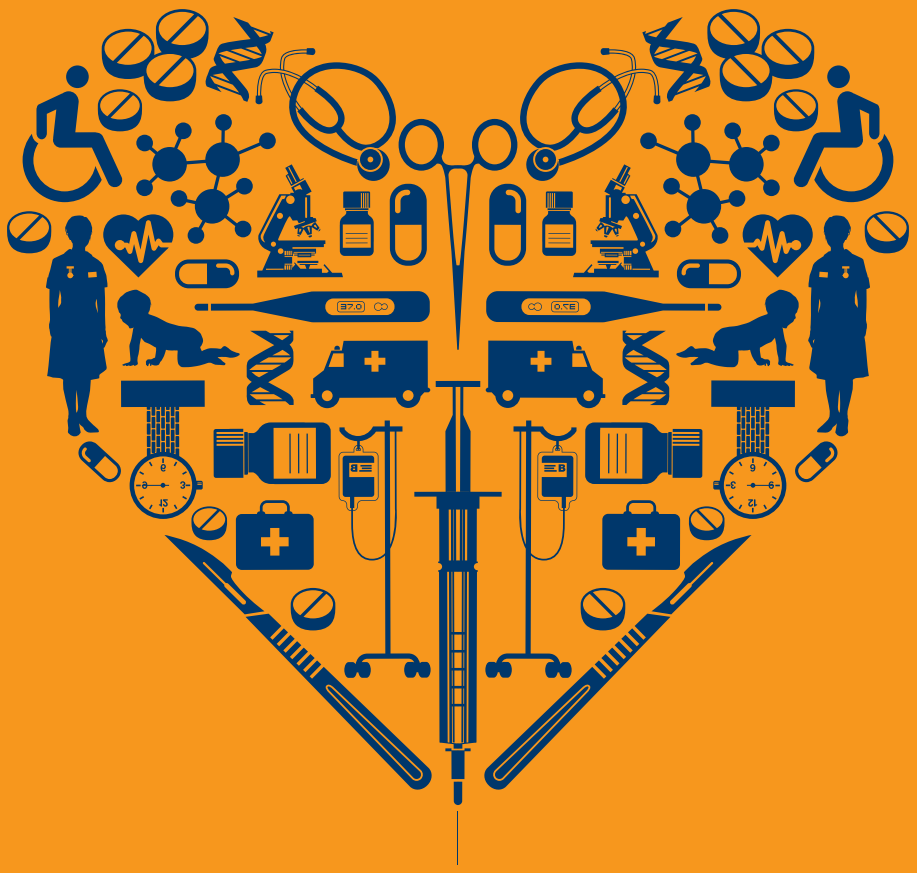
LUTON & DUNSTABLE UNIVERSITY HOSPITAL



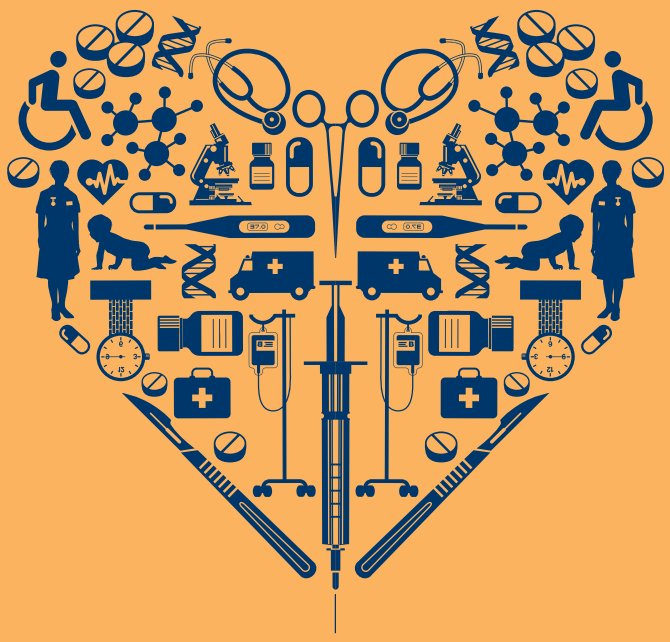
Quality Account

for the period April 2018 to March 2019

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 2017/18 is included in this account alongside our priorities and goals for quality improvement in 2018/19 and how we intend to achieve them.

How the 'quality' of the services provided is defined?

We have measured the quality of the services we provide by looking at:

- Patient safety
- The effectiveness of treatments that patients receive
- How patients experience the care they receive

About our Quality Account

This report is divided into sections.

- A statement on quality from the Chief Executive and sets out our corporate objectives for the coming year.
- Our performance in 2018/19 against the priorities that we set for patient safety, clinical effectiveness and patient experience.
- Our quality priorities and goals for 2019/20 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.
- Statements related to the quality of services that we have provided and includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.
- Our quality performance and includes performance against national priorities and local indicators. It also provides examples of how we have improved services for patients.
- A statement of Directors' responsibility in respect of the quality report.
- Comments from our external stakeholders.

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 Luton Annual Public Health Report 2015/16 focussed on school aged children and identified particular issues in relation to language, poverty, obesity and activity, looked after children and mental health.

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 new-born babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

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 Orthopaedic Centre situated further along Dunstable Road and chronic obstructive pulmonary disease (COPD) and Diabetes services for South Bedfordshire.

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

Division	Specialties	
Medicine	Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine Respiratory Medicine Diabetes and Endocrinology Gastroenterology	Cardiology Dermatology Heptology Neurology Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery – Colorectal – Upper Gastrointestinal – Vascular – Bariatric Surgery Urology Paediatric Surgery Trauma & Orthopaedic Hospital at home Critical Care	Plastic Surgery ENT Cancer Services Medical Oncology Ophthalmology Oral & Maxillofacial Surgery Anaesthetics Pain Management Orthodontics Audiology

Division	Specialties	
Women and Children's	Obstetrics Community Midwifery Early Pregnancy General Gynaecology Gynae-oncology	Paediatrics Fertility Neonatal Intensive Care Unit Uro-gynaecology Ambulatory Gynaecology
Diagnostics, Therapeutics & Outpatients	Pathology Services - Blood Sciences - Cellular Pathology - Microbiology - Phlebotomy Haematology Care Pharmacy Physiotherapy and Occupational Therapy	Imaging Musculoskeletal Services Dietetics Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2018/19 Divisional Directors, General Managers and Executive Directors met in the Executive Board.

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

Other Executive meetings are dedicated to the Clinical Operational Board that reviews the clinical performance of the Trust and Executive Seminars for ensuring the Trust Board is up to date on Quality initiatives.

A Statement on Quality from the Chief Executive

At Luton and Dunstable University NHS Foundation Trust we are committed to providing high standards of care for each of our patients. This is underpinned through our key values all of which support delivery of our corporate objectives and quality priorities. Our vision statement reflects our belief that the creation of a quality services starts with the recruitment and retention of staff with the right motivation and values.

During the last year we have maintained a focus on building a culture where safety, excellent outcomes and patient experience are our overarching concern and where every member of staff understands their role to deliver this together. Our quality strategy remains a key focus for advancing this objective and we actively foster an organisational commitment to continual quality improvement in an atmosphere built on respect and support.

I am delighted that, as in previous years, we delivered against most of the national and local quality and performance targets. In particular we continue to be one of the best performing hospitals in the country for the waiting time targets for emergency care. Our CQC inspection reaffirmed our status as a 'Good' hospital and we will take the learning from that inspection to understand our areas for improvement.

Whilst pressures and demands on the NHS and its services continue it is pleasing to note the significant progress against the aspirations of our quality priorities for last year. Of particular note are:

- The improvements in care for 'Care at the End of Life' as evidenced through the national audit outcomes
- Reductions in the length of time our patients need to stay in hospital through the improvement work of our Needs Based Care programme
- The marked improvement our cardiac arrest rate which is now below the national average
- The reduced incidence of blood clots caused by a failure to prescribe thromboprophylaxis and a 99% compliance rate with risk assessing patients as to their need for this medication
- The use of mortality review and learning from deaths as overseen by our mortality Board, leading to the Trust achieving its lowest crude mortality rate for many years with a downward trend for other mortality indicators
- Improvements to our mental health support provision for patients accessing our emergency department has reduced their need to attend the emergency department on a more regular basis
- Improved advice and guidance by telephone and / or email for our GP partners to avoid patients having to visit the hospital
- The numbers of our staff receiving their flu vaccine exceeding the national target

The organisation does, however, recognise that as well as building on the success of these initiatives there are still areas we need to do much better and it is these that have been highlighted as key priorities within this within this quality account.

Our aim is to continue to encourage a culture of continuous quality improvement to underpin all of our initiatives to ensure we remain focussed on our journey to 'Outstanding' and the things that matter most to our patients and staff.

David Carter
Chief Executive Officer
22nd May 2019

Corporate Objectives 2018/19

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

1. Deliver the Quality Priorities outlined in the Quality Account

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

2. Deliver National Quality and Performance Targets

- Deliver sustained performance with all CQC outcome measures.
- Deliver nationally mandated waiting times and other indicators.

3. Implement our Strategic Plan

- •Progress plans to work collaboratively with BLMK STP (local Health Economy) in delivering integrated care and maximising sustainable clinical outcomes of secondary care.
- Implement preferred option for the re-development of the site.

4. 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 and reducing our agency use.
- 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.

5. Optimise our Financial Plan

- Deliver our financial plan

The updated plan sets out:

- How we will achieve further progress against our Strategic Plan during 2017 – 2019.
- Our key deliverables to ensure that we are able to maintain operational performance during the year against national and local priorities.
- How our plans are underpinned by our workforce and financial projections.
- How this plan takes account of the Sustainability and Transformation Plans (STP).

Achievements in Quality Improvement Priorities 2018/19

The Trust's overarching quality strategy was updated and launched for 2018-2021 and this described four key priority areas based on local, national and sustainability and transformation (STP) programme priorities, they are:

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

Quality priorities for 2018/19 listed ambitious programmes of improvement work to ensure that the Trust continues on the journey to become an outstanding organisation for people who both use and work within our hospital.

The outputs from this work are listed below.

Priority 1: Improving Patient Experience

1.1 Collaboratively develop a contemporary set of Trust values with staff, patients and public and further develop and spread ways of working that allow team behaviours to flourish.

Why was this priority?

The Trust had developed a new set of organisational values to support a range of activities that underpin organisational culture, quality and performance.

What did we do?

There were several strands of work which supported this priority. In particular, in line with our values reflecting that caring for our staff will support them to care for our patient, we produced a new document for use across the organisation called 'The Way We Work at the L&D: our Vision, Values and Behaviours'.

The content of the document reflected engagement activity and contributions by staff gained through events spanning the previous two years and the document articulates the behaviours expected of people in a way that demonstrates our values. We launched the booklet through one of our Good, Better, Best staff engagement events in December 2018.

In addition work was undertaken to revise our corporate Induction programme for all new starters in the Trust and this now includes information on our values and what they mean in reality for the organisation to the Trust. At this point new staff receive our 'The Way we Work at the L&D – our Vision, Values and Behaviours' document to reinforce the messages. To provide further support for our new staff we have also developed a comprehensive guide for Trust managers to support the delivery of local induction which is aimed at facilitating improvements to staff retention.

The Trust puts great importance on staff receiving their regular appraisal to help them develop and understand what support they need to provide the best for our patients and the documentation associated with this has been updated to allow them to reflect on how they contribute and work to our values for the benefit of other staff they work with and our patients.

Work is currently underway to develop values based recruitment and we are designing a set of questions which will be tested and improved with a range of manager and team leaders. This will help to ensure that we continue to bring people into the organisation who share our ethos and philosophy.

We have also communicated our values work to a range of stakeholders, including the Care Quality Commission during their recent inspection visit and intend to continue this active promotion of the values moving forward.

How did we perform?

Feedback from 2018 NHS Staff Survey indicates that our staff have appreciated that the organisation has listened to feedback regarding appraisals and that previous values were discussed and updated.

Early feedback is that the new values, accompanied by the underlying behaviours that are descriptors of what they mean in practice, are helpful and enrich the conversation between the manager and their direct report.

It is hoped that the introduction to our values at induction and follow up through appraisal within the year will reinforce staff understanding of their role in delivery against those value and we expect this to have a positive impact on team working and patient experience moving forward.

Whilst this will not be a quality priority for the coming year the improvement work will continue in relation to the Trust values with progress reviewed through several indicators but particularly feedback from the staff and patient surveys.

1.2 Collaboratively develop a set of "Always Events" with staff and patients to address feedback from local and national surveys

Why was this priority?

Always Events® is a tried and tested improvement methodology using co-production between staff, carers and patients to ensure that patients and families are true partners in designing improvements to services. We wanted to use this co-production design to ensure that patients are having the best possible experience of care. Always Events® improvement methodology was aimed at helping us make sure that care was focused on what matters most to our patients.

What did we do?

We firstly signed up to the NHS England Always Event campaign with our staff attending a launch in May 2018. This was followed up with a number of meetings across ward and clinical areas to spread the word and generate interest, enthusiasm and ideas amongst staff initially who then became involved in the programme of work.

This was underpinned with a communications strategy which was aimed at ensuring we had a dialogue of information sharing with patients and their families. This resulted in several patients signing up to join co-design working group.

The programme of work was supported and overseen by a group chaired by our Chief Nurse

How did we perform?

Past patients became engaged in the work through attendance at a coffee morning, providing feedback about what mattered to them and in providing suggestions for change.

The co-production team are designing a communication book using the ideas generated through the work and this is due to be tested using quality improvement methodology and further refined as required.

Whilst this will not be a quality priority for the coming year the improvement work will continue with the Always Events methodology to next be implemented within the Accident and Emergency Department. It is hoped that the benefits of this work will be reflected in our Friend and Family test feedback and our staff surveys.

1.3 Continue to improve the end of life care offering and experience to patients and their carers

Why was this priority?

Improving End of Life (EOL) care was a priority to ensure the best possible quality of care to our patients and families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment.

This is often a difficult area to gain meaningful feedback from the families and carers of those patients who are dying because of the sensitive nature of the situation. However, we knew from the analysis of complaints and other anecdotal evidence, that there was more we could do to improve the end of life care experience for both patients and their families and carers.

What did we do?

The Trust has undertaken several steps to make improvements and in particular we invested in our EOL care (EOLC) team, appointing a full time Palliative Care Consultant and a second EOLC Nurse. This has provided improved resource and allowed for team representation at system wide EOLC groups to facilitate improved communication across the health system.

We have also made improvements to the systems we use to communicate with primary care partners and a communication system called SystemOne has now gone live within the Trust. This allows more effective communication across acute and primary care, giving access to patient advanced care planning thus improving the decision making process. At present we continue to train staff in utilising the system effectively.

As part of making improvements the team have piloted the use of the "Specialised EOLC trolley" on four of our wards to support the "little things make a difference" strategy that the team are advocating. These trollies provide information/toiletries/music etc. for our EOLC patients with a plan that if successful we will roll this out more widely across the Trust. In addition two of the wards have created EOLC space, to include a trolley, that is and dedicated for patients and families. A further ward has created an area to accommodate families either overnight or a dedicated space to have a break.

Many complaints we received from patients and families as well as our primary care colleagues highlighted difficulties with discharge from hospital particularly in relation to the information provided for those on the EOLC pathway.

In reaction to this the team met with colleagues in the community teams and this has resulted in design and production of a joint Nursing Referral Form. Plans are underway in implementation of the new form to coincide with a re-launch of the priorities for EOLC discharge planning continuing into 2019/20.

In addition to re-launch of priorities the Trust has updated its End of Life Guidelines to better support teams. This is supplemented with increased training for staff, with a program of ward based learning delivered on directly on wards to avoid staff leaving their clinical area. Also the EOCL team have actively contributed to the EOLC Competency programme delivered for acute, primary care and hospice staff and from January 2019 the EOLC nurses have been able to attend the Board rounds on three of our main wards which has improved decision making and enhanced the advanced care planning process.

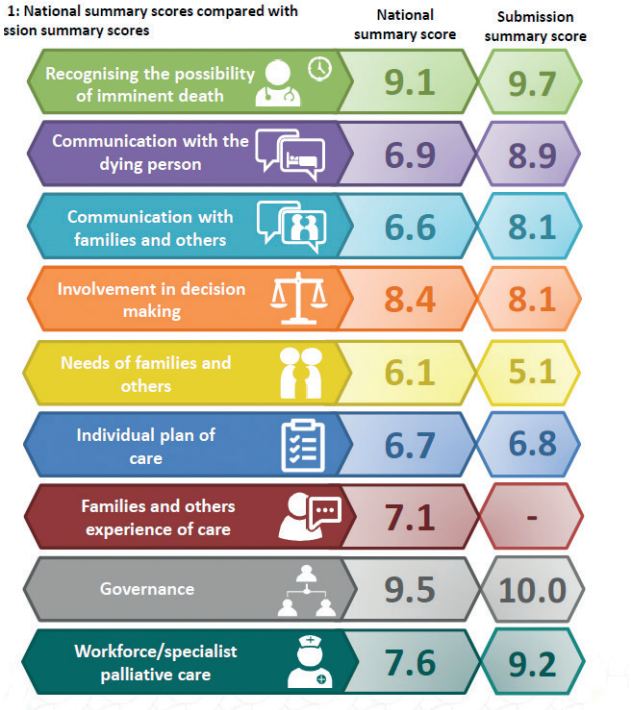
Finally the EOCL team have been working hard to improve data collection and quality in order to further progress the improvement plan as well as demonstrate the quality of care provided to our patients and their families.

How did we perform?

The National Audit of Care at the End of Life (NACEL) aims to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five priorities for care set out in *One Chance to Get It Right* and *NICE Quality Standard 144*, which addresses last days of life, within the context of

NICE Quality Standard 13, which addresses last year of life.

This dashboard compares the result to all acute and community hospitals in England and Wales taking part in the first round of NACEL.



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

1. Recognising the possibility of imminent death
2. Communication with the dying person
3. Communication with families and others
4. Involvement in decision making
5. Needs of families and others
6. Individual plan of care
7. Families and others experience of care
8. Governance
9. Workforce/specialist palliative care

The report shows the trust submitted data for 8 out of 9 sections. Overall above average scores were achieved in 6 out of the 8 sections covering the five priorities of care. However areas for improvement have been identified:

Priority 4 – Involvement in decision making

- Evidence of patient having capacity assessed in order to be involved in decision making.
- Communication with patients and families regarding appropriateness of treatments.
- Documentation of DNACPR discussions.

Priority 5 – Needs of families and others - assessment of spiritual, religious, cultural, social, and practical needs

- Families to be asked regarding their specific needs.

- Documented evidence of care and support provided at the time of and immediately after death.

Whilst this will not be explicitly defined as a quality priority for the coming year the investment and improvement work within EOLC will continue, particularly in relation to the identified improvements above. This will be overseen by the Trust's End of Life Group and performance improvement monitored through the audit.

In respect to themes from complaints however the number related to discharge more generally are still seen as a quality challenge for the Trust and will be a quality priority for 2019/20 as described later in our quality account.

Priority 2: Improve Patient Safety

2.1 Improve continuity through the delivery of Needs Based Care

Why was this 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 always been a focus for 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 and 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 potential clinical risk as a result 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 did we do?

