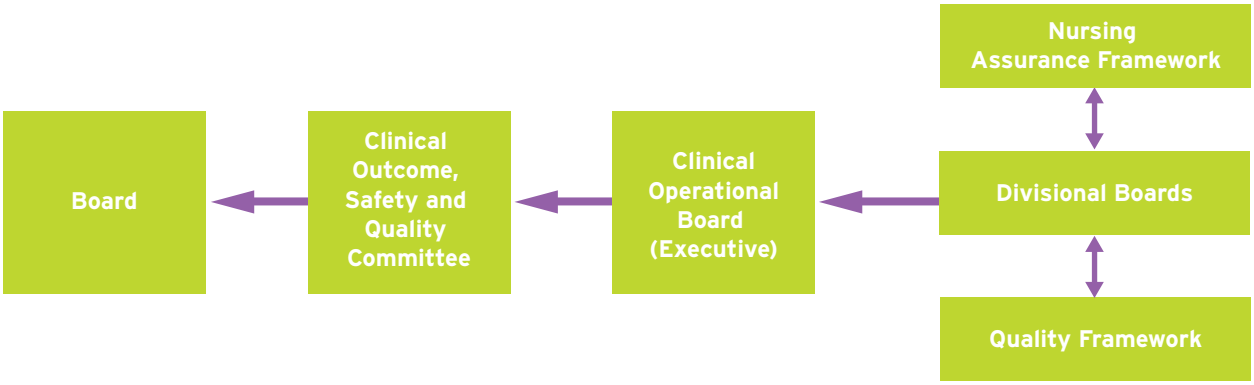
4. Statements related to the quality of services provided

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

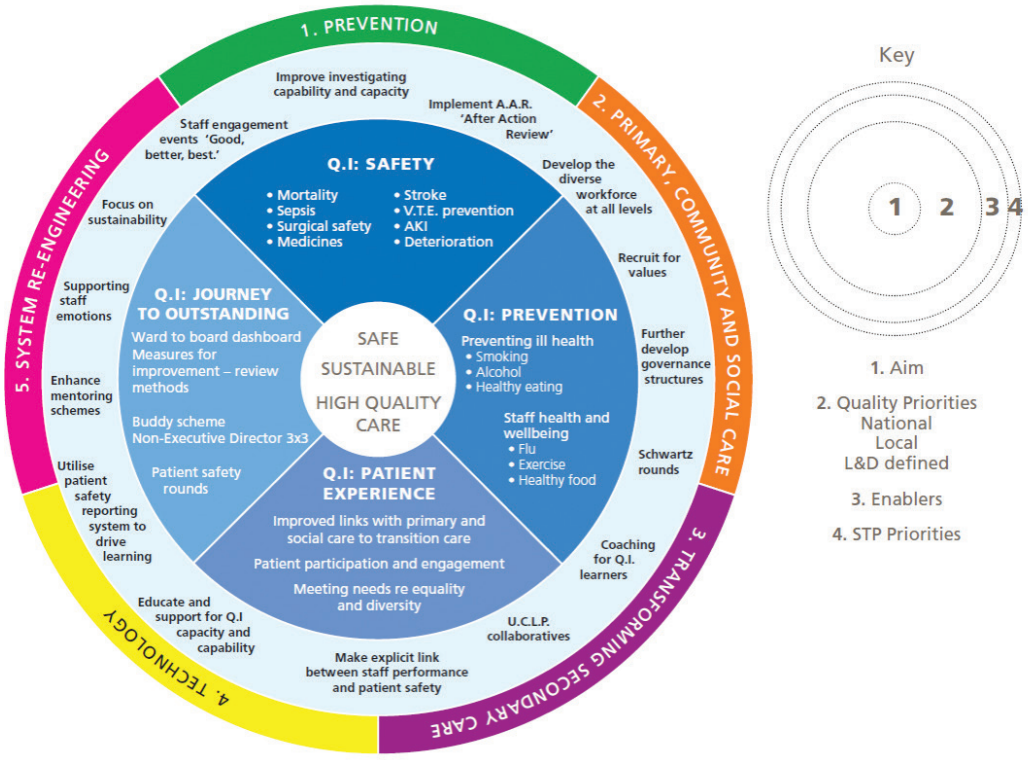
The CQC report was published in June 2016 and although the CQC Inspection Report did not mandate any actions for the Trust it did highlight a 'requires improvement' for safety.