In achieving the aspirations related to Needs Based Care the Trust implemented several strands of service redesign and quality improvement.
Firstly the introduction of a respiratory in-reach model to the front door of the hospital and the on-going introduction of direct admission of patients to respiratory specialists over seven days of the week

The front door in-reach allows for speciality teams to be actively present in our Accident and Emergency department (A&E) and for the acute medical areas and wards to ensure the specific medical plans are put in place as early in the patient pathway as possible.
This model of placing ensuring an appropriate medical plan is in place at the front door and point of admission, together with the provision of expert advice and guidance, supports the prevention of avoidable emergency admissions.

The key service improvements delivered by the respiratory team are:

- Confirmation of medical diagnosis supporting admission prevention and/or earlier discharge
- Hot clinics where GPs may directly refer a patient with respiratory problems who meets specific criteria to immediately see a specialist. These patients may be at threat of requiring admission but quick intervention and treatment plan from a respiratory consultant may avoid this so they can remain in their own home
- Early Supported Discharge (ESD) supporting patients to stay at home and avoid coming into the hospital

The Trust has also developed a Frailty Unit which has a simple referral system with a single point of access for frail older people. Expert decision makers are available at the front door of the hospital with specialist assessment available. Our patients that are admitted and frail can often be supported to return home and their care managed outside of the hospital if treatment and intervention happens quickly with the right range of multi-disciplinary support available. This is important as once an elderly patient starts on a full admitted pathway they are at risk of losing their mobility and independence, as well as the confidence in their ability to manage at home.

Within the Unit all appropriate patients now undergo a frailty / comprehensive geriatric assessment. Following this if they are recognised as having complex medical or social care needs they are admitted to one of our complex medical ward facilities where they will be cared for by one of the geriatricians, with support from other specialist physicians as required. If the assessment shows

they do not have complex medical or social care needs, they are admitted to a speciality ward and cared for by the specialist team.

The Trust has appointed a Lead Nurse for Frailty specialist role and this skilled individual has high levels of autonomy and decision making ability to ensure provision of specialist care. These specialist and advanced nurse practitioners are able to manage clinical care in partnership with patients and carers, enabling innovative solutions to enhance patient experience and improve outcomes.

Another strand of work has seen the introduction of a pharmacy team at the front end of the hospital. This team now work between the A&E department and our Emergency Assessment unit and key changes this has facilitated include

- Identification of patients where there has been a decision to admit to hospital and then rapidly take an accurate medication history and rapid reconciliation of medicines
- Ability to discuss medication taking patterns directly patients and their carers to identify any compliance issues, if they are suffering from any side effects and then provide support through education on improved medication taking
- An ability to assess the patient's own drugs for continued use and ensure these accompany patients to their next ward. They also facilitate quick supply of any new medicines to ensure treatment is started as soon as possible
- They can advise and support staff on prescribing, administration and monitoring of unusual, complex or high risk medicines
- It allows improved compliance with all required standards including NICE Guidance on Medicines Optimisation

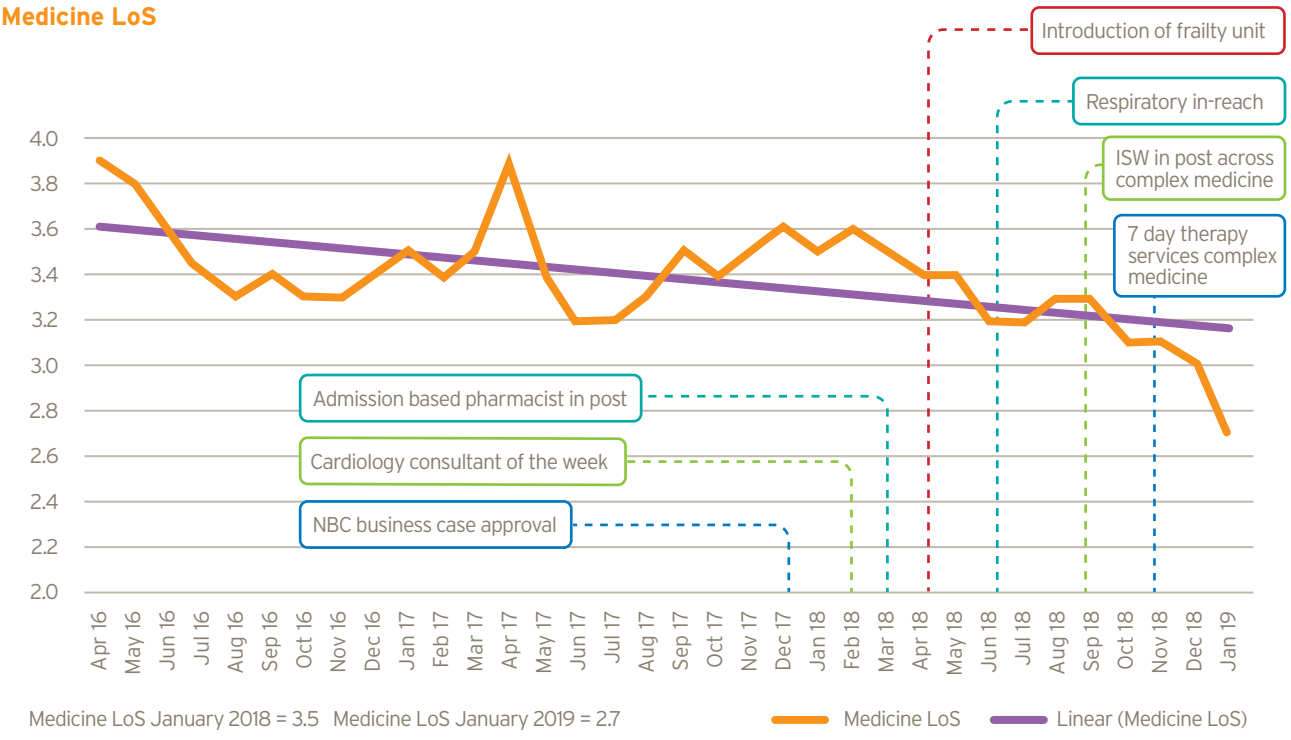
Finally, the model for use of our Therapy staff has also been reviewed leading to significant improvements. This staff optimisation was not to simply an increase in staffing numbers but was the use of more experienced "decision makers" from the therapy team in addition to extending the scope of their role within the A&E department. These changes along with some increased staffing has supported a more robust seven day service with extended hours of service and increased autonomy for those staff in the A&E department.

How did we perform?

We are pleased to see that this improvement work has shown a downward trend in length of stay for patients in medical beds as indicated in the charts below. The average length of stay of 3.5 days in January 2018 has reduced to 2.7 days in January 2019.

The steepest reduction has been seen following the expansion of therapy services to a seven day service thereby complimenting the range of initiatives to have been put in place over this year.

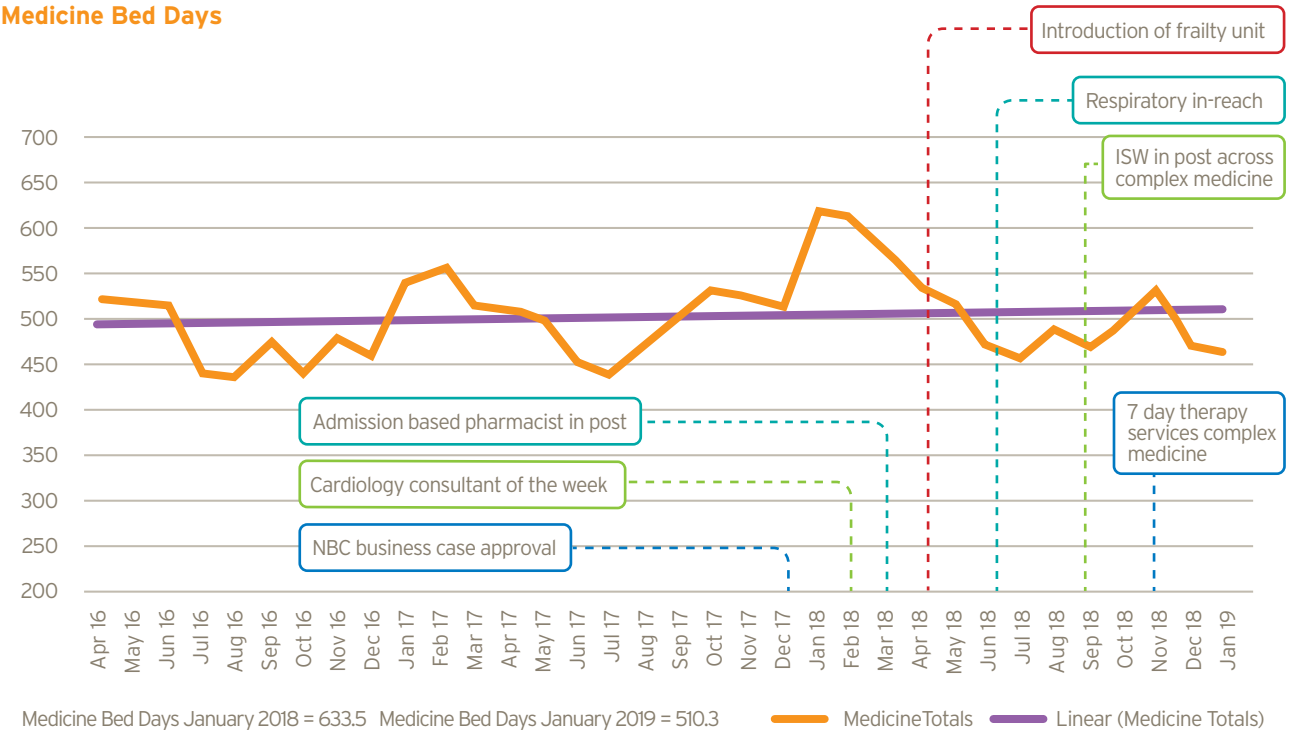
Medicine LoS



Whilst there has been a reduction in bed days by 19.4% in January 2019 compared to January 2018 (510.3 bed days compared to 633.5), the Trust has provided care and treatment to more patients as seen by the steady increase in medicine ward stays. In January 2019, there were 5,791 ward stays, which represents an additional 3% over and above the peak number of patient stays seen in January 2018.

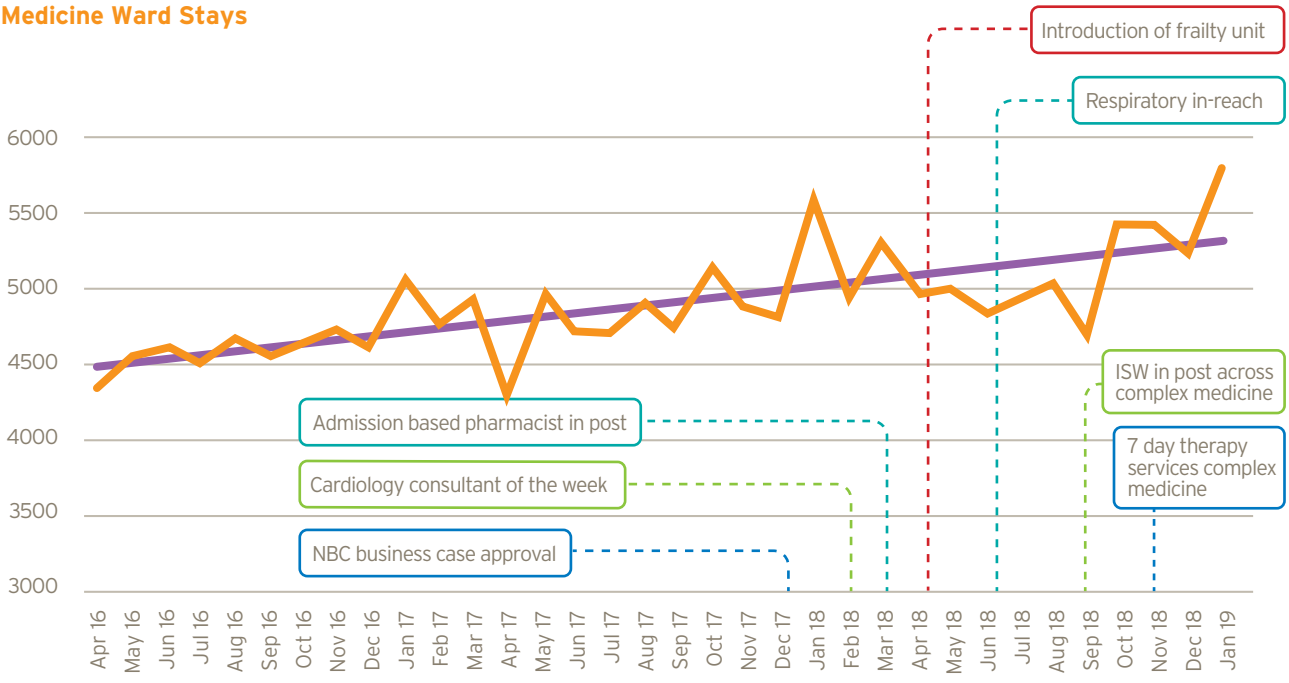
This can only be made possible by the more efficient delivery of care and treatment resulting from the cumulative effect of a range of best practice initiatives and patient pathways.

Medicine Bed Days



Medicine Bed Days January 2018 = 633.5 Medicine Bed Days January 2019 = 510.3 — Medicine Totals — Linear (Medicine Totals)

Medicine Ward Stays



Medicine Ward Stays January 2018 = 5,608 Medicine Ward Stays January 2019 = 5,791 — Ward Stays — Linear (Ward Stays)

Whilst work around Needs Based Care continues, it is not explicitly defined as a quality priority for the coming year the improvement activity will be on-going to support admission avoidance for our patient and reduce length of stay to get them home to their loved ones quickly. This will be monitored through our data related to length of stay and other metrics. In addition, as this work supports development of seven day services it's continuation will be essential for the improvements the Trust needs to make in relation to compliance with seven day standards and compliance with these standards has been identified as a key quality objective for the coming year.

2.2 Reduce the incidence of falls amongst patients staying in hospital.

Why was this 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 continues to have a lower incidence of falls than the national average, we remain committed to continuing to focus on reducing our rate of inpatient falls as when a patient does fall in hospital, the effect can be both physically and psychologically detrimental and may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the efficient 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 may prevent 20-30% of falls (NICE 2013). Whilst we have shown an improvement in our audit results, the Trust wanted to continue to build upon the work already undertaken to strengthen our approach to the prevention of falls.

What did we do?

During 2018/19 the Trust undertook an external review of the trends related to inpatient falls. This provided the organisation with helpful information on further areas for improvement and these were added to the improvement work plan already underway. Success of this work plan was and continues to be addressed through the setting of a formal falls reduction trajectory as part of monthly "ward to board" reporting system and the use of an analysis of themes and trends from review of incidents related to falls.

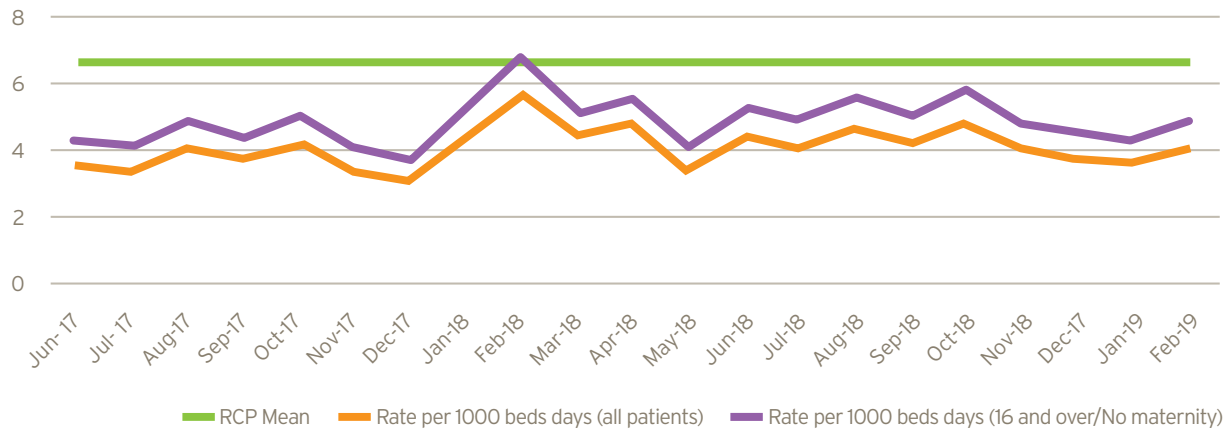
The improvement work plan included several key actions which have been undertaken, for example.

- Development of a new nursing assessment and care planning document, now in use across adult inpatient areas. This contains a multifactorial risk assessment for all patients aged 65 and over and those for those patients aged 18 – 64 with clinical risk factors which may cause a fall. This information is audited and results shared with relevant matrons to take further improvement action for their wards of responsibility.
- We have updated our bedrail assessment document and again this is subject to regular audit where results are used discussion at their quality performance meetings.
- A review of toilet and bathroom areas in the Trust was undertaken and has resulted in development of an estates improvement plan, this focuses on call bell availability, storage and ergonomics of the areas in relation to preventing falls.
- The Trust has implemented a scheme called "Baywatch". This is an enhanced observation initiative, with staff using an assessment tool to identify high risk patients and placing them a specific bay with increased observation for closer monitoring. To support initiative we use digital therapy systems in these areas as a support for staff who use interactive reminiscence activities for patients who may be restless or agitated.
- A common cause of fall is postural hypotension, this happens when a patient's blood pressure drops when suddenly standing up from a lying or sitting position and the Royal College of Physicians recommend that all patients aged 65 and over should have their Lying and Standing (L/S) blood pressure checked as soon as practicable and actions taken if postural hypotension is identified. The Falls improvement Link Nurses based on our wards are now completing monthly audits on compliance in monitoring L/S blood pressure for patients aged 65 and over. Again these are fed back at regular quality performance meetings for review.
- The Trust has agreed a new bed supplier contract and by end of April 2019 all of our adult acute beds will have low rise function. This will enable staff to reduce height of beds for patients at risk of falls from bed and minimise risk of harm.
- The protocol related to actions to take after a patient has fallen has also been updated and this now includes specific requirements related to the need for a CT scan. This will ensure that patients, particularly those anti-coagulation treatment have timely scans to ensure appropriate management.

How did we perform?

The Trust's actions have seen some improvements with the rate of falls at less than 6.0 per 1000 bed days. In addition falls specifically associated with the use of toilets and bathrooms have reduced from 0.63 per 1000 bed days in 2017/18 to 0.54 this year.

Falls Rate per 1000 Bed Days



We are encouraged by these results but believe that further improvements can still be made, therefore for the coming year we are including fall indicators as one of our quality priorities.

2.3 Improve the management of deteriorating patients

Why was this 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 2017-18 highlighted some areas for improvement. This included earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, this linked with the need to continue in our improvements in delivering more sensitive, appropriate care at the end of a person's life. In particular, it is key that those nearing the end of their life, receive care based on appropriate decisions for compassionate and dignified care where aggressive treatment or resuscitation are not indicated.

What did we do?

We undertook a review looking at all cardiac arrest incidents which was led by one of our led by a consultant anaesthetist. In doing so we specifically looked at the monitoring of the deteriorating patient and subsequent escalation of concerns to ascertain whether there were any missed opportunities to discuss the treatment plan and whether to resuscitate with patients and their families.

The review indicated some opportunities for improvement for clinical teams and during we have particularly worked with three of our wards to pilot an innovative fluid chart to improve processes for monitoring of fluid balance aimed at reducing the incidence of patients acquiring acute kidney injury (AKI) while in hospital. In addition further training was also provided to A&E staff in recognizing patients that present with AKI.

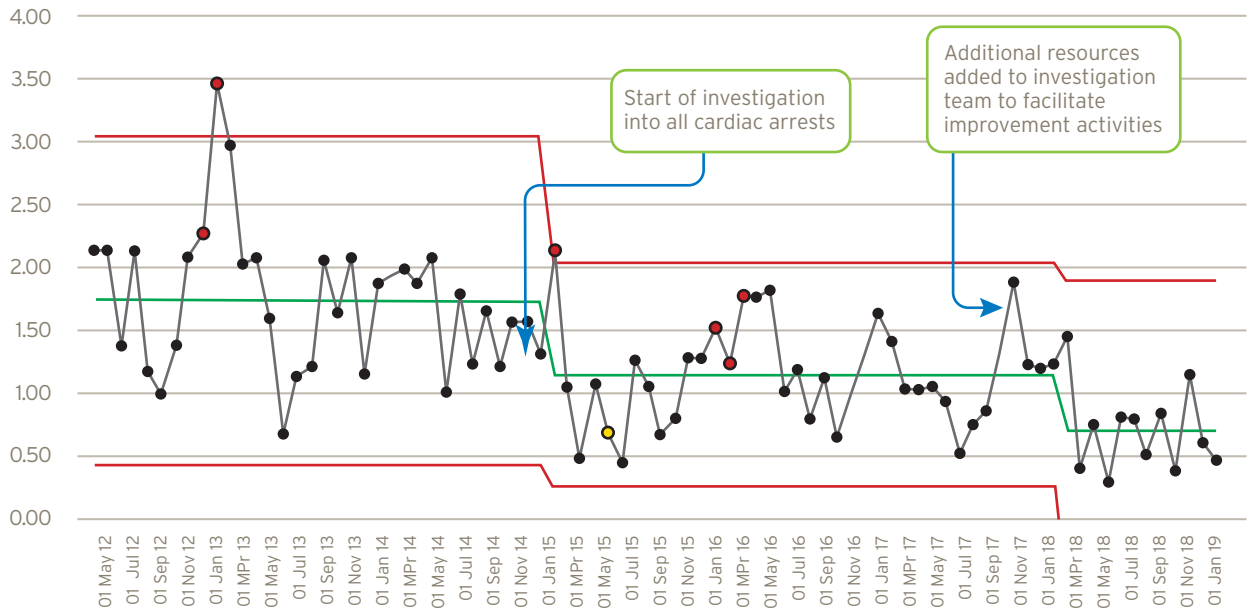
In addition to further improve expertise around treatment and resuscitation of patients at end of life specialist palliative care team implemented extra training around having difficult conversations aimed at improving skills enabling clinicians to develop the confidence to facilitate these discussions.

How did we perform?

The results of the work have been very encouraging for the Trust and the focus on ensuring recognition of patients presenting to A&E with AKI (acute kidney injury), has led to 94% of patients achieving the target of been seen within the four hour standard during the year. In addition more timely recognition of other patients has led to 92% of patients getting the appropriate treatment within the timeframe standard of treatment within six hours of presentation.

In respect to our cardiac arrest rate, it continues to be lower than the national average . As shown in the Chart 1 below, when comparing the cardiac arrest rate in 2017 with 2018 there has been a 37% reduction. Chart 2 indicates that the Trust now has one of the lowest cardiac arrest rates in the country.

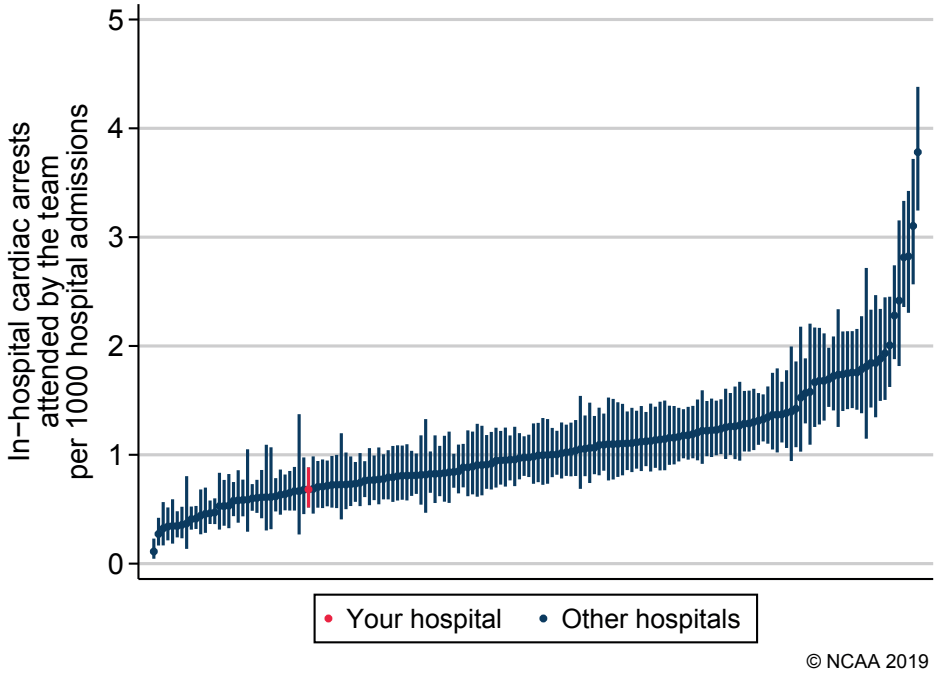
Chart 1 SPC Chart of of cardiac Arrests 2012-18



BaseLine 1.31 09

The following graph presents the reported number of in-hospital cardiac arrests attended by the team per 1,000 hospital admissions for adult, acute hospitals in NCAA.

Chart 2 Rate of in-hospital cardiac arrests



The benefits of this work stream have been to improve fluid monitoring, understanding, recognition and escalation of the patient with deteriorating renal function. Whilst this will not be designated as a quality priority in the coming year work will continue and refinements will focus on making best use of an anticipated electronic solution to further aid the monitoring of intake and output in recognition of a patient that is deteriorating.

2.4 To improve our reliability in ensuring that patients receive timely Venous Thrombo-Embolism (VTE) assessment and thromboprophylaxis where appropriate

Why was this priority?

VTE is a significant cause of mortality, chronic ill health and disability in England with an estimated 25,000 people in the UK dying from preventable hospital-acquired thrombosis (HAT) every year (House of Commons Health Committee, 2005).

A national audit showed that 71% of patients, at medium or high risk of developing DVT did not receive any form of mechanical or pharmacological VTE prophylaxis (NICE 2010, updated 2015) and in 2017 the Trust had a number of incidents related to HATs which indicated non-adherence with best practice recommendations. Therefore the Trust decided that for 2018/19 improvements to reliability around VTE would be a key priority.

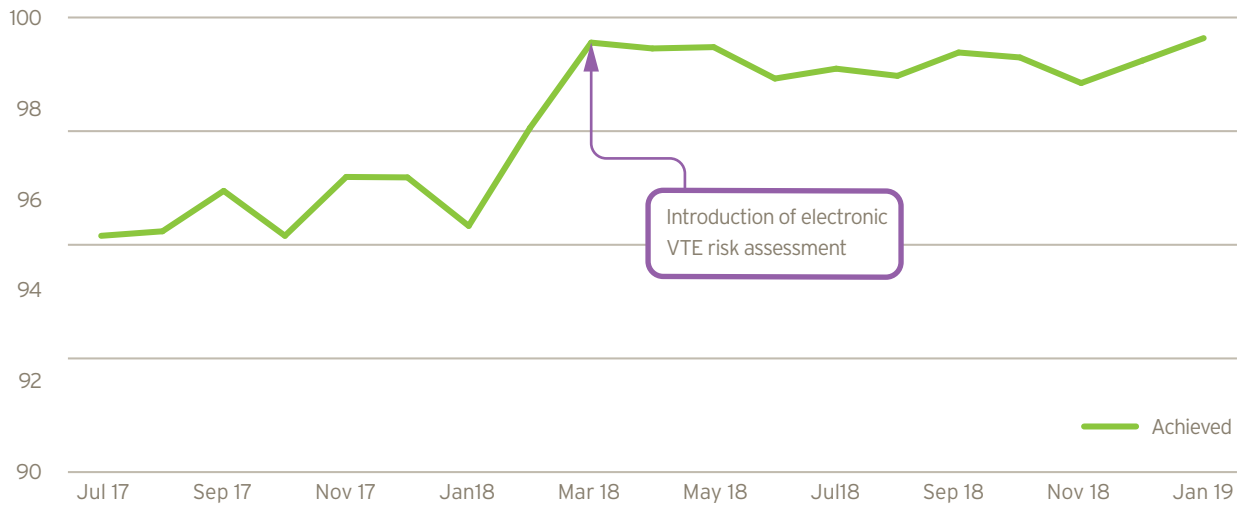
What did we do?

The improvement programme included a raft of actions to look at ensuring improved compliance with the policy for avoiding hospital acquired thrombosis and VTE assessment, which included:

- Introduction of an electronic VTE risk assessment tool, this mandates risk assessments on admission and prompts our clinicians to consider prescribing thromboprophylaxis at the same time.
- We ran an organisational wide "Stop the Clot" campaign aimed at raising awareness around the risks of VTE with education and training opportunities for our staff.
- We continued with a review and audit process for those patients who may have developed a HAT with a full root cause analysis where any patient was identified as acquiring a thrombosis which was potentially avoidable. The learning from this process has helped develop other improvement actions including:
  - Introduction of a system to remind clinicians to re-assess any patient's VTE risk when there is a change in condition.
  - Revision of patient and carer information which informs them about the risks of thrombosis to support their greater personal involvement in prevention of thrombosis.
  - Implement point of care guidance to support clinicians in prescribing correct dosages tailored to meet individual patients' needs.
  - Development of a new process in A&E that ensues that patients with lower limb fractures where an in-patient stay is not required are provided with appropriate prophylaxis in the community.

How did we perform?

% VTE Risk Assessment compliance



As the chart above indicates since implementation of the raft of improvement plan actions there is an average of 99% of patients receiving VTE risk assessment on admission.

Analysis shows that we have also reduced the incidence of thrombosis caused by a failure to prescribe thromboprophylaxis in addition to improvements for those patients with raised body mass index not getting the correct thromboprophylaxis dose, patients returning to the hospital with VTE following a fractured ankle and reduced the delay in administering the first treatment dose for patients with a newly diagnosed thrombosis from over seventeen hours to four hours.

We are delighted that use of campaigns, such as "Stop the Clot", has supported a change in organisational culture where staff are now proactively reporting potential suboptimal care that may lead to HAT and whilst this will not be a key quality priority moving forward the use of awareness campaigns and monitoring of compliance will continue to support organisational assurance.

2.5 To reduce the incidence of medication errors for inpatients

Why is this 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, so that effective and sustainable solutions can be put in place to reduce the risk of similar incidents occurring. Within the organisation drug incidents accounted for 9% of all incidents reported on our patient safety incident reporting system during 2017/18, of which 98% caused no or low harm, In line with the launch of the WHO third Global Patient Safety Challenge: Medication without Harm, our aim is to reduce avoidable medication related harm.

Although medication errors are often avoidable, they can occur when weak medication systems and/or human factors (e.g. fatigue, poor environmental conditions or staff shortages) affects the medicine use process (prescribing, transcribing, dispensing, administration, monitoring and use) and can at times result in severe harm.

The Trust has a Medication Safety Review Group (MSRG) which oversees review medication error reports each month, identifying themes and ensuring multidisciplinary, trust-wide learning is shared and their work was identified as a quality priority for 2018/19 with a focus on reducing the incidence of avoidable medication errors with the potential to cause harm to patients and strengthening measurements and safety monitoring systems.

What did we do?

Through the analysis of trends and themes undertaken in our Medication Safety Review Group (MSRG) several specific actions were taken. Firstly we undertook an audit looking at compliance with standards related to a missed medication dose with feedback shared amongst the multi-disciplinary team.
There was a review of prescribing errors across junior doctor prescribing and the feedback session was well received and this work will continue.

The Trust has worked on an insulin self-administration policy; this aims to improve user input into taking insulin and therefore possibly reduce risk in insulin related administration errors.

Finally the learning from recurring medication errors was highlighted and disseminated through a medication safety newsletter developed by Pharmacy and will continue to be published quarterly.

How did we perform?

The impact of this work indicates some reduction in the number of insulin related incident reports our monthly medication error analysis but more work still on-going to improve insulin use.

Similarly whilst the awareness work has improved reporting and recognition of incidents leading to a rise in medication error reporting, administration errors continue to account for the highest number of medication errors reported and constitute about 27% of the medication errors reported. Encouragingly there were no errors that resulted in patient death or severe harm.

The MSRG continues to work on improvements related to medication safety and the regular newsletter is well read and whilst this is not identified as a key quality priority for the coming year it will remain important for review at local clinical governance meetings as part of themes and trends analysis, learning and quality improvement activity.

Priority 3: Deliver Excellent Clinical Outcomes

3.1 Reduce our HSMR so that we are consistently within the expected range for overall mortality and for each coded diagnosis.

Why was this priority?

In March 2017, the NHS Quality Board published a paper entitled "National Guidance on Learning from Deaths. " The paper outlined the principles behind Mortality Reviews, their methodology, and how their conduct, and the learning from them, needed to be reported. The guidance made a number of recommendations which have since been incorporated into the Trust's Mortality Review Policy (LDH 2017).

There is national focus on improvement opportunities that can present when mortality is reviewed, therefore the recommendations of the paper included:

- Use of "Structured Judgement" Reviews a new methodology for mortality reviews
- Appointment of a Board-level Executive lead for the Mortality Review Process, and a non-Executive lead charged with oversight and challenge.
- The requirement for outcomes from Mortality Reviews to be shared through a Board level report. This has also been contractually enforced through changes at a national level to the Quality Accounts regulations.

What did we do?

The Trust has instigated a Mortality Board, chaired by the Medical Director to oversee the learning from Mortality reviews process. We have implemented key recommendations from the national guidance paper and this includes the following:

- On-going Use of "Structured Judgement" as a methodology for mortality reviews
- We have appointed a Board-level Executive lead for the Mortality Review Process, and we have a non-Executive lead charged with oversight and challenge.
- The outcomes from Mortality Reviews are shared quarterly through a Board level quality report as from September 2017.

In addition to high level actions we have implemented other improvements in developing a system of learning from deaths. Following completion of any Structured Judgement Reviews, these are fed through to the regular morbidity and mortality learning meetings held within each of the organisational Divisions and services. Through this the front line teams then look at any improvement activity that is required to address areas of learning.

WE have instigated a standard template which is then completed by the Divisions to provide assurance feedback to the Mortality Board on actions taken in respect to concerns, which is then escalated via the quarterly report to our Trust Board.

Membership of our Mortality Board has been broadened to include representation from external stakeholders; including our lead Clinical Commissioning Group. This allows oversight to ensure that any deaths that require a community review are subject to a consistent process. This also allows feeds back related to particular concerns that can be escalated to primary care partners through established groups such as the members forum which is attended by GP cluster chairs and other providers, thus spreading opportunity for sharing and implementation of any system wide learning.

Our Trust policy has particular requirements in respect to the learning from deaths of people with learning disabilities in line with the national Learning Disabilities Mortality Review (LeDeR) programme. We have four trained LeDeR reviewers who are available to conduct reviews across the local area should that be deemed necessary.

Any neonatal and paediatric deaths are reviewed through the Child Death Overview Panel (CDOP) and maternal deaths are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK) a national oversight programme.

How did we perform?

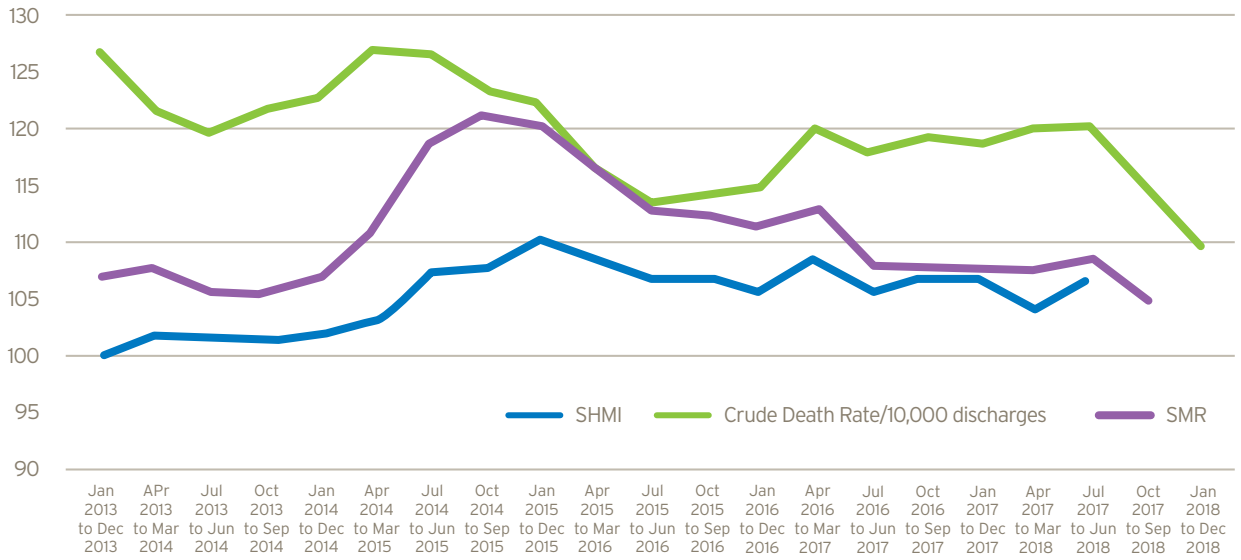
The Trust is very encouraged by the improvements made throughout the year and during 2018 we saw the lowest crude mortality rate seen at the Trust for some years, as demonstrated by the green line on the chart below. Despite a particularly high number of deaths in January and February and a 5% increase in our inpatient activity within the year the Trust saw 1278 deaths which are 49 fewer than in 2017.

During 2018/19 the Trusts switched its provider of benchmarking data provider to CHKS and this provides a new mortality comparison for review in the Risk Adjusted Mortality Index (RAMI). This comparator not only adjusts for age, gender and case mix but also factors in the length of stay. To ease understanding the national RAMI average has been rebased so it is always 100 as seen for the SMR and HSMR and the Trust RAMI for the year ending October was 3% better than average.