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

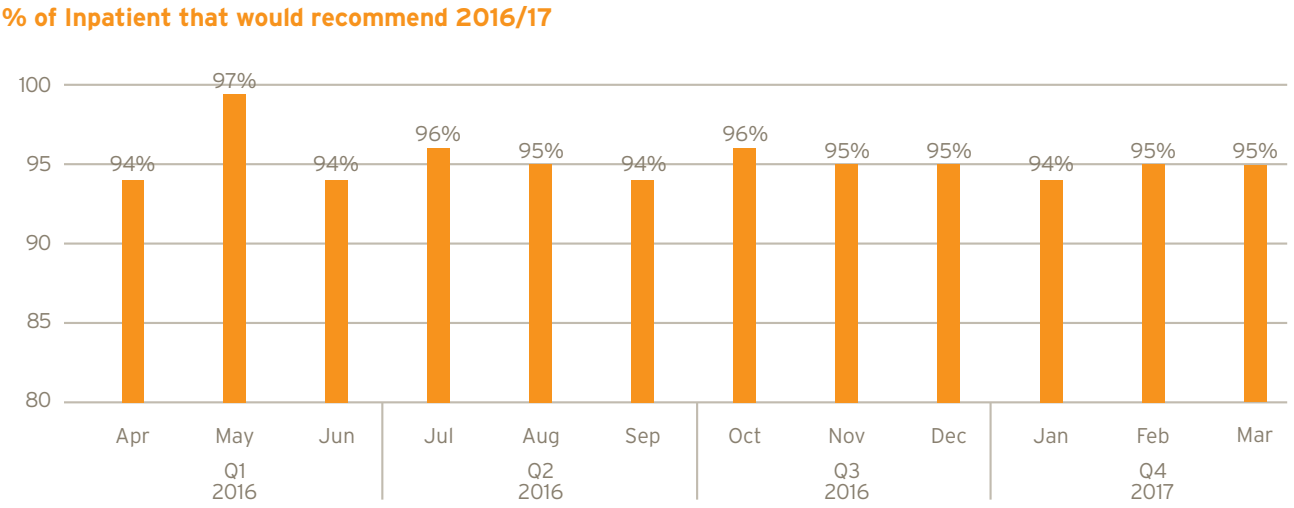


Table 2 Accident and Emergency Percentage Recommend Scores 2016/76

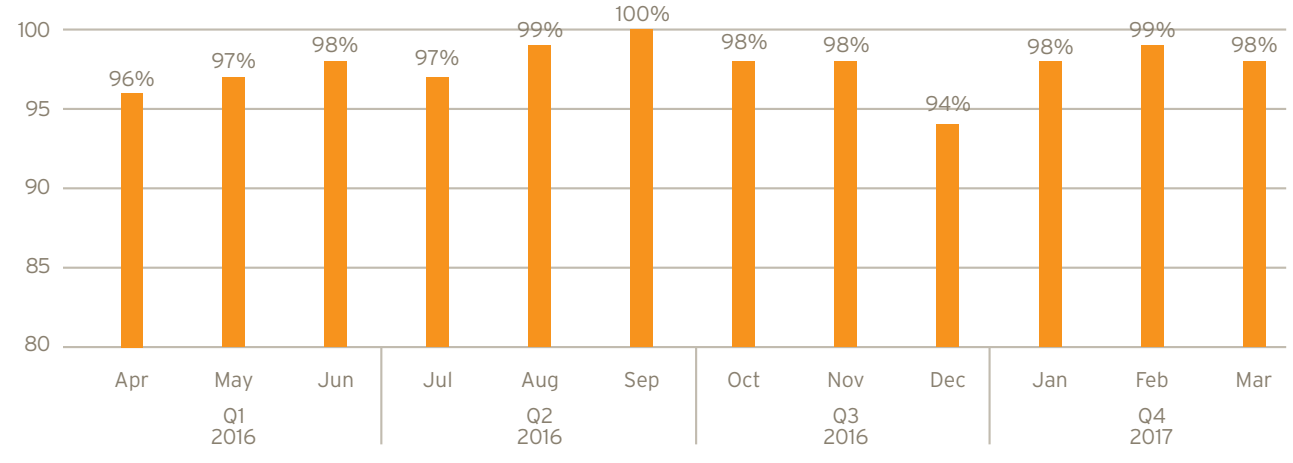


Table 3 Maternity Percentage Recommend Scores 2016/17