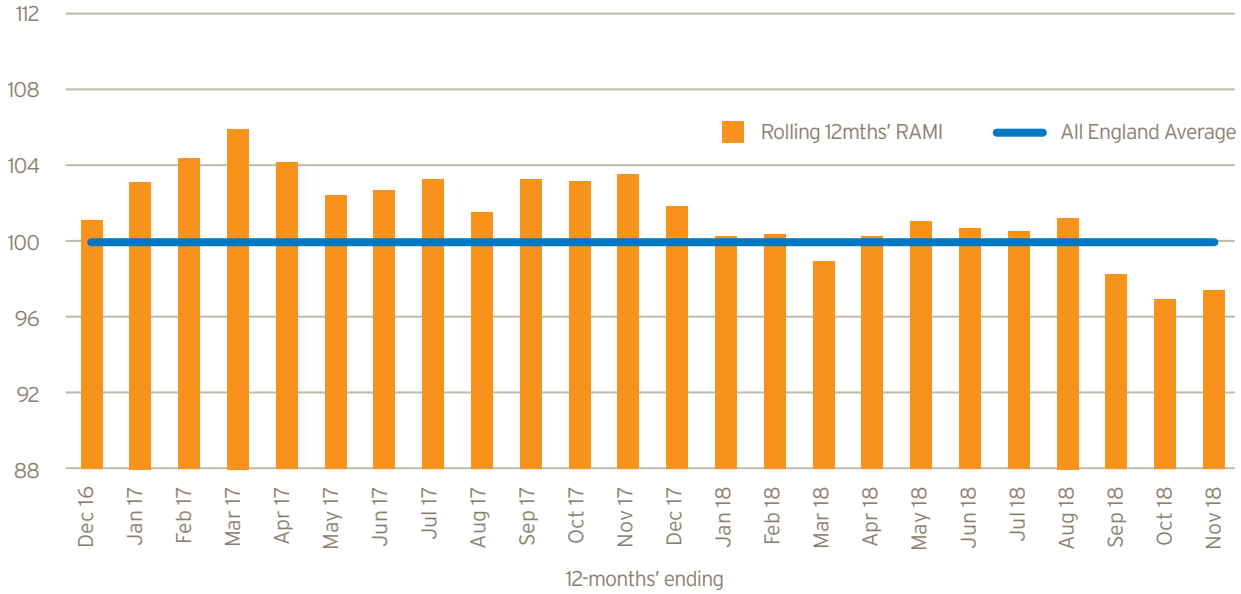
Whilst the latest data to October 2018 shows our Standard Mortality Ratios (SMR) and Summary Hospital-

level Mortality Indicator (SHMI) as both just 2% higher than the national average we are encouraged that the overall trend is decreasing and this result shows these at their lowest for several years as indicated by the blue and red lines in the chart below. The Trust is delighted that results are showing encouraging mortality trends across all indicators.

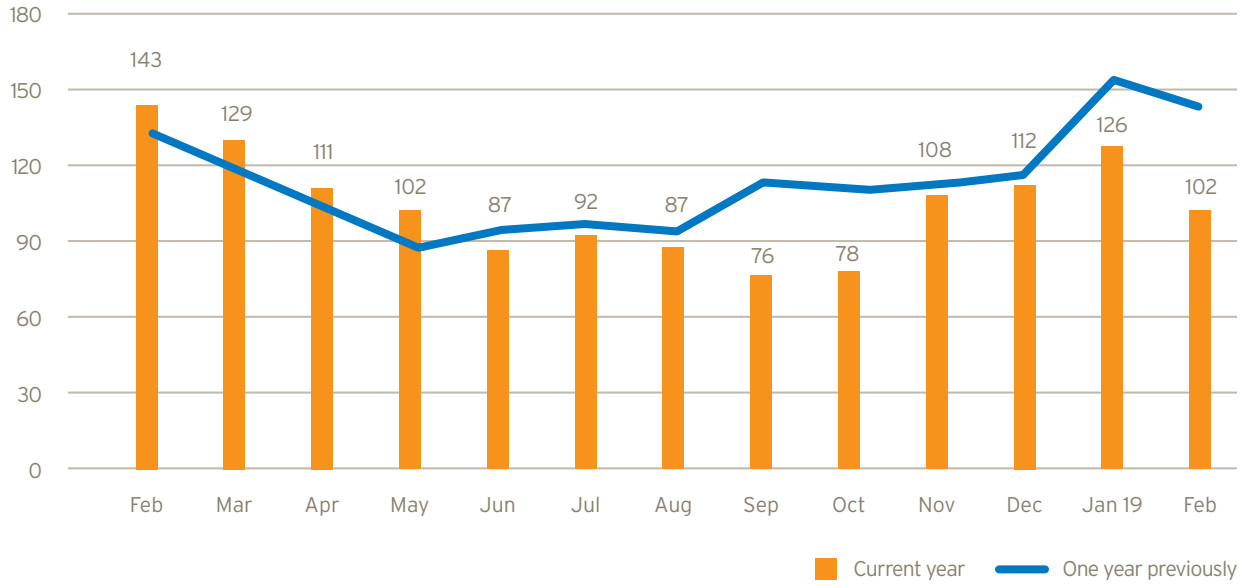
Crude Death Rate, SMR and SHMI - rolling 12 month updated quarterly



Rolling 12-month' RAMI Adjusted to make England average a constant 100



Monthly deaths for the last two years



Whilst the processes around mortality review will no longer be a key quality priority for the organisation the Trust's Mortality Board will continue its focus on improvements related to learning from deaths and review of mortality indicators will continue to be a focus for the Board's quality committee.

3.2 Reduce the impact of serious infections through effective treatment of Sepsis

Why is this 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.

In response to this our quality improvement initiative, is aimed at embedding NICE guidance to improve sepsis management we aimed to combine a responsive approach to the detection and treatment of sepsis 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.

This approach to these two key healthcare challenges was used as that the issues of sepsis and antimicrobial resistance are complementary and use of a joint improvement scheme would provide a coherent approach towards reducing the impact of serious infections.

What did we do?

Recognising the organisational wide impact of sepsis we set up a "champions" group through engagement with front line clinical staff working across several of our wards. This group supported and promoted the work of our improvement campaign, entitled 'Could this be Sepsis'.

As part of the work associated with this campaign staff developed improved pathways for those patients who may have reduction in their white blood cells and therefore be less able to fight infections. These pathways have streamlined the process of assessment and antibiotic provision for these patients when they present to our A&E department with suspected sepsis.

Within our paediatrics department a single sepsis screening pathway and management tool has also been developed, this is for both in-patient and emergency department use and promotes awareness for the appropriate screening of children for sepsis.

In respect to stewardship of antibiotics our pharmacy team have undertaken a review of antibiotic availability across our wards areas to ensure availability at point of need. In addition a visual prompt and red card has been used to promote more timely antibiotic administration. In the event that an antibiotic is not available on the ward this process allows staff to obtain the antibiotics from pharmacy more speedily.

Finally we have reviewed and refreshed our on-going teaching provision around the recognition and management of patients with sepsis for both current staff and newly appointed staff. We continue to use our best practice care sepsis pathway and audit of this allows opportunities for learning where best practice has not been followed.

How did we perform?

The Trust is delighted with improvements in the recognition of patients with signs and symptoms of sepsis and we have an average screening rate of 98%. In addition this year has shown an average compliance for provision of antibiotics within one hour of 89% in the A&E department.
Of particular note is a reduction of 40% in respect to mortality from sepsis and whilst this will not form a key quality priority for the coming year these measures will continue to be reviewed to ensure change is embedded and improvements continue.

3.3 Improve services for people with mental health needs who present to Accident and Emergency

Why is this priority?

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 who attend A&E more 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. Tin recognition of these issues this is a national priority and included in our commissioning for quality and innovation (CQUIN) scheme and therefore a Trust priority with specific requirements to support cross-provider working to deliver improvements in care through provision of enhanced packages of care from the most appropriate services.

What did we do?

In starting our work we undertook a review of the cohort of patients attending our A&E most frequently and through this process identified those that would most benefit from assessment, review and care planning alongside specialist mental health staff.

Co-produced care plans were developed together with patients and, with individual patient's permission these were shared with partner care providers across the system.

The Trust collaborated with the East London Foundation Trust (ELFT) as our provider of mental health services in addition to a range of other partners, for example, the ambulance service, primary care, police, substance misuse services and 111 in order to provide support for these more frequent attenders by ensuring care plans met individual needs and there was provision of additional or different support where needed. This was facilitated by better use of our IT systems ensuring that the information related to patient's conditions was accurately collected and recorded to support improved targeting of support the most appropriate patients.

How did we perform?

As a baseline measure there was a cohort of thirty one patients across both Luton and Bedfordshire who had between then 464 attendances to the A&E department. During 2018/19 the initial work of the programme show this reduced to 139 attendances, representing a 70% decrease in attendances.

This is a pleasing result for the organisation and whilst this will not continue within the key priorities the A&E department will continue to work in partnership with mental health providers to continue this support to patients.

3.4 Embed the frailty service in order to better meet the needs of elderly frail people attending the hospital

Why was 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 was to implement best practice guidance to enable us to take action to prevent these adverse outcomes as well as support people with frailty to live as well as possible. It was hoped that appropriate services, delivered effectively to this group of patients would support a reduction in length of stay, reduced morbidity

and mortality and a better experience for patients and those who care for them.

What did we do?

Work in respect to this quality priority ran alongside our priority related to Needs Based Care previously described. A Frailty Unit was developed initially with ten beds that were supported by five geriatricians rotating on a weekly basis. In addition the Trust appointed a Lead Nurse for Frailty specialist role and this skilled individual has high levels of autonomy and decision making ability to ensure provision of specialist care. A dedicated multi-disciplinary team also support the unit including social worker , therapist and pharmacy support. These specialist and advanced nurse practitioners are able to manage clinical care in partnership with patients and carers, enabling innovative solutions to enhance patient experience and improve outcomes.

Within the Unit all appropriate patients now undergo a frailty / comprehensive geriatric assessment. Following this if they are recognised as having complex medical or social care needs they are admitted to one of our complex medical ward facilities where they will be cared for by one of the geriatricians, with support from other specialist physicians as required. If the assessment shows they do not have complex medical or social care needs, they are admitted to a speciality ward and cared for by the specialist team.

How did we perform?

The table below shows a definite improvement in the length of stay for our Care of the Elderly patients across the Trust and our data also indicates a reduction of patients that were outliers within a surgical bed base (outliers are patients that are moved from their speciality inpatient beds into beds in a different speciality ward/bed during times of peak bed pressure).

Time Period	Number of Admission	Number of Discharge	Average Length of Stay
Mid- March – May 2018	88	70	7.1
June - August 2018	250	185	6.99
September -November 2018	267	270	5.77
December 2018	90	81	5.34
January 2019	88	75	4.28
Total	**783**	**606**	**5.0**

These results are encouraging for the Trust and use of the frailty unit will continue although it is no longer required to be viewed as a key quality imperative for teh coming year.

3.5 Offering advice and guidance (A&G) - Requires providers to set up and operate A&G services as appropriate for non-urgent GP referrals. A&G support has been provided through the NHS e-referral system.

Why was it a priority?

The A&G system has been in place for many years through the NHS e referral system however uptake of the system has not been widespread. It was felt that increasing the use of the system could deliver benefits to patient care by enabling access to secondary care clinician expertise more rapidly allowing a GP to ask for specific clinical advice regarding their patient, or to enable signposting to alternative primary care clinics or treatments. It is hoped that this will reduce unnecessary hospital attendances for conditions that could be treated in a primary care setting.

What did we do?

Initially the following criteria were agreed with the clinical commissioning Group (CCG) via the Quality Standard:

- The timeframe for response to an A&G request would be to the GP within two working days
- It was agreed that the experience level of the clinician providing A&G during the first year would be at consultant level only and then in the second year was expanded to include A&G from a specialist nurse, where deemed appropriate.
- The need for a sustainable system to aim to increase A&G uptake and maintain the increase.
- In order to ensure learning, joint audits with the CCG and primary care colleagues would be completed in three designated specialities.
- To ensure secondary care success there would be an audit of our Evolve electronic patient record to ensure A&G requests and responses were uploaded to the patient record. A report regarding the volume of A&G requests that then translated into a referral into secondary care within a 12 week period would be undertaken.

A&G services were mobilised for all specialties. The requirement during 2017/2018 was to ensure specialties receiving 35% of referrals were offering A&G. In the second year the requirement was for additional specialties to ensure those receiving 75% of referrals were then available for A&G. The Trust was able to roll

out these requirements ahead of plan and the table below identifies the specialities included:

- **Specialties that cover 35% of referrals received (year 1):**

Specialty	Percentage of Referrals
Gastroenterology	4.5%
Endocrinology	2.3%
Breast	3.7%
Cardiology	4.9%
Diabetes	0.8%
Dermatology	5.2%
Respiratory Medicine	2.4%
Gynaecology	11.8%
ENT	7.7%
Total	**43.3%**

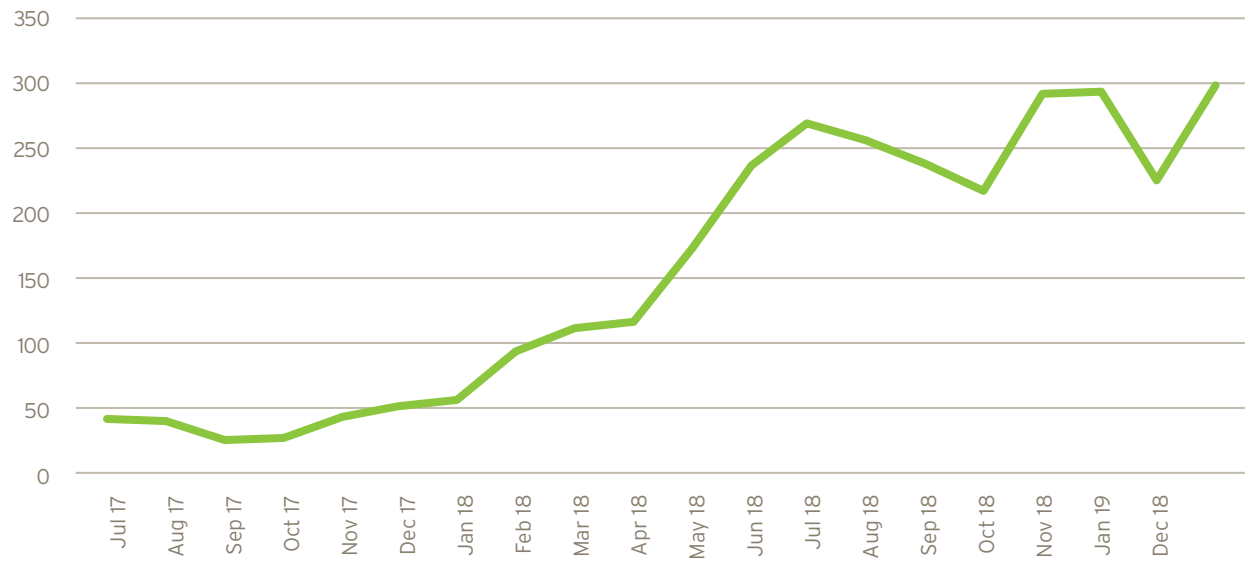
- **Specialties that cover 75% of referrals received (year 2):**

Specialty	Percentage of Referrals
Ophthalmology	12.3%
T & O	12.1%
Paediatrics	8%
Total	**32.4%**

How did we perform?

During the running of this scheme the Trust was able to roll out the number of services providing A&G requests ahead of plan. We encouraged increased utilisation and GP take up of system through regular communications included in the quarterly new letters sent to GPs. During this time we saw a successful increase in uptake of A&G from 27 requests per quarter at commencement to 414 per quarter more recently. It is pleasing to note that this level of activity has been sustained.

Total number of advice and guidance requests received April 2017 to January 2019



The compliance with timeliness of secondary care consultant responses has also been good with turnaround times of 2 days met in all but one quarter over the 2 year period as below and 100% of A&G responses were provided by Consultant relevant to the specialty

CQUIN compliance April 17- December 2018

	Count of Patient	within 2 days	Compliance %
Quarter 1 - 17/18	27	25	93
Quarter 2 - 17/18	15	12	80
Quarter 3 - 17/18	52	44	85
Quarter 4 - 17/18	185	153	83
Quarter 1 - 18/19	354	291	82
Quarter 2 - 18/19	357	286	80
Quarter 3 - 18/19	414	311	75

The requirements related to audits of Evolve demonstrated 100% of A&G requests had been uploaded.

The trust has not continued this as a key quality priority as data collection over two years has shown sustained improvement with mechanism remaining in place to support timely advice and guidance.

Priority 4: Prevention of Ill Health

4.1 Patients aged 18 and over, admitted to hospital for one night or more will be given support, where appropriate to reduce tobacco or alcohol consumption.

Why was this priority?

Nationally this was defined as a priority and part of the CQUIN scheme which sought to deliver on the objectives of the NHS Five Year Forward View, particularly around the need for a radical upgrade in prevention supported by healthier behaviour.

Smoking is estimated to cost £13.8bn to society – of which £2bn cost to the NHS through hospital admissions, it is also England's biggest killer, causing nearly 80,000 premature deaths a year. Indications are that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis, and the interventions can reduce wound infection rates and improve healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. Nationally, the coverage of advice and referral interventions for smokers is patchy. In secondary care, not all patients are asked if they smoke and fewer are given brief advice to stop as an inpatient.

In respect to alcohol, evidence shows that in England, 25% of the adult population consume alcohol at levels above the UK low-risk guideline and this increases their risk of alcohol-related ill health. Alcohol is estimated to cost society £21bn per year – of which £3.5bn are costs to the NHS. Around three quarters of the NHS cost is incurred by people who are not alcohol dependant, but whose alcohol misuse causes ill health and is the group for whom Identification and Brief Advice (IBA) is most effective. Previously IBA delivery in secondary care was patchy and this priority aims to improve delivery to optimum levels with large scale delivery impacting most significantly on the population.

What did we do?

In making the required improvements the Trust worked in collaboration with our partners as Luton Well Being and designed a training template for the scheme. We established that pharmacy staff were best placed to deliver improvements due to their interactions related to medicines reconciliation in our ward areas. Therefore training was delivered to these staff in respect to how to deliver smoking cessation advice and deliver brief verbal advice on alcohol consumption.

This was supplemented with other tools such as visual aids around alcohol which were used to assist patients in understanding what alcohol consumption looks like in units consumed.

In relation to smoking cessation referral pathways were established for our in-patients to the smoking cessation service upon their discharge and training was provided for surgical pre assessment staff, nurses and pharmacists so that as part of the pre-assessment process we established any patient were their surgery could act as a prompt to help quit smoking or think more carefully about the amount of alcohol they consume. During the pre-assessment process any identified smokers wishing to quit are now prescribed Nicotine Replacement Therapy (NRT) before they are admitted for surgery. In order to provide evidence of success we designed a data collection that allowed required information to be documented for each admission and this was regularly audited to demonstrate progress.

How did we perform?

The results of audit have shown the following performance against this quality priority.

Tobacco screening: 84% of all patients audited in the third quarter (random selection of 500 patients above the age of 18 who spent 24 hours or more in the hospital)
Tobacco brief advice: 32% of all eligible patients received documented tobacco brief advice
Tobacco referral and medication offer: 24.6% of patients who were smokers and received advice took up offer for referral and medication
Alcohol screening: 53% of audited patients in the third quarter were screened for alcohol consumption and results are recorded in patient's record
Alcohol brief advice or referral: 54% of eligible patients were given brief advice or offered a referral to specialist alcohol services which was recorded in the notes

This information demonstrates that there are further improvements to be made and the delivery of advice around alcohol and tobacco remains a key priority for the coming year.

4.2 To support staff, patients and visitors to eat and drink more healthily when using our outlets by providing more healthy food and drink options 24 hours a day, seven days a week

Why was this a priority?

25% of adults in England are obese, with significant numbers also overweight. Treating obesity and its consequences alone costs the NHS £5.1bn every year. High proportions of NHS staff are also obese or overweight leading to an increase in musculoskeletal problems and mental health issues – two of the key drivers of sickness absence rates in the NHS.

In addition Public Health England's document "Sugar Reduction – the evidence for action" outlined a need to focus on improving the quality of food on offer.

Therefore it was apriority for the Trust to support staff, patients and visitors to make healthier choices when on NHS sites aimed at lowering sugar consumption through ensuring all food and drink outlets on NHS premises provide healthier options for staff, patients and visitors.

What did we do?

As a Trust we, together with all our retail outlets, signed the NHS England "Sugar-Sweetened Beverage Sales Reduction commitment". This committed that outlet retailers and the in-house Trust facilities would reduce the total volume of monthly sugar-sweetened beverage sales to 10% or less of total volume of drinks sales. In addition we agreed alongside retail outlets to ensure there was no advertising or offerings such as price promotions on food and drinks high in fat, sugar and salt.

How did we perform?

These actions were successful and within all the retail outlets on the hospital site, including shops, cafes, vending machines and the restaurant resulted in:

- Almost 95% of drinks sold on site were free from added sugar against a target of 90%
- Over 85% of confectionary and sweet lines available were no more than 250kcal against the target of 80%
- More than 80% of pre-packed sandwiches and other savoury pre-packed meals stocked are 400kcal or less and contain no more than 5% saturated fat against teh target of 75%.

As an organisation we are delighted with the success of this campaign and whilst not a key priority for next year aims to maintain the progress made to date.

4.3 To ensure that at least 75% of our frontline clinical staff is provided with the flu vaccination by February 2019

Why was this a priority?

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

What did we do?

The Trust's occupational health team led on this key priority and ran a successful communications campaign which encouraged our staff to take up the flu vaccine. This was supplemented with the use of multiple opportunities for staff to receive the vaccine in terms of venue and time of day.

Our Trust Board and other senior staff provided support by actively role modelling behaviour with photographs of the teams receiving their flu vaccination.

In order to understand reasons for abstaining and also providing an opportunity to "myth-bust" the staff who actively declined the vaccine were asked to sign a declination form.

How did we perform?

We were delighted to have had a successful campaign with 76.6% of frontline clinical staff receiving the flu vaccine which surpassed the required target.
Of our staff 3% signed a declination form indicating that they are actively opting out of having the vaccination despite the advice given. We are currently analysing this information to inform the key messages for the next flu vaccine campaign.
The uptake of flu vaccination remains important for the health and well-being of both our staff and patients and is therefore continuing as a key priority for the coming year.

4.4 To continue to deliver support mechanisms to reduce workplace ill health through stress and musculoskeletal problems.

Why was this priority?

The estimate from Public Health England as to the cost of NHS of staff absence due to poor health is £2.4bn a year – around £1 in every £40 of the total budget and this figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment.

As well as the economic benefits that could be achieved, evidence from the staff survey showed that efforts in the improvement of staff health and wellbeing develops staff engagement, improves staff retention and provides better clinical outcomes for patients.

Within the Five Year Forward View a commitment was made 'to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy'.

Linked to this commitment a Health & Wellbeing CQUIN introduced in 2016 encouraged providers to improve their role as an employer in looking after employees' health and wellbeing and for 2018/19 the CQUIN rewards organisations who make a sufficient impact on staff perceptions about the changes organisations make to improve health and wellbeing as evidenced through questions within the NHS staff survey.

NHS England has developed a new 'Staff Health and Wellbeing Framework' which sets out the support that all NHS organisations should provide to their staff in order to promote health and wellbeing. The framework is based on evidence based best practice and has been jointly developed working with leading NHS organisations as well as NHS Employers, NHSI and PHE. This framework covers the following areas:

- Enablers: cross-cutting activities that ensures staff health and wellbeing is effectively led, managed and embedded within wider organisational activities;
- Mental health: guidance on how to identify, prevent and support staff to manage mental health issues;
- MSK: guidance on how to identify, prevent and support staff to manage MSK issues;
- Healthy lifestyles: guidance on how to promote healthy lifestyles and how to support staff with lifestyle change interventions.
- Tools will be made available to assist organisations in effectively utilising the Framework. These will include:
- Diagnostic tool- this allows organisations to measure their current staff health and wellbeing offer against best practice;
- Action planner- this guides organisations to develop an achievable plan to implement the Framework and support them to work towards the CQUIN targets.

What did we do?

Supported by the appointment of a lead for Staff Engagement and Health and Wellbeing the Trust has implemented a raft of activities throughout the year, which include:

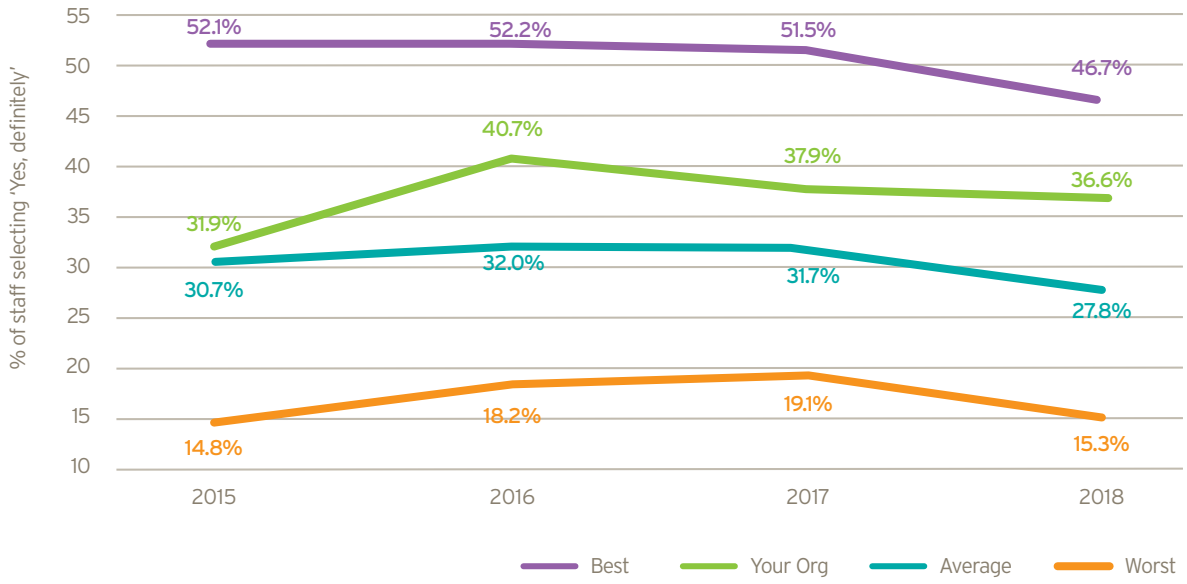
- An annual health and well-being day offering activities such as laughter yoga, chair based exercises, smoothie bikes, healthy eating demos and table tennis,
- Monthly campaign of "Apples & Pears to take the Stairs" which encourages staff to use the stairs rather than ten lift to increase activity and exercise levels but also fun and stress relieving
- Wednesday walking a weekly exercise and stress relieving walk led by occupational health
- Provision of fast track to physiotherapy service for staff with musculo-skeletal issues
- Safe Handling training for staff with on-site advice
- Provision of an Employee assistance programme service, offering counselling, legal advice and debt and financial management advice.
- Provision of Occupational Health Service (SEQOHS Accredited), supporting managers to manage attendance and offering advice for staff with regard any issues that affect them be it home or work related issues
- Bi monthly newsletter promoting activities and good news stories in promoting fitness and healthy living
- Over 40 NHS Health checks
- Fit in 50 seconds providing quick easy exercises particularly for office based staff to encourage regular movement.
- Monthly distribution of information sheets as supplied by CiC our employee assistance and counselling programme providers with recent examples including "Healthy gut=healthy mind", Mind your Mind, Hydrated and Healthy, Healthy sleep information amongst others.
- Ensuring all areas perform yearly stress risk assessments, in line with our health and safety related assessments, and that follow up action is taken accordingly.
- Full programme of in house training such as resilience, coaching for managers, human factors training, seven habits of highly effective people, and mental health first aid.

How did we do?

In determining progress we used information from our 2018 national staff survey, to which 52% of staff responded. Feedback provided in the national staff survey indicated that:

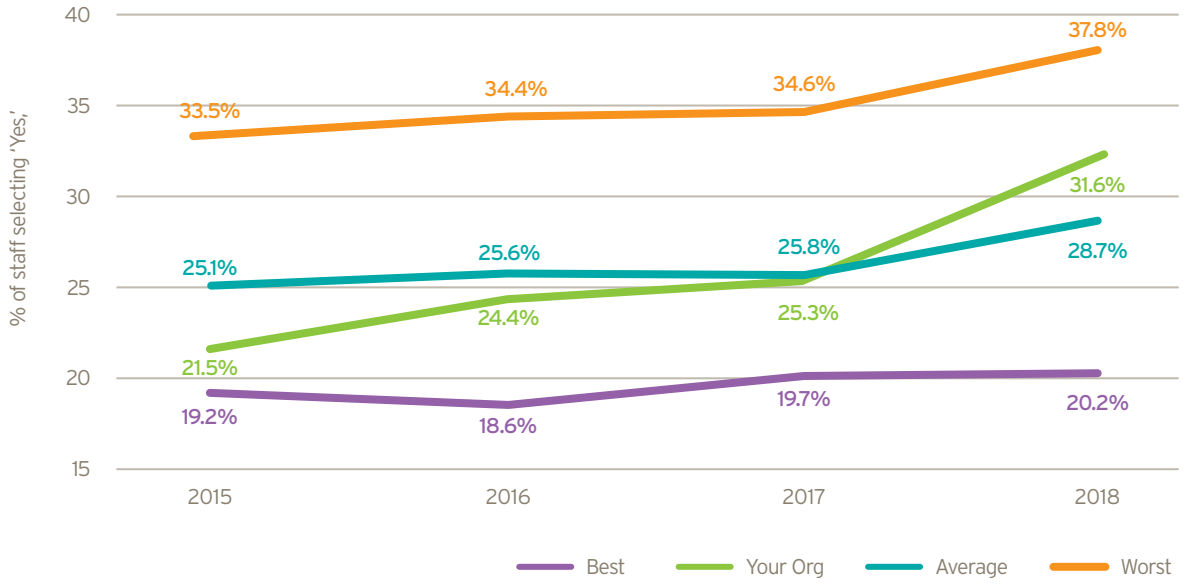
- 37% of staff reported that they believe our organisation takes positive action on health and wellbeing. Whilst this is a small reduction on last year's result, it was noted the Trust performance is 9% above the average for NHS Trusts in England.

Does your organisation take positive action on health and well-being?

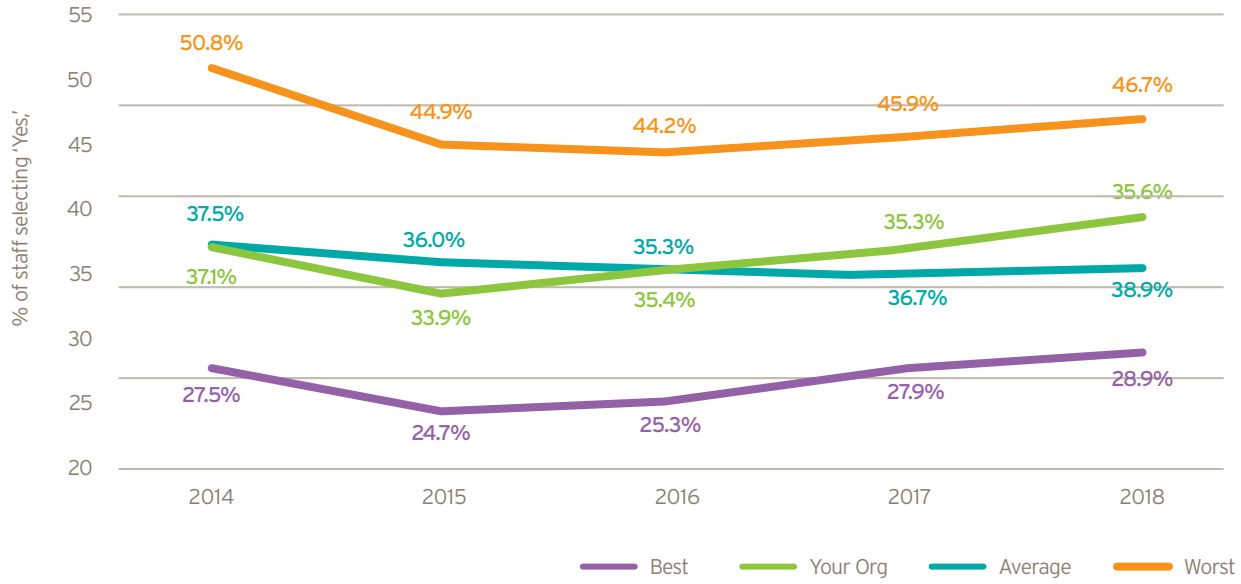


- In the last 12 months, 31.6% of staff reported that they have experienced musculoskeletal problems as a result of work activities. The result is 6% worse for the Trust than last year and for the first time, the Trust response is worse than the England average.

In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



During the last 12 months have you felt unwell as a result of work related stress?



- 35.6% of staff reported that during the last 12 months they have felt unwell as a result of work related stress. This result has remained static for the third year and remains slightly below the national average.

Whilst this is not indicated as a key priority for the coming year the results related to the staff survey are being developed into a programme of work within Human Resources and Divisions are being provided with tailored information to look at improvements at local level.

Quality Improvement Priorities 2019/20

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

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

In considering the key steams of quality improvement activity consideration has also been given to content of the NHS long term plan, national quality priorities and indicators within the Commissioning for Quality and Innovation (CQUIN) specification together with locally identified improvement opportunities from staff and patients which all form the drivers for the programme.

The quality priority works steams are aligned with the Trusts four main quality priorities;

-
- to deliver excellent clinical outcomes,
- to improve patient safety,
- to improve patient experience and
- to prevent ill health.

The diagram below describes each of the priorities under these headings together with a rationale for their inclusion, how we will measure success and how we will oversee the progress we make throughout the year.

Corporate Objectives	Deliver Excellent Clinical Outcomes
Quality Priorities	• Developments to further improve our fractured neck of femur pathway • Ensure compliance against all 4 key clinical standards in respect to 7 day services • Same day emergency care – pulmonary embolus/tachycardia with atrial fibrillation/ Pneumonia
Rationale	• We have had challenges in respect to outlier alerts in relation to mortality rates and outcomes related to our fractured neck of femur pathway. We therefore intend to continue to make this a key focus of improvement work through 2019/20 with increased attention on embedding sustainable improvements. • The 7 day services programme is designed to ensure that patients admitted as an emergency, receive high quality consistent care whatever day they enter hospital. The latest exercise to demonstrate compliance with key clinical standards indicated that we still had particular areas which need to be a key focus for improvement • **Standard 2:** All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hrs from time of admission to hospital. • **Standard 5:** Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • within 1 hour for critical patients • within 12 hours for urgent patients • within 24 hours for non-urgent patients **Standard 6** Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. (Interventional radiology)

Corporate Objectives	Deliver Excellent Clinical Outcomes
Rationale	• **Standard 8** Patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hrs, seven days a week, unless it has been determined this would not affect the patient's care pathway • Roll out of same day Emergency Care is part of the NHS long term plan and – pulmonary embolus/tachycardia with atrial fibrillation/pneumonia are all conditions from the top 10 conditions with which patients present in a SDEC setting. These are selected due to the fact that a focus on a limited set of clear actions can be taken by the Trust to improve same day treatment. This will reduce pressure on the hospital's beds, improve length of stay and the patient's experience.
Measures of Success	• Development of Quality Improvement programme for pathway for #NOF • Design an improved multi-disciplinary pathway monitored by key performance indicators • Sustained improvement for mortality rate related to #NOF pathway • Improved performance of key clinical standards which is approved through the Board Assurance tool for 7 day services • 75% of patients with confirmed pulmonary embolus being managed in the same day setting where clinically appropriate • 75% of patients confirmed with atrial fibrillation being managed in the same day setting where clinically appropriate Patients with community acquired pneumonia should be managed in the same day setting where clinically appropriate
Monitoring Committee	Clinical Outcomes, Safety and Quality Committee
Corporate Objectives	Improve Patient Safety
Quality Priorities	• Achieving 80% of older inpatients receiving key falls prevention actions • Improve compliance rates for statutory and mandatory training, particularly for medical staff, particularly infection control and safeguarding
Rationale	• Taking these three key actions as part of a comprehensive multidisciplinary falls intervention could result in fewer falls, causing hip fracture or brain injury leading to improvements in safety, length of stay and reduced treatment costs. They are – Lying and standing blood pressure to be recorded – No hypnotics or anxiolytics to be given during stay OR rationale documented – Mobility assessment and walking aid to be provided if required • During our last Care Quality Commission inspection the inspectors noted in their report that the Trust needed to improve performance in respect to staff attending mandatory training. This is therefore a key focus for improvement during the coming year with specific focus on infection and control and Safeguarding children and vulnerable adults to ensure our staff deliver safe care with up to date information and training

Corporate Objectives	Improve Patient Safety
Measures of Success	• 80% of older inpatients (65 or over) receive key falls prevention actions • Improved compliance with annual statutory and mandatory training attendance compliance across the organisation including infection control and safeguarding training
Monitoring Committee	Clinical Outcomes, Safety and Quality Committee
Corporate Objectives	**Improve Patient experience**
Quality Priorities	• Provide a responsive, high quality complaints service • Improve our discharge processes to provide our patients with improved experience when leaving our hospital
Rationale	• As part of our drive to improve the experience of our patients and their carers we want to ensure that when they are concerned that their interaction or care within the hospital has not been to the standard they expect that we respond to their concerns in a timely manner. Currently some of the timescales in which we are responding are taking too long, therefore we will make it a priority to review the system and make sustainable improvements. • Hospital discharge describes the point when hospital care ends with on-going care transferring to a home, community or other care setting. Therefore hospital discharge is not an end point but part of the on-going patient journey. The Trust recognise that failures in getting all the steps right to support our patients along this journey is leading to high levels of complaints not only from our patients but also some partners and therefore improvements to the quality of discharge for our patients is a priority for this year.
Measures of Success	• Improvements to response rates for patients and/or carers who have raised a concern. Improvement learning outputs from complaints to avoids recurrence of issues of concern • Reduction of complaints from patients or carers related to discharge Reduction in complaints or raising of incidents by external partners related to the discharge process
Monitoring Committee	Clinical Outcomes, Safety and Quality Committee
Corporate Objectives	**Prevent ill health**
Quality Priorities	• To ensure that at least 80% of our frontline clinical staff are provided with the flu vaccination • Alcohol and Tobacco – Screening and Brief advice • Antimicrobial resistance – Lower urinary tract infections and antibiotic prophylaxis in colorectal surgery

Corporate Objectives	Prevent ill health
Rationale	• Every year the influenza vaccination is offered to NHS staff as a way to reduce the risk of staff contracting the flu virus and transmitting it to patients or family members. Health care workers can transmit illness to patient if only mildly or sub clinically infected, therefore it is an important way to prevent ill health. • This Screening and brief advice is part of an on-going programme to deliver the Long Term Plan for the NHS and is expected to result in 170k tobacco users and 60k at risk alcohol users receiving brief advice which is seen as a key component of their path to cessation.
Rationale	• The Long Term Plan includes antimicrobial resistance and stewardship as a major priority and use of the four steps outlined for UTI will bring reduced inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improved treatment and management of patients with UTI. • The Implementation of NICE guidance for Surgical Prophylaxis will reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines. • With these improvements aimed at delivering safer patient care, increase effective antibiotic use, thus leading to improvement in both patient mortality and length of stay.
Measures of Success	• Uptake rate for staff at the L&D having their flu vaccination in line or exceeding the target of 80% • Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use Achieving 90% of smokers been given brief advice Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered specialist referral • Achieving 90% of antibiotic prescriptions for lower urinary tract infection in older people meeting NICE guidance for lower UTI and Public Health England diagnosis of UTI guidance in terms of diagnosis and treatment. Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in line with antibiotic guidelines
Monitoring Committee	Clinical Outcomes Board

Statements of Assurance from the Board

3.1 Review of services

During 2018/19 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 its Clinical Outcomes, Safety and Quality sub committee

The income generated by the relevant health services reviewed during 2018/19 represents 100% of the total income generated from the provision of relevant health services by the Luton and Dunstable University Hospital NHS Foundation Trust.