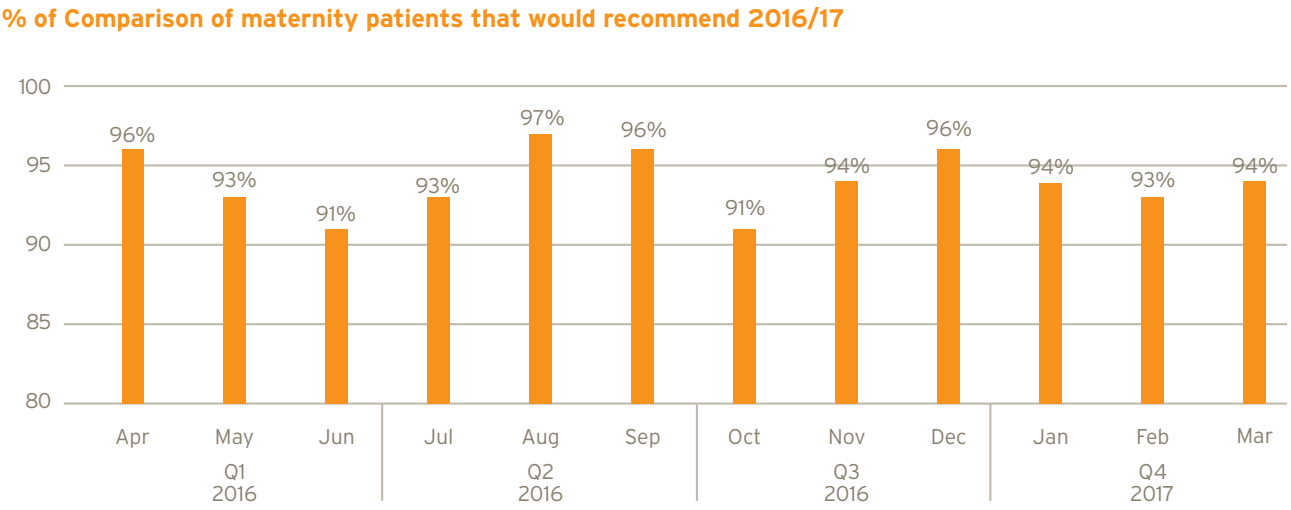
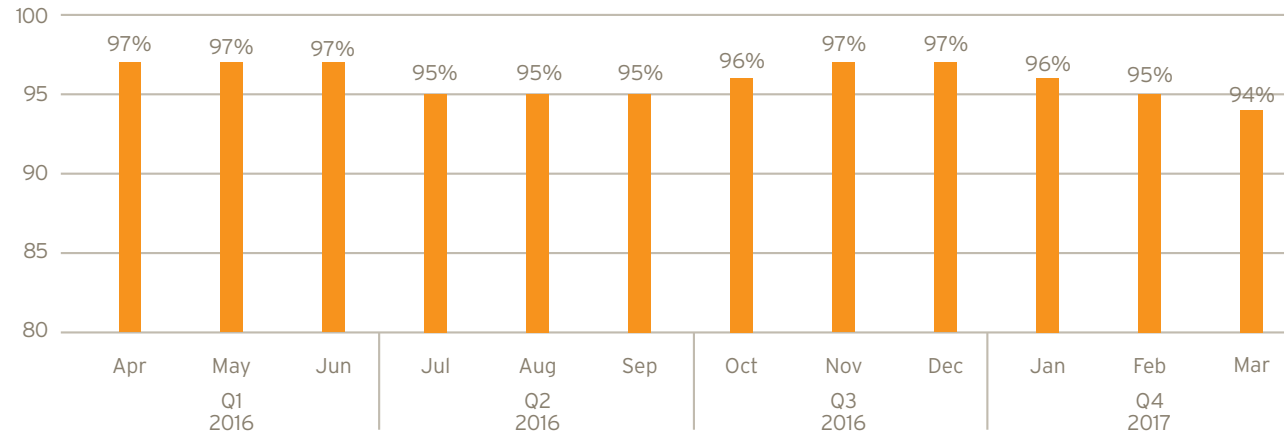
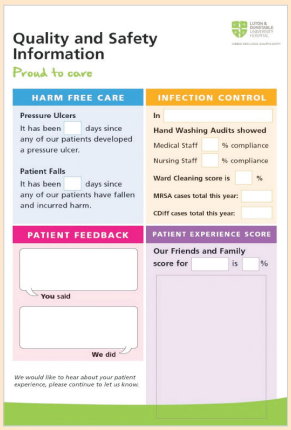


Table 4 Outpatients Percentage Recommend Scores 2016/17



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.