3.2 Participation in Clinical Audits and National Confidential Enquiries

During the year the Trust was eligible to participate in 50 of the 2018/2019 National Clinical Audits that was applicable to the Trust and met the Quality Accounts inclusion criteria.

Over the financial year the Trust participated in 47 of the eligible national audits. The Trust did not participate in 3 national audits although the Trust was eligible.

Name of Audit	Number of cases submitted
Adult Community Acquired Pneumonia	All required cases
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	All required cases
BAUS Urology Audit – Nephrectomy	All required cases
BAUS Urology Audit - Percutaneous	
Nephrolithotomy (PCNL)	All required cases
Cardiac Rhythm Management (CRM)	All required cases
Elective Surgery (National PROMs Programme)	88.5% participation
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database	297 cases
Feverish Children (care in emergency departments)	60 cases
ICNARC Case Mix Programme (CMP)	All required cases
Inflammatory Bowel Disease programme / IBD Registry	All required cases
Learning Disability Mortality Review Programme (LeDeR)	All required cases
Major Trauma Audit (TARN)	All required cases
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	All required cases
Maternal, New-born and Infant Clinical Outcome Review Programme	5400
Myocardial Ischaemia National Audit Project (MINAP)	All required cases
National Asthma and COPD Audit Programme*	All required cases
National Audit of Breast Cancer in Older People	All required cases
National Audit of Cardiac Rehabilitation	784
National Audit of Care at the End of Life (NACEL)	55
National Audit of Dementia - round 4	50
National Audit of Percutaneous Coronary	370

Name of Audit	Number of cases submitted
National Bariatric Surgery Registry (NBSR)	All required cases
National Bowel Cancer Audit (NBOCA)	All required cases
National Cardiac Arrest Audit	59
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	All required cases
National Comparative Audit of Blood Transfusion programme - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	11
National Diabetes Audit – Adults* (Multiple work streams)	3676
National Emergency Laparotomy Audit (NELA)	All required cases
National Heart Failure Audit	181
National Joint Registry (NJR)	All required cases
National Lung Cancer Audit (NLCA)	All required cases
National Maternity and Perinatal Audit (NMPA)	5235
National Mortality Case Record Review Programme	All required cases
National Neonatal Audit Programme (NNAP)	949
National Oesophago-gastric Cancer (NAOGC)	All required cases
National Paediatric Diabetes Audit (NPDA)	163
National Prostate Cancer Audit	253
Non-Invasive Ventilation – Adults	20
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	All required cases
Sentinel Stroke National Audit programme (SSNAP)	657
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	3
Seven Day Hospital Services	222
Surgical Site Infection Surveillance Service	All required cases
Vital Signs in Adults (care in emergency departments)	80
VTE risk in lower limb immobilisation (care in emergency departments)	65
BTS Paediatric Pneumonia Audit 2016-2017	118
National Comparative Audit of Blood Transfusion programme- Management of massive haemorrhage	10

The three National Clinical Audits that the Trust were eligible to participate but did not participate are listed below:-

Audit Title	Reason for non-participation
National Audit of Seizures and Epilepsies in Children and Young People - Epilepsy12	Staff resourcing issues
National Ophthalmology Audit	Decision was taken to not participate owing to the cost of software required to submit data to the provider
BTS National Paediatric Bronchiectasis	Small number of patients seen with Bronchiectasis Trust agreed not to participate

The Trust has reviewed 18 national audit reports in 2018/19 and the Trust intends to take the actions listed in the tables below to improve the quality of the care and services it provides:

National Audit of Breast Cancer in Older People

Recommendations/outcomes discussion points and action points we intend to take

Poor quality HES/cancer registry data recommended that local units record their own data.

The audit showed variation in the use of radiotherapy across Trusts. In Luton, radiotherapy was used more frequently in the older cohort. Recommended that radiotherapy is offered in keeping with national guidelines. Luton variation is likely to be in part due to increased use of radiotherapy in the axilla in accordance with Association of Breast Surgery guidance on management of axillary disease. There is also good evidence that some older women do not gain a survival benefit from radiotherapy.

Each patient will be considered for radiotherapy on a case by case basis in the Multidisciplinary team.

National Emergency Laparotomy Audit (NELA)

Recommendations/outcomes discussion points and action points we intend to take

Our data shows that we are generally performing well. However, there are areas for improvement like risk prediction which we had identified a while ago.
Findings/risks:

1. Assessing and recording the P Possum mortality risk before surgery needs to improve

2. Data filling on the NELA sheet to make sure that CT scan is reported by a consultant radiologist (which is routine in this hospital)

Recommendation is to disseminate the report amongst surgeons and anaesthetists. Booking forms in theatre to be specifically changed to capture this information.

National Prostate Cancer Audit

Recommendations/outcomes discussion points and action points we intend to take

Key concerns/lessons learnt :
We do not record performance status enough.
Key Successes:
We capture reasonable data relating to PSA and stage.

Learning Disability Mortality Review Programme (LeDeR)

Recommendations/outcomes discussion points and action points we intend to take

1. Strengthen collaboration and information sharing, and effective communication, between different care providers or agencies.

a) Develop and encourage use of 'red bags' within Bedford Hospital and Luton and Dunstable Hospital;
b) Improve quality of hospital passports, with individualisation being key e.g. indicators when a person is in pain, what do they like to eat
c) Ensure communication abilities of the person are considered - 'they can'
d) Encourage GP surgeries to use the services of Experts by experience

2. Push forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively, and share relevant information in a timely way.

a) Liaise with STP work stream relating to IT to monitor and report progress back to Steering Group
b.) Promotion of use of assistive technology within Social care to Health e.g. fit bits and iPads

3. Health Action Plans (HAP's), developed as part of the LD Annual health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process).

a) Raise awareness of the need for GPs to complete HAPs

4. All people with learning disabilities with two or more long-term conditions (related to either physical or mental health) should have a local, named health coordinator.

a) To what this role would look like/ how it might differ from current GP and Community matron roles

National Audit of Cardiac Rehabilitation (NACR)

Recommendations/outcomes discussion points and action points we intend to take

Key concerns/lessons learnt : Cardiac Rehabilitation (CR) assessed as meeting sufficient standards to be classified as Amber (meet 4 -6 Key Performance Indicators (KPIs) with programme meeting 5 out of the 7 required KPIs:
Multi-Disciplinary Team: KPI met
Priority Groups: KPI met
Percentage with Assessment 1: KPI met
Percentage with Assessment 2 : KPI met
Duration : KPI met
Wait time Myocardial Infarction/PCI (too long by/days): 23

Key successes
Out of 229 UK Cardiac Rehabilitation programmes that contribute to NACR 46 meet all 7 KPIs. In England 77 programmes are amber. This is 79% of programme and is where we are. 63 are red (meet 1 – 3 standards) and 23 met none of the standards. We met 5 out of 7.

The 2 we failed to meet were the time patients had to wait from referral to start the Phase 3 – Exercise component - of the programme for patients post Myocardial infarction/PCI and post Coronary Angiography Bypass Graft. We performed well in our multi-disciplinary team, the patient groups we accept and the initial assessment times.

Have improvements been identified?
Waiting times to join the exercise classes once seen in assessment clinic are reduced to 1 – 2 weeks at present. Due to an imminent move off site with the exercise component this will temporarily increase as to facilitate the move there will be a cancellation period for exercise of 2 weeks. However longer term we are considering introducing an extra exercise group.

We are also reviewing our process for contacting patients and once we are fully staffed we are positive we can reduce the time taken to contact patients which will then reduce the wait for patient's s to commence the core component of the programme.

Wait time CABG (too long by/days): 11
It has been shown that the quicker patients are seen and started on their rehab journey, the more likely they are to engage with the process and have better outcomes. The national averages for Wait time MI/PCI is 46 days England or less. This is a longer waiting time than for MI/PCI as patients will have had major surgery, and will take longer to be ready to start a rehab programme.

Key actions:
Waiting times had begun to address waiting times prior to the NACR report outcomes. Our main issues were the time it took to contact the patient to arrange follow up and then the time until we could offer them a clinic appointment. This was due to a combination of factors including staffing issues, clinic capacity and an increase in numbers. These delays contribute to the longer time for the patients to commence exercise.

To address this we have introduced a cancellation list in order to maximize clinic slot wastage for late notice UTAs. Extra clinics have been added as staffing allows.

Going forward we have recruited a full time physiotherapist which will enable us to increase our clinic slot capacity. Waits are reviewed regularly and we are endeavouring to reduce delay

National Audit of Percutaneous Coronary

Recommendations/outcomes discussion points and action points we intend to take

Key concerns/lessons learnt : Waiting time for inpatient intervention remains long compared with the national average

More cath lab capacity is needed. This has been escalated

Key actions: More capacity is being considered, including less use of the lab for contingency, appointing substantive interventional cardiologists

National Cardiac Arrest Audit (NCAA)

Recommendations/outcomes discussion points and action points we intend to take

Key points:
The cardiac arrest rate at the Luton and Dunstable Hospital continues to lower and the seasonal variability noted is reflected nationally. The Luton and Dunstable Hospital cardiac arrest rate is lower than the national average.

The return of circulation rate post cardiac arrest is significantly higher at the Luton and Dunstable hospital than the national average.
The rate of survival post cardiac attest is higher than the national average at the LDH.

Key actions:
1. Continue to submit data to the NCAA

2. Investigations post cardiac arrest to continue and learning to be shared

3. Link audit report into Key Patient Safety Priority 3 actions

BTS Paediatric Pneumonia Audit

Recommendations/outcomes discussion points and action points we intend to take

Compared with the Pneumonia audit undertaken in 2012/13 there have been some significant improvements noted. Our results continue to remain in line with, if not better than, national data.

Findings & Recommendations:
1. More than recommended no of children are having Chest x-ray (although this has dropped). BTS aim for < 10%; we should continue to try to reduce from where we are (71%)

2. No local guideline for Community Acquired Pneumonia. Develop local guideline/cement BTS guideline into clinical practice

3. More than recommended are being followed up (14%). BTS aim for < 5%, we should continue to try to reduce from where we are

National audit of Dementia – spotlight audit on Delirium

Recommendations/outcomes discussion points and action points we intend to take

- Adding Single Question in Delirium to Emergency room assessment documents.
- Assessment available in the medical proforma.
- 4A's testing used by orthogeriatrician
- Develop an e-learning module for junior doctors
- Facilitate an education programme in collaboration with Psychiatric services
- Incorporate Delirium awareness in nurse training
- Develop a Delirium pathway for discharge with Clinical Commissioning Group

National Pulmonary Rehabilitation audit

Recommendations/outcomes discussion points and action points we intend to take

- Ensure correct documentation of date referral received
- Ensure referrals booked into next available appointment
- Create additional appointment slots to allow flexibility for patients who are unable to attend their original appointment date
- To start carrying out practice walk (per guidelines)
- Identify patients who are unlikely to complete enough sessions during their cohort and offer additional sessions

Title	Key concerns/lessons learnt	Key successes:	Key actions:
The efficacy and safety of sleep deprivation for EEG examination - national service evaluation BSCN / ANS Joint audit	Sleep deprivation is a useful activator of Epileptiform activity with a higher yield than just a repeat standard EEG (38%). There is no enhanced risk of sleep deprivation on seizures occurring during the recording compared with a standard EEG (0.5%). It is a safe and useful modality.	We meet all the recommended standards.	Nil required.
Standardising visual, somatosensory and brain stem auditory evoked potential recording -national service evaluation BSCN / ANS Joint audit	Evoked potentials are useful modalities for assessing central pathway function. It is important that these be performed according to accepted standards, protocols and filter settings and with local normative data.	We meet all the recommended standards.	Nil required.
Post Exposure Prophylaxis after Sexual Exposure (PEPSE) - Regional Audit	1. Baseline HIV test should be ideally done before starting PEPSE or within 72 hours in all cases 2. PEPSE should ideally be administered Within 24 hours of exposure in most cases 3. Improve follow-up HIV test up take	Proportion of individuals seeking PEPSE undergoing testing for STIs: 90% Regional LSH Result 99.2% (92-100%) 100%	• Recall system to be set up in the department for follow-up bloods • Encourage sexual assault cases to attend within 72 hours for PEPSE flow-up
Emergency Contraception/ FSRH bench marking audit	Poor uptake of emergency IUD -incomplete documentation why Cu-IUD was offered	Above average in all four standards	• Encourage all the staff the use of the emergency contraception proforma at all times when giving emergency contraception. • Actively offer emergency Cu-IUD for suitable cases.
Re-audit of testing for Hepatitis B and C in Luton Sexual Health	Rates of testing for hepatitis B and/or C (according to departmental criteria) at Luton Sexual Health measured 50-62% at the last audit in 2017. We implemented an action plan (departmental teaching sessions and consensus criteria for testing) with the intention of improving our hepatitis screening in practice.	Since the previous audit in 2017: • Testing according to standards for hepatitis B has increased from 62% to 90% • Testing according to standards for hepatitis C has increased from 50% to 100%	• Place list of hepatitis testing criteria in all clinical rooms (already actioned) • Add history if intravenous drug use, and country of origin of patient/partners, to Screen and Go template (already actioned)

Title	Key concerns/lessons learnt	Key successes:	Key actions:
National Audit Percutaneous Coronary Intervention (PCI)	Waiting time for inpatient intervention remains long compared with the national average More cath lab capacity is needed, escalated NICOR is behind time in publishing Cardiac data	Safe, excellent outcome, higher than national average using Radial approach for safety	More capacity is being considered, including less use of the lab for contingency , appointing substantive interventional cardiologists
BRA	IBRA provided national outcome data which can be used for benchmarking. There was no unit specific data. It aimed at providing outcome data for different products used in implant reconstruction but there were too many products to enable meaningful statistical comparison. • 2000 patients, 81 sites • 10% smokers, 6% RTx • 53% biological mesh, 11% synthetic, 14 different products • Loss rate up to 30% • 16% unplanned readmission (<5%) • 25% 3 month infection (<5%) • 9% implant loss at 3 months The results of patient QOL data at 3 and 18 months have not been published as yet.	Our implant loss rate of 10% is comparable to the national average	Protocol for implant management in line with current guidelines from ABS and BAPRAS with the aim of reducing infection and implant loss rates.

Title	Key concerns/lessons learnt	Key successes:	Key actions:
GIRFT	The aim is to improve the quality of breast surgery care and to identify unwanted variations. The HES data has not been validated as yet and is not unit specific. It gives a snapshot of national performance which can be used as a benchmark. This included a 35% immediate reconstruction rate, 52% of which were implants, 18% LDs and autologous 30%. Length of stay, re-admission, 30 day implant loss, haematoma evacuation, outpatient attendance, and inflammation and implant removal at 1 year were all recorded. Haematomas occurred in 13%. 4% of mastectomy patients and 8% of implant patients were admitted with complications. 7.5% of implants were removed by 1 year. Our unit implant loss rate is slightly higher than the national average at 10% (range was not supplied with the data). This is in keeping with the results of the NMBRA which also showed average implant loss rates of 10%.	Our immediate reconstruction rate is around 50% which is considerably higher than the national average	Protocol for implant management produced in line with current guidelines from ABS and BAPRAS with the aim of reducing infection and implant loss rates. From 2018-2020 there will be visits to all Trusts. Questionnaires will be sent pre-visit. There will be 2-3 months' notice and surgeons, nurses, managers and coders would be involved in the visit. The result will be a Trust-specific report with an analysis of our own data and service improvement opportunities. There will also be a national report which will highlight variations, good practice and quality improvement recommendations.
NABCOP (National Audit of Breast Cancer in Older Patients)	The data attributed to Luton includes all patients within the prescribed age group diagnosed at the screening unit. Many of these patients are treated in other hospitals and it is therefore not possible to use the data to benchmark the performance of the Luton Breast Unit. The audit was discussed at the Association of Breast Surgeons Meeting May 2018. There was concern about the reliability of HES data nationally and its impact on the results of audit.	N/A	We have introduced a pathway for older patients with assessment using a frailty index and fast tracking to care of the elderly for appropriate patients. These patients are now identified on a Friday morning at the MDT and seen by a designated surgical liaison care of the elderly physician on the following Tuesday. This is in line with the recommendations of NABCOP. We are developing a prospective cancer database which will enable us to check data accuracy

Title	Key concerns/lessons learnt	Key successes:	Key actions:
T&O Readmissions audit	1. Sub optimal reduction of complex extra capsular neck of femur fracture 2. Sub optimal reduction of supracondylar fracture of elbow. 3. Sub optimal management of shaft of femur fracture in a 6 years old child with rotational deformity at the fracture site.		1. Better reduction and possible wiring during first operation for complex sub trochanteric fracture. 2. Better reduction and use of 2mm K wire during first operation. 3. Operative stabilisation should be preferred over Hip Spica in definitive management of fracture shaft of the femur in children with high BMI. Rotational deformity doesn't remodel and operative management should be considered in deformities beyond acceptable limits.
Audit & re-audit of orthognathic treatment efficiency	1. Treatment (total time) can be up to 4.5years 2. Standard of PAR efficiency factor of 1.61 from previous audit not met		1. Inform patients of realistic timescale for total treatment duration – can take up to 4.5 years; Analyse parameters that may delay treatment such as – Decision for extraction vs non-extraction on treatment duration – Number of missed appointments + effect on treatment duration 2. Re-audit process in 2 years
NELA	2017 Findings showed we weren't risk stratifying patients and had higher than average mortality P-POSSUM or NELA scores are both available online or on the NELA app. NELA are less likely to overestimate Pre-operative labels should be attached to notes. Uptake has been poor. More pre-op P-POSSIM done, not enough post-op. From now, will have a booking form which will do away with the sticker. Integrated P-POSSUM and urgency (<2h, 2-6h, 6-18h, >18h) is now on form (examples of risks are on the back of the form.	we achieved the Best practice tariff target in the third quarter, only managed by 27% of participating Trusts	New NELA booking form Disseminate this quarter's results when they are available (09/2018)

Title	Key concerns/lessons learnt	Key successes:	Key actions:
Pain relief and patient satisfaction after bariatric surgery	The audit was designed to audit patient feedback about a bariatrics produced booklet. Suggestions for improvement included waiting times(when running late) and parking facilities	86% of patients read the booklet and 89% found the booklet helpful Generally patients were very happy with the department. Anaesthetists thought to be welcoming, helpful and caring	Review booklet - slightly out of date, update pathway and risks Leaflets given at general pre-assessment (not bariatrics) include DVT, anaesthetic booklet and specialty specific booklets. Also the RCOA leaflet is now given. Patients to be asked at the end of surgery about the information they thought they did not know.
Record Keeping Audit Gynaecology FY2018/2019	1. No hospital numbers or NHS numbers on documentation. 2. Handwritten entries illegible and not signed 3. No instructions and plans for follow up investigations. 4. EDL not actioned. 5. Information not shared	NA	1. Patient identifiers to be on all documentation 2. All names to be printed and signed clearly. All staff to write clearly in notes 3. Clear plans to be documented. 4. EDL need investigations and results added 5. Staff flyer sent out to update of changes.
Reduced fetal movements audit	Extracting information from Evolve to complete the documentation review aspect for each individual patient was a complicating factor. 1. Midwives need to document that they are auscultating FH prior to commencing external FH monitoring. 2. Midwives are not documenting that they have given the reduced fetal heart leaflet. 3. Midwives are not documenting that fetal movements was discussed. 4. Gain assurance that learning has been embedded	All of the women questioned recognised and had received a copy of the leaflet	1. FH must be documented in the notes and on the CTG sticker. 2. Midwives must document Reduced foetal movement leaflet given and discussed. 3. Midwives must document the discussion about reduced fetal movements each time they do so. 4. Re-audit in 6 months

National Confidential Enquiries

	Topic/Area	Database/ Organiser	% return*	Participated Yes/No
1	Cancer in Children, Teens and Young Adults	NCEPOD	100%	Yes
2	Peri-Operative Diabetes	NCEPOD	50%	Yes
3	Pulmonary Embolism	NCEPOD	**	Yes
4	Acute Bowel Obstruction	NCEPOD	**	Yes
5	Long Term Ventilation	NCEPOD	**	Yes
3	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

** Enquiry initiated during the year – questionnaires not yet required

3.3 Participation in Research

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

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2018/19 and who were recruited during that period to participate in research approved by a Research Ethics Committee was 1421.

This research can be broken down into 168 research studies 147 Portfolio and 21 Non-Portfolio).

3.4 Commissioning for Quality and Innovation payment framework (CQuIN)

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. In April 2017, NHS England published a 2 year national CQUIN scheme and so for 2018/19, the Trust entered the second year of this two year scheme.

A proportion of the Luton and Dunstable University Hospital NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Luton and Dunstable Hospital and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework. Further details of the agreed goals for 2018/19 are below with an indication of our achievement of the quality indicators to date.

The Trust monetary total for the associated CQUIN payment in 2018/19 was £6.5m (17/18 £6.2m) and the Trust achieved 95% (17/18 94%) of the value.

Scheme	Description	Q1	Q2	Q3	Q4
1. Health and Wellbeing	Improvement of health and wellbeing of NHS staff	**	**		
	Healthy food for NHS staff, patients and visitors	**	**		
	Improve uptake of flu vaccine to 70% frontline clinical staff	**	**		
2. Reducing the impact of serious infections	Timely identification of sepsis in ED and acute inpatient settings				
	Timely treatment for sepsis in ED and acute inpatient				
	Clinical review of antibiotic prescriptions between 24-72 hours				
	Reduction in consumption of antibiotics per 1000 admissions	**	**	**	

Scheme	Description	Q1	Q2	Q3	Q4
3.	Improving services for people with mental health needs who present to A&E				
4.	Offering Advice and Guidance				
5. Preventing Ill Health by Risky Behaviours – tobacco and alcohol	Tobacco Screening				*
	Tobacco Brief Advice				*
	Tobacco Referral and Medication Offer				*
	Alcohol Screening				*
	Alcohol Brief Advice or Referral				*
	Did not meet the threshold for achievement of the element of the CQUIN				
	Met the threshold for partial achievement of the element of the CQUIN				
	Fully achieved the element of the CQUIN				
*	Data not available at time of publication				
**	No submission required				

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

The CQUINs for 2019/20 are all national schemes and are:

1	1a. Antimicrobial Resistance – Lower Urinary Tract infection in older people
	1b. Antimicrobial Resistance – Antibiotic prophylaxis in colorectal surgery
2	Staff Flu Vaccinations – uptake of the vaccine by 80% of frontline clinical staff
3	3a. Alcohol and Tobacco Screening
	3b. Tobacco Brief Advice
	3c. Alcohol Brief Advice or Referral
4	Three high impact actions to prevent hospital falls
5	5a. Same Day Emergency Care – Pulmonary Embolism
	5b. Same Day Emergency Care – Tachycardia with Atrial Fibrillation
	5c. Same Day Emergency Care – Community Acquired Pneumonia

3.5 Care Quality Commission Registration (CQC)

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 required to register with the CQC and its current registration status is GOOD and is current registration is **Registration without Conditions.**

No enforcement action has been taken against the Trust during the reporting period April 1st 2018 and 31st March 2019 and we have not participated in special reviews or investigations by the CQC during the reporting period.

3.6 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 2018/19 and 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:

- Data Accuracy checks: Assertion 1.7.2
- Completeness and Validity checks: (Previously IG Standard 507)
- Clinical Commissioning Group (CCG) challenges: Investigation,
- resolution\rejection and monitoring of issues highlighted to us by the CCGs
- Monthly and weekly data quality reports for key Departments i.e. Emergency, Outpatients, Wards, Theatres
- Benchmarking analysis: Secondary Uses Services (SUS) and dashboards, Data Quality Improvement Plan (DQIP),

During 2018/19 we have taken the following actions to improve data quality:

- The Senior Data Quality Analyst continues to work with the Data Quality Analyst to identify and resolve Data Quality Issues.
- Continued our extensive programme of data quality checks and initiatives involving staff and managers at all levels.
- Continued with Data Quality Procedures to improve on areas e.g. overnight stays on day wards.
- Increased 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.

Action Plan for Data Quality Improvement for 2019/20

Information Governance

- Data Quality Accuracy Checks – ensure sufficient checks take place to prove compliance.
- Completeness and validity checks – Continue to monitor, even though not required for Information Governance. With results feedback results to relevant staff and departments.

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 activity
- Continue to improve the NHS Number coverage
- Continue to monitor Multiple Firsts and highlight areas that are consistently creating first appointments
- Monitor the additional 18/19 DQIP metrics and ensure improvements made are reflected in reporting
  - Non pre-booked outpatient attendances
  - Non pre-booked day cases
  - Incorrect emergency admission method

Outpatients

- Continue to produce weekly and monthly reports identifying patients with an attendance status of 'not specified'. Also work with Outpatients, IT and Divisions to reiterate the importance and financial impact of not recording information accurately
- Resume regular Outpatient Data Quality meetings to highlight main Data Quality issues in this area
- Present Data Quality awareness seminars within the main areas registering patients and referrals

Inpatients

- Continue to work with General Managers, Ward Managers and Ward Clerks to improve the data that is entered and identify good working processes

Waiting List

- Regular reporting to identify data quality issues for waiting list
- Resume regular Waiting List Data Quality meetings

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

Referrals

- Continue to send referrals reports to users to rectify the referral source
- Present Data Quality awareness seminars within the main areas registering patients and referrals

Patient Demographics

- Continue to monitor and update Invalid Postcodes, DBS errors and missing NHS numbers
- Highlight within all DQ meetings the importance of patient registrations, QAS and GP details
- Present Data Quality awareness seminars within the main areas registering patients and referrals

A&E

- Continue to improve the NHS Number coverage
- Regular attendance at the ED system review meetings, to voice Data Quality issues with department and IT
- Support the handover of Data Quality reports to be actioned by the department

SUS+ dashboards

- Identify Data Quality problems where the Trust does not meet the National Average percentage
- React to requirements and work closely with department to improve the Trusts percentage compliance

3.7 NHS Number and General Medical Practice Code Validity

Luton and Dunstable submitted records during the reporting period 2018/19 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data.
The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 99.3% for admitted patient care
  - 99.8% for outpatient care and
  - 97.0% for accident and emergency care

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

3.8 Clinical Coding Error rate

Luton and Dunstable was not subject to a Payment by Results clinical coding audit during the reporting period April 2018 – March 2019 and the error rates reported in the latest published audit for that period for diagnosis and treatment coding 90.94% and 91.8%

3.9 Information Governance Toolkit Attainment levels

The Information Governance toolkit has been replaced by the Data Security and Protection Toolkit (DSPT). Organisations are expected to achieve 'Standards Met' on the DSP Toolkit.

Luton and Dunstable University Hospital NHS Foundation Trust published the assessment on the 31st March 19 as Standards NOT met with

- **95 of 100** mandatory evidence items provided
- **37 of 40** assertions confirmed

As a result the Trust has developed an improvement plan related to how it plans to bridge the gap between the current position and meeting the DSP Toolkit 'Standards Met'. NHS Digital will review this plan and once agreed it will be displayed as 'Standards not fully met (Plan Agreed)'. This will **not** show any detail of which area requires improvement as it could be considered a security risk if for example it highlighted a potential vulnerability patching.

3.10 Learning from Deaths

During 2018/19 1154 of Luton and Dunstable University Hospital NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 300 in the first quarter
- 255 in the second quarter
- 298 in the third quarter
- 333 in the fourth quarter

By 31st March 2019 710 case records reviews and 131 investigations have been carried out in relation to 1154 deaths. In 131 cases a death was subjected to both a case review and an investigation. The number of deaths in each quarter for which a case record review of investigation was carried out was

- 58 in the first quarter
- 37 in the second quarter
- 28 in the third quarter
- 17 in the fourth quarter

2 cases representing 0.2 % of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 1 representing 0.33% for the first quarter
- 0 representing 0% for the second quarter
- 1 representing 0.36% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been derived from a Mortality Excel spread sheet, with a structured judgement review and figures for Q4 are provisional and are subject to on-going review.

Learning from Case record reviews
A senior team including Medical Directors have reviewed 63% of all deaths and identified where it was felt any deficiencies in medical or nursing care may have contributed to the patient's death as part of a primary review process. This is then followed up with a full mortality review by Consultant staff using a structured judgement review which results in an avoidability score.

Quarter 1
This death occurred as a result of death following the insertion of a central line into a femoral vein involving a complication whereby the femoral artery was inadvertently punctured. The procedure was abandoned and the bleeding stopped following which the patient

returned to the ward. Unfortunately the site started to bleed once again and the patient had a cardiac arrest.

Key learning has included the use of ultrasound scan guided femoral puncture to reduce the risk of femoral arterial complications and improvements to the pathway would have benefitted this patient.

Additionally, improvements in timeliness of communication pathways for patients and their family members around initial clinical concerns and the investigation processes were noted and actions taken with oversight from our Trust Mortality Board.

Quarter 3
This case involved a patient initially scheduled for surgical repair of a hip fracture who sadly died prior to surgery due to rapid deterioration prior to the procedure.

Review of the case indicated that a delay in the surgery and his pre-operative management warranted further exploration in establishing whether a better outcome might be achieved. This was a complex case and among the key improvements covered was:

- Improvements to multi-disciplinary working related to the hip fracture pathway
- Documentation review
- Increased out of hours junior doctor cover
- Methods for maximising theatre utilisation and prioritisation
- Changes to the anaesthetic pre-operative assessment process
- Increased staff training
- Improvements to guidance for pain management in hip fracture patients
- Review of use of nerve blocks as an alternative to opioid use
- Standardisation of hand overs
- Improvements in leadership and accountability across the pathway and multi-disciplinary team

A fractured neck of femur quality improvement Board has been established to oversee the implementation of improvements for this clinical pathway.

Other key learning from reviews throughout the year has included:

- Cross system working in respect to community prescribing of venous thromboembolism prophylaxis for patients who may be less mobile
- Improvements to communication pathways related to "Do Not Attempt Resuscitation" decisions
- Improvements to documentation related to treatment escalation plans for a patient who may be on an end of life pathway
- The need to avoid delay in immediate treatment of suspected pulmonary emboli whilst confirmatory investigations are completed.
- Improvements to ensure effective use of our fast track discharge process when patients are identified as at end of life with timely end of life decision making to ensure patients are treated and cared for optimally.

3.11 Seven Day Services Board Assurance Framework

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. In 2013 ten clinical standards were agreed and these were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

Early in 2019 our Trust Board undertook an assurance exercise in respect to our compliance with the standards and this highlighted further work was necessary to fully comply with four of the standards and the improvement work associated with meeting the standards has been defined as one of our key priorities as defined in the Quality Priorities for Improvement 2019 – 2020 section of this quality account.

3.12 Freedom to Speak Up (F2SU) and Guardian

The trust has a well-established Freedom to Speak Up Guardian (F2SU) role within the organisation. To further support this important work the Trust has recently appointed further support to the role by way of local F2SU champions.

Staff are encouraged to raise concerns and there is a formal policy outlining how they can do this which is available to all our staff via the intranet, our staff app and through staff induction.

Our staff are encouraged to raise any concerns they have with their line manager in the first instance, but they are informed that if for any reason they don't feel comfortable or able to speak to their manager they can raise them with the Freedom to Speak Up Guardian, with an HR advisor, with Occupational Health, with their Trade Union or professional association or L&D staff can speak to a confidential advisor through the CiC Employee Assistance Scheme.

There is a well-established process for accessing our F2SU guardian, with a dedicated email address and mobile telephone number for the Guardian.
In addition staff can download a form from the intranet and post in confidence to the guardian. These can all be done anonymously if staff prefer.

Once contact is made the Guardian will arrange a telephone or face-to-face conversation dependent on the wishes of the staff member with concerns escalated to the appropriate director (if consent is given).

All contacts receive a response and where necessary a follow up investigation is instigated. The Guardian, where possible, will always provide feedback progress to the individual who raised the concern and will inform them of any changes and/or lessons learned as a result of their contact.

The Trust through its Guardian works very hard to ensure that staff do not suffer detriment for speaking up and do this through a raft of measures including maintaining confidentiality in respect to their name when escalating the concern to a relevant Director. This is often a particular concern when issues of bullying and harassment are being raised.

3.13 Guardian of Safer Working Hours Report Statement

In line with the Terms and Condition of Service (TCS) (2016) of the Junior Doctors
Contract the Trust Board has received an annual report from the Guardian of Safe Working (GoSW). This contained information relating to exception reports, rota gaps and the plan for improvement to reduce gaps to ensure the safe working of doctors within the Trust.

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

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

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

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

- The 48 hour average weekly working limit
- Contractual limit on maximum of 72 hours worked with any consecutive 70day period
- Minimum 11-hour rest has been reduced to less than 8 hours
- Where meal breaks are missed on more than 25 per cent of occasions

Within the Trust there have been no Guardian fines to date as our Guardian has been liaising directly with individual departments to improve their engagement and understanding of the terms and conditions to improve the trainee environment and rotas in place. This has facilitated timely responses and changes to rotas to support requirements within the junior doctor contract.

Improvements
Themes identified from the Junior Doctor Forum, exception reports, reviews carried out by the newly appointed Head of Medical Workforce and other sources of intelligence included

- Gaps and Recruitment
- Post Allocation
- Operationalisation of Rotas
- Rota Design

Gaps and Recruitment
The Trust has undertaken improvement work within our Medical Workforce team to streamline the recruitment process and maximise the use of technology to reduce time to hire, improve the recruitment experience for candidates and minimise attrition. In addition the Medical Workforce team work have worked closely with the clinical divisions and our finance teams in the development and use of a workforce planning tool to forecast rota gaps with the aim of recruiting to these gaps in advance.

In addition, the Trust has supported NHS Employers to highlight the difficulties caused by the Tier 2 immigration cap. In June 2018 the government excluded doctors from the cap on skilled workers which enabled more doctors to be recruited from overseas. This combined focus on recruitment and exclusion of doctors from the Tier 2 immigration cap has enabled the Trust to embed an overseas recruitment process which enables recruitment within ten weeks.

The use of new roles is also supporting the improvement of rotas and work includes piloting of a Surgical Care Practitioners role and development of an F3 role supported by Health Education England. This new F3 role will enhance the flexibility of medical training offering doctors finishing their F2 post the opportunity to stay on for a further 12 month period to gain more experience in their role coupled with the offer of some support in respect of their professional development. Our Director of Medical Education is also exploring other workforce developments including use of Physicians Associates, Advanced Care Practitioners, Critical Care Practitioners and Advanced Nurse Practitioners.

Post Allocation
Our Surgical Division management team along with our Medical Staffing team and the GOSW engaged have spent time engaging with our Junior Doctors to particularly resolve the issues with our F1 surgery rota in time for the rotation in August 2018 and responsibility for allocation of posts and individuals to a rota will now move from Divisional Rota Co-ordinators to the Medical Workforce Team. This is aimed at ensuring posts will be allocated in line with medical establishment and ensure even distribution of doctors over the full reference period to maximise service availability and meet minimum staffing levels.

Operationalising Rotas
In order to improve how junior doctor rotas' are made operational the Trust now has monthly training sessions for those staff within divisions with responsibility for coordinating rotas. The sessions are designed to develop the knowledge of rota co-ordinators regarding requirements of the terms and conditions of the 2016 contract and how these effect the daily management of rotas.

Also a Trust wide set of rules to govern rota swaps is under development to ensure shift swaps are on a like-for-like basis and compliance with Terms and conditions are achieved.

Rota Redesign
During the year all junior doctor rotas were subject to an initial high level review and changes were made in order to maximise educational content and improve working patterns. However, we recognise that there remains scope for a larger scale in-depth redesign of all rotas in line with service and educational needs.

A programme of work is now planned for the coming year to undertake an in-depth redesign of all rotas which will explore the required service and educational needs as a result of the Shape of Training initiative.

The Trust has also invested in eRostering technology for medics to support the implementation of The Good Rostering Guide issued jointly by the BMA and NHS Employers which places additional controls to ensure rotas are managed in accordance with terms and conditions of employment. The deployment of this electronic system is aligned with the rota review programme described previously and the project will see the first deployment within the Emergency Department in early 2019/20 closely followed by our Medicine Division in summer 2019.

Finally a new rota build and authorisation process has been developed and put into place to improve controls. This process requires sign off by a Clinical Director, General Manager, Director of Medical Education, Guardian of Safe Working, the Head of Medical Workforce as well as 75% of the trainees on the rota.

Review of Quality Performance

3.14 Review of clinical indicators of quality – progress 2018/19

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	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	2018* 2018/19	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	1	1	1	1	N/A	The Trust has a zero tolerance for MRSA. During 18/19 there was an isolated case.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	112*	108.7*	105.1*	102.3	100	The HSMR indicators are monitored and demonstrates an improving position.
Number of hospital acquired C.difficile cases (n)	Patient Safety Trust Board Reports	11	8	9	5	N/A	Demonstrating a 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	11	3	12	14	N/A	Maintaining a good performance
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	2	4	5	5	N/A	Maintaining a good performance
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.04	1.4	1.08	0.72	1.2 Apr-Oct 18 1.15 Oct 18-Mar 19	Maintaining good performance below the national average
Average Length of Stay (LOS) (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.2 days	3.2 days	3.2 days	5.4 days	N/A	Noting a slightly increased LOS. However, some targeted work in key areas is reducing LOS.
Rate of falls per 1000 bed days for all patients Rate of falls per 1000 bed days for 16+ no maternity***	Clinical Effectiveness Trust Board Report	4.32	4.06	3.97 4.73***	4.08 4.89***	 6.63	Maintaining good performance and below the national average.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (to November)	Clinical Effectiveness	69.4%	78.3%	85.3%	79.9%	Target of 80%	The Trust is just below this target for the annual average and performance is being maintained.