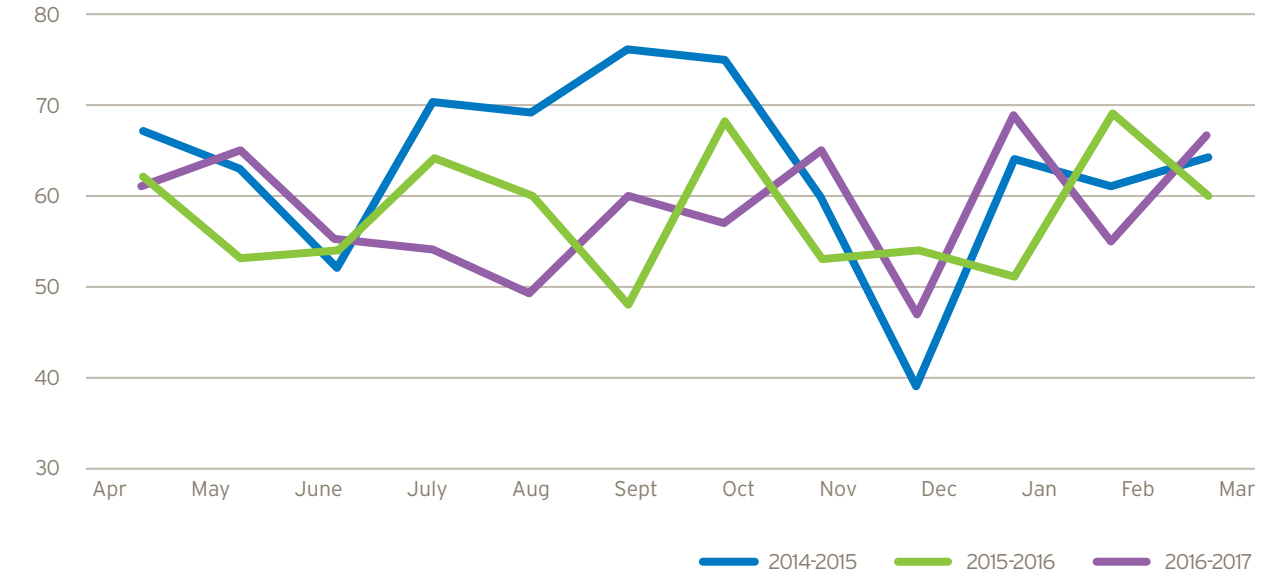
5.5 Complaints

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.

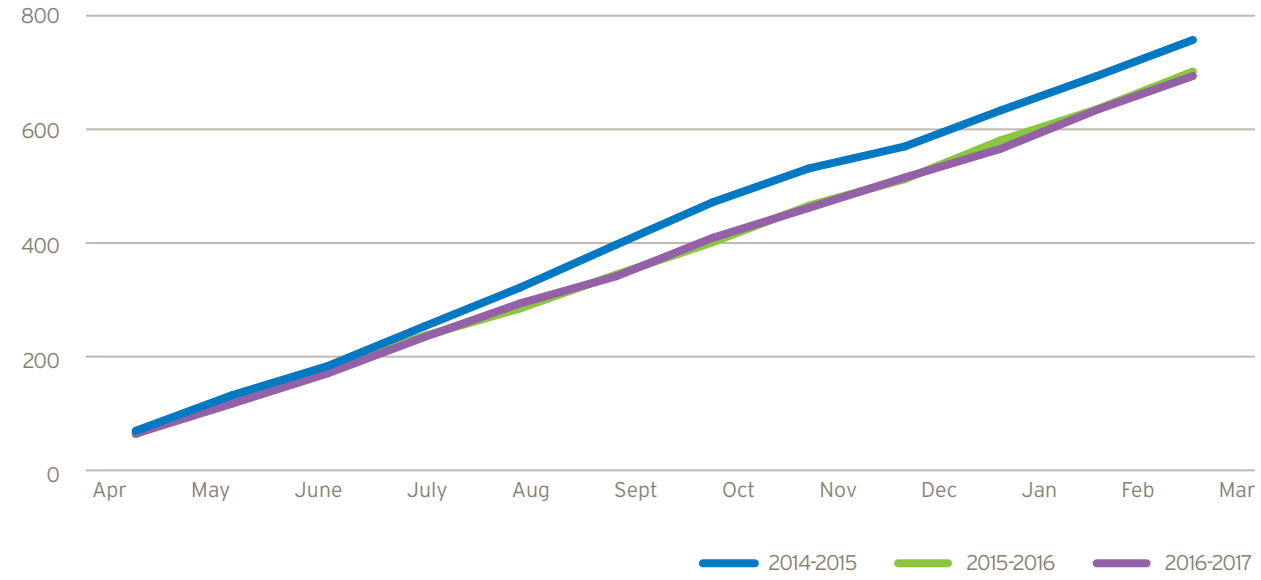
The Trust has made significant efforts to resolve people's concerns quickly, thereby reducing the need for them to follow the formal complaints process.

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

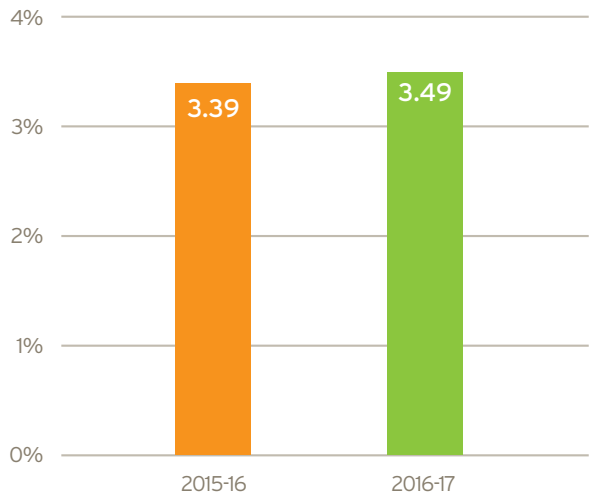
In October 2016, the Trust reduced the Bradford Score trigger point from 200 to 150 as a way of managing employee attendance more effectively through providing earlier formal support and continuing to deliver against the Trust's operational requirements.

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:

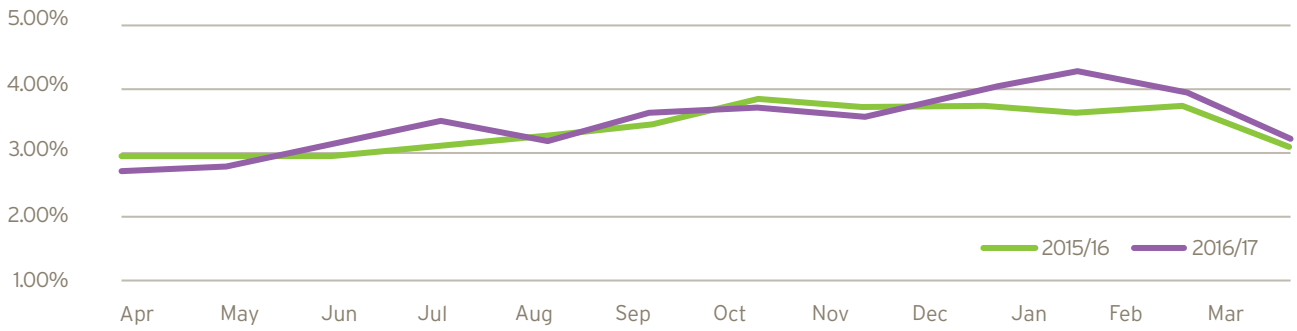
- Suitable support mechanisms and appropriate, reasonable adjustments implemented at an earlier stage, allowing employees to achieve and maintain maximum attendance;
- A reduced absence rate resulting in alleviating staffing pressures on wards and departments;
- A reduction in costs associated with sickness 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)

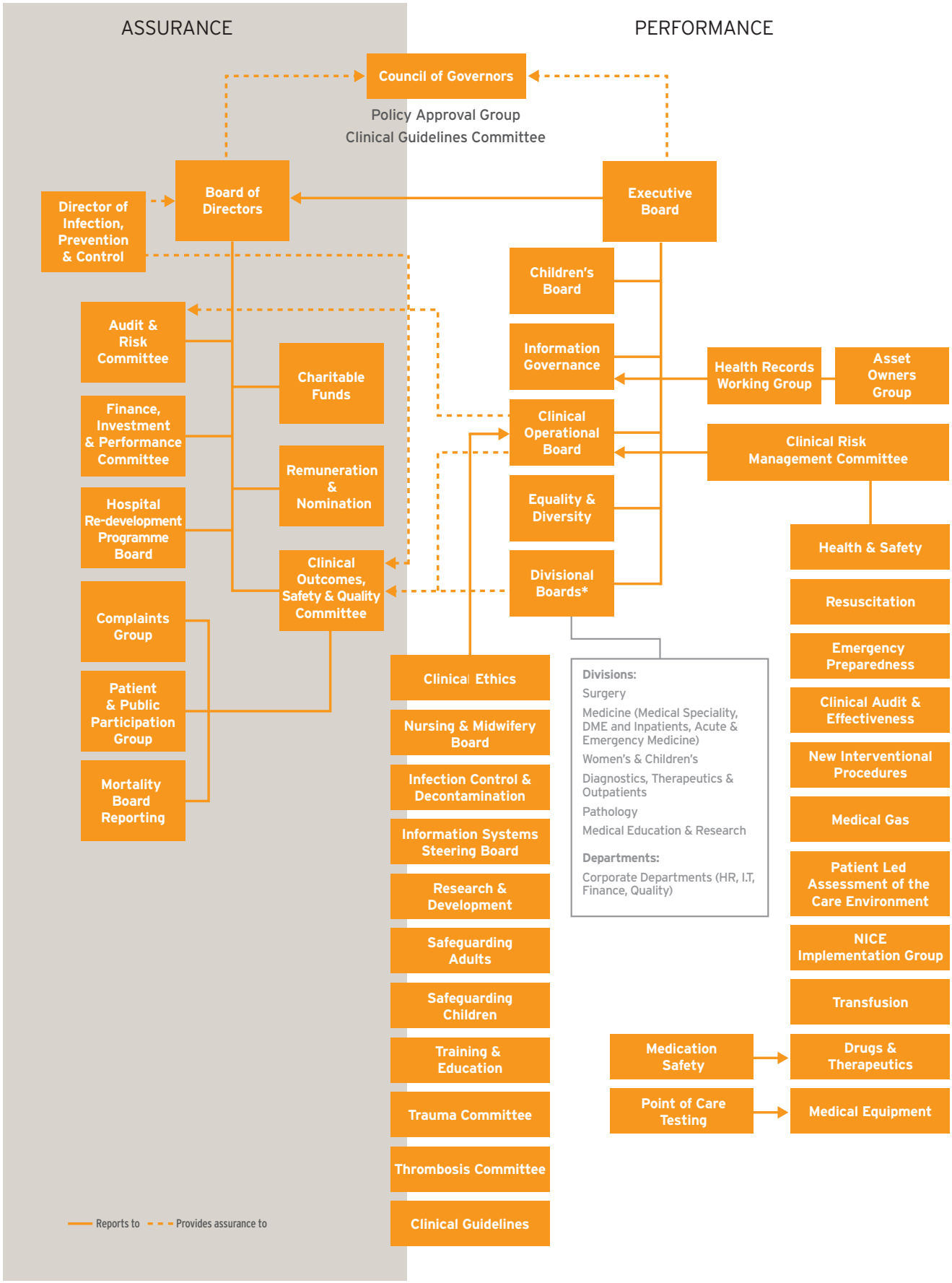
- There was little evidence to show that the All About Me document is being used by hospital staff. Action: Document is in the process of being updated using feedback from hospital staff Consider ways to promote this document (discuss with Communications)

- 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

Luton & Dunstable University Hospital
NHS Foundation Trust
Lewsey Road Luton LU4 0DZ
Telephone 01582 49 11 66
www.ldh.nhs.uk