Performance Indicator	Type of Indicator and Source of data	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	2018* 2018/19	National Average	What does this mean?
% of fractured neck of femur to theatre in 36hrs	Clinical Effectiveness Dr Foster	78%	62%	76%	71.3%	69%	The Trust is in line with the national average.
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	69.7*	70.79*	50.8*	63.16*	100	This is demonstrating the Trust as a positive outlier.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	112.8*	89.56*	100.3*	76.5*	100	This is demonstrating the Trust as a positive outlier.
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness Dr Foster	7.2%	7.09%*	7.00%*	3.7%	N/A	This shows an improving position for the Trust
% Caesarean Section rates	Patient Experience Obstetric dashboard	28.3%	32.9%	31.2%	31.3%%	25%	The Trust shows a higher rate than average and continues to monitor rates.
Patients who felt that they were treated with respect and dignity**	Patient Experience National in patient survey response	9.0	8.8	9.0	Not available until May 2019	Range 8.5 - 9.7	Demonstrating an improving position.
Complaints rate per 1000 discharges	Patient Experience Complaints database and Dr Foster number of spells for the year	6.29	6.64	5.50	4.70	N/A	The Trust continues to encourage patients to complain to enable learning but has seen a reduction in formal complaints.
Patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	7.4	7.6	8.1	Not available until May 2019	Range 7.1 - 9.1	Demonstrating a slightly poorer position but still within range.
Venous thromboembolism 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 consistently due to the introduction of an electronic solution

(n) Denotes that this is data governed by standard national definitions
* Denotes calendar year
** The Trust has maintained low rates of MRSA but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
*** The Royal College of Physicians requires the Trust to report this figure to be 16+ and non-maternity cases. This new result is now included.

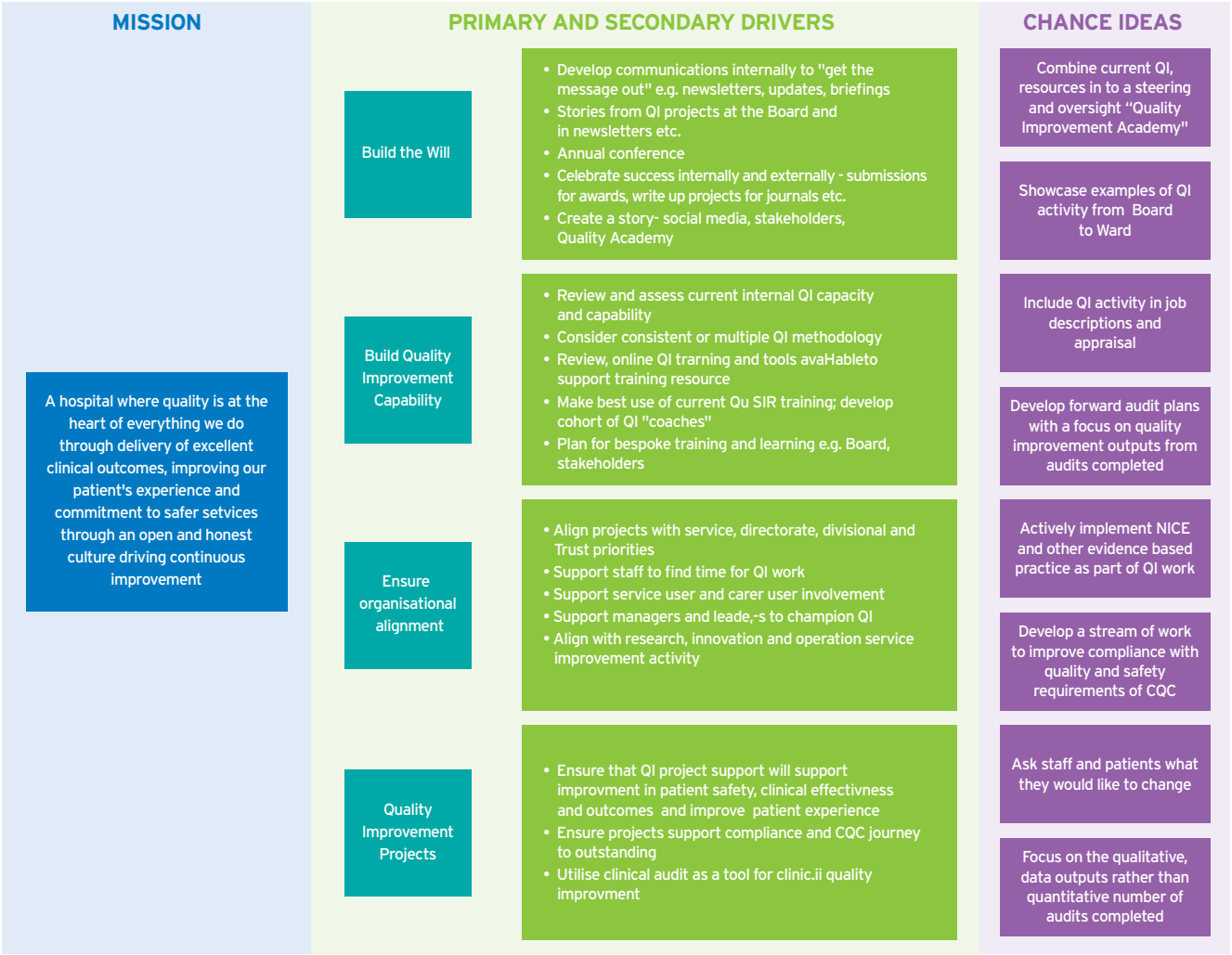
3.15 Quality Improvement

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

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

To support that delivery the Trust has appointed an executive Director of Quality and Safety Governance to provide leadership to our quality improvement plans, with specific objectives around maintaining the Trust's Care Quality Commission's (CQC) rating of good together with developing a programme of work to support the organisation on its journey to outstanding.
A delivery plan has been developed to provide a focus for the quality improvement agenda and a broad outline of key elements for that plan are summarised in the diagram below.

Journey to Outstanding Creating a Culture of Leaming and Clinical Quality Improvement at L&D



This programme of work aims to support and enhance an organisational culture where quality improvement is part of our day to day business and to encourage an environment where our staff feel empowered to identify improvement need and then create the change with sustained improvement.

In considering the key steams of improvement activity consideration has been given to content of the NHS long term plan, national quality priorities and indicators within the Commissioning for Quality and Innovation (CQUIN) specification together with locally identified improvement opportunities which all form the drivers for the programme. These works steams are then aligned with the Trusts four main quality priorities;

- to deliver excellent clinical outcomes,
- to improve patient safety,
- to improve patient experience and
- to prevent ill health.

In addition to these quality account priorities, other improvement drivers include;

- key findings from national audit,
- use of gap analysis against NICE guidelines and standards, for example improvements to fractured neck of femur pathways
- findings from patient and staff surveys and FFT results
- expectations related to health economy plans for a reduction of Gram-negative blood stream infections
- Getting it Right First Time (GIRFT) reviews,
- contractual quality requirements within the Quality schedule,
- findings and learning from serious incidents, Never Events, complaints, inquests and litigation, for example external review of colorectal services
- outputs from the Freedom to Speak Up Guardian
- recommendations from external agency accreditation and inspection visits for example, JAG accreditation and deanery visit findings
- benchmarking information from the recommendations of national reports and enquiries, for example the Gosport Independent Panel findings
- findings from mortality reviews and CHKS benchmarking data
- implementation of patient safety alerts
- risk registers
- CQC inspection outcomes and outlier alerts

Capacity, Capability & Sustainability of Quality Improvement

In ensuring the on-going implementation of its quality strategy the Trust has established a Quality Improvement steering Board with membership from the key staff across the organisation. This QI Board, chaired by the Director of Quality and Safety Governance, will drive delivery of the quality strategy and other improvements and signals the Trust's ambition to ensure a culture of continuous learning and improvement that is supported by senior oversight to ensure alignment against the quality priorities and other key improvement drivers.

This is underpinned through a programme of education aimed at building capacity and capability across the organisation to deliver the improvement agenda.

The Trust has for some time offered a Quality, Service Improvement and Redesign programme (QSIR) and also has developed a range of shorter courses and faster sessions ensuring that all staff receives an introduction to quality improvement as part of their induction to the Trust.

The QSIR programme is just one element of a wide range of 'enablers' and engages staff by harnessing local skills, knowledge and experience to improve the service delivered thus building on our improvement capability. The aim is to ensure all our staff are able to identify opportunities for quality improvement and to be skilled in using a common language and understanding of processes to deliver sustainable change.

The programme covers the following topics,

1. Leading improvement
2. Project management
3. Measurement for improvement
4. Sustainability of improvement
5. Engaging and understanding others
6. Creativity in improvement
7. Process mapping
8. Demand and capacity

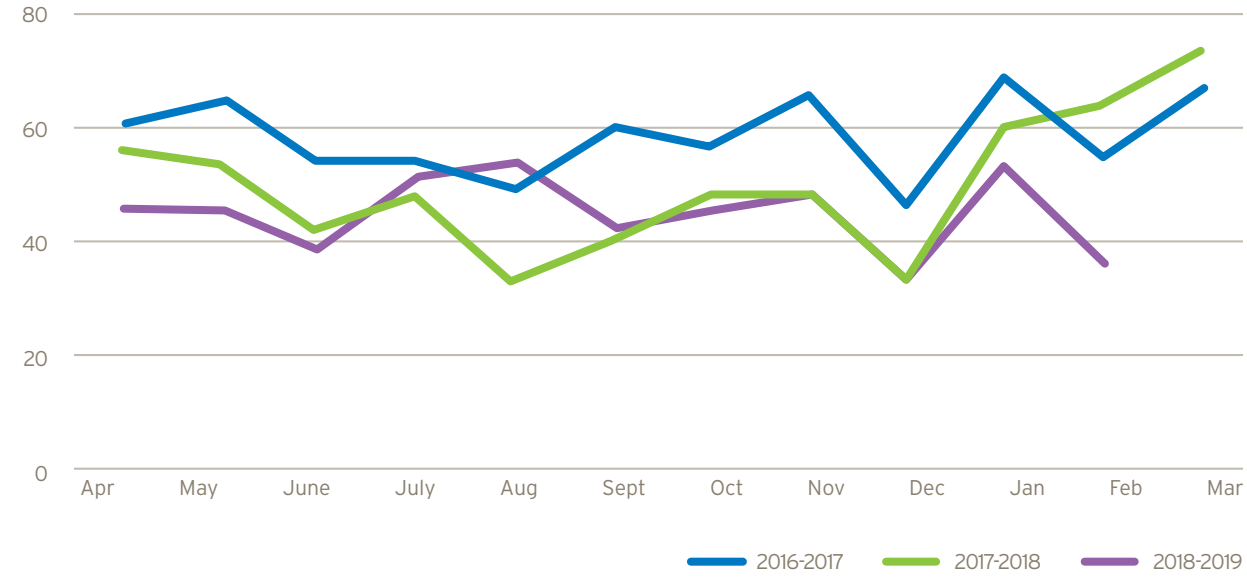
3.18 Complaints

The Trust has continued to work towards streamlining processes and achieving goals set in 2018/19. Not only is it important that we listen to people who give us feedback, whether they are patients, loved ones, carers or visitors, but that we also respond to them in a timely and robust way that addresses the issues they raise. We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations.

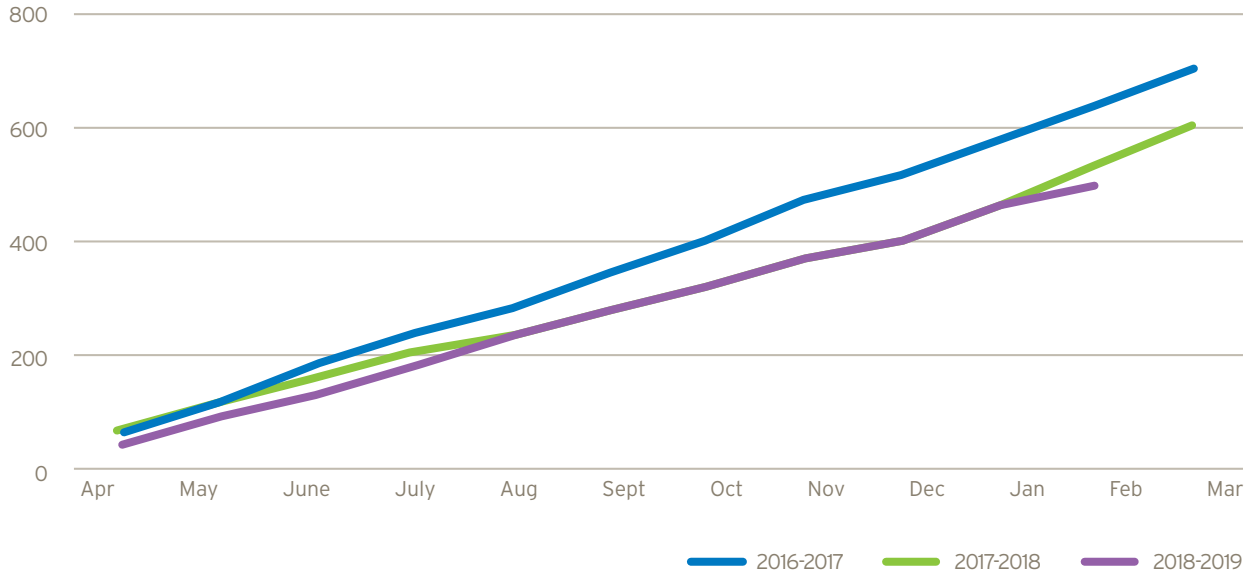
The Patient Advice and Liaison Team (PALS) have maintained a crucial front of house presence in the last year, in order to resolve issues raised with them to prevent escalation to formal complaints. Service Managers have been pro-active in contacting complainants to help resolve their complaints informally, thereby also reducing the need for them to follow the formal complaints process.

During 2018/18 we received **551 formal complaints** compared to 601 in 2017/18 and 704 in 2016/17 respectively. There has been a decrease in formal complaints due to early intervention by the PALS Team, resolving issues before they get to the formal stage, as well as work by Service Managers to deal with them early. This is a continued improvement year on year which is to be commended particularly as the patient footfall has increased this year.

Formal Complaints - 2016/17 to 2018/19



Formal Complaints received in 2018/19 compared with 2016/17 and 2017/18



We endeavour to acknowledge all complaints within 3 working days and have achieved an average of 98.3 % compared to 97.5% in 2017/18. So far YTD 100% acknowledged within the 3 day lead time has been achieved in 6 out of 10 months.

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

Learning from Complaints

In 2018/19 we continue to share learning from complaints at divisional level through the governance process. Below are examples of some of the improvements made during 2018/19:

- A recurrent theme in the Medical Division this year related to concerns about decisions not to resuscitate (DNAR). The key issue related to discussions with families prior to the decision being made. Most of the complaints were between April and October and some were unavoidable because next of kin (NOK) could not be contacted or the patient was too unwell to have the discussion. The theme has been shared with medical to staff to ensure they are aware of the requirement to have appropriate conversations with the patient's and/or their NOK. Since October there has only been one concern raised about DNAR.
- A Trust wide theme which has been raised by complainants relates to delayed discharges due to patients waiting for medication to take away. When patients are told they can go home they are frustrated when medication is not available. The Pharmacy Team has worked with services to implement a satellite pharmacy unit closer to wards in the Surgical Unit, which means patients do not need to go to the main pharmacy department. This speeds up their discharge process and reduces pressure on the main department.
- The Surgical Division has implemented changes to the pre-operative assessment process for patients awaiting surgery. Themes from complainants identified frustrations with the delay in being assessed when surgery is required. This has resulted in the division developing a 'one stop' pre assessment hub. This allows patients to have all tests and checks completed at the time of their outpatient appointment. Although their time at the hospital may be increased, it saves them returning on another day for their pre-op assessment checks.

Listening to Patient Concerns

The top five themes of complaints related to clinical treatment, communication, appointment delays and cancellations, admissions and discharges and attitude of staff.

The majority of complaints were resolved at local resolution level, with 5 complainants requesting that the Parliamentary and Health Service Ombudsman (PHSO) review their complaints. All 6 are still under investigation by the PHSO.

In quarter four the Chief Nurse commissioned an external review of the management of the complaints process, as the consensus amongst management staff was that we could work more effectively. The recommendations from the review were shared with the Complaints Board in February and proposals have been drafted for consideration. The recommendations we will be considering in the coming year are;

- Rebranding the Patient Affairs Team as the Complaints Team, which is in line with most other Trusts
- To join the PALS and Complaints Teams to provide a more seamless approach to managing concerns and thus prevent escalation to complaints
- Review of the Complaints Policy and development of a Standard Operating Procedure
- Review of template letters and documents used in correspondence with complainants
- Move across to improved electronic storage and processing of complaints

Compliments

We also keep a log of all compliments and if received centrally the relevant staff or service is given the feedback. The comments below demonstrate some of that feedback.

Thanks to everyone in A&E
In August I fell from a desk at home and sustained a Colles Fracture. We were received at A&E Reception and all staff were efficient, kind and went out of their way to put me and my husband at ease. My husband was due for a routine GP appointment, so once explained, we were ushered thought the formalities, treated and home within 3 hours. Sadly in October my grandson had to attend the Children's A&E with a dislocated elbow. Again the treatment was swift and excellent, seen immediately by very helpful and friendly staff, who put my poor son's mind at rest by explaining this is a common injury in small children. All in all, an excellent service for us all and, although we don't want to be using it too often, a service we praise, give thanks for and would highly recommend.

Excellent handling of my case (breast cancer)
I wish to express my sincere appreciation and gratitude for the excellent care I received from all staff at the L&D during my recent health concerns. Throughout my pathway of care which included the Breast Screening Unit, Radiology, Theatre and the Outpatient Unit, I experienced the highest level of professionalism, care and compassion from all staff involved, as they demonstrated immense patience care and empathy

as I struggled to come to terms with my diagnosis. As someone who has worked in the NHS for over 40 years, it is pleasing to know that patients receive this level of care when they need it most.

Thank you
I would like to thank you and your teams in Urology One Stop and in theatre for the excellent way I was treated recently for kidney stones and stents removal. Knowing I was anxious the care and consideration shown by everyone concerned was exceptional at all times. I felt I was being treated as a whole person not a NHS number.

Thank You to the Outpatient Team
I brought my relative to a clinic appointment and failed to advice the staff we needed to book Hospital Transport to get us back home. We were left stranded at the end of clinic but two staff nurses stayed with us after their shift ended, trying to organise the transport and provided welcome cups of tea. One of the doctors assisted and authorised a taxi to take us home and the nurses arranged that. People are too quick to criticise and fail to say "thank you" to staff who have gone the extra mile.

Compliments to Maternity Services
I would like to thank all the staff who dealt with me and our new baby throughout my pregnancy. The midwives and the students, who train with you, as well as the rest of the staff, really do go the extra miles and deserve a lot more praise that I can express. We have been frequent visitors with family friends on both happy and sad occasions, but never once has anyone made us doubt the competence, professionalism and kindness of the staff there.

3.17 Friends and Family Test

The Friends and Family Test (FFT) continues to be a mandated programme to gather patient feedback. The organisation submits monthly data to NHS England, which is benchmarked against other Trusts and also at regional level. The process of providing staff with weekly results has gathered momentum this year, as staff wait to see their results and friendly competition is evident across the organisation. It has also allowed us to identify reason why areas may have not performed as well as others and this has been taken into consideration when reviewing results. This had resulted in the development of different types of surveys dependent on the patient cohort. Patients who complete the survey are also asked to make comments about their stay. If they report they would be 'unlikely' or 'extremely unlike' to recommend the services a linked action is reported. This allows teams to read the comments made, alerts senior nursing staff and the Patient Experience Team. Actions have to be taken and these are monitored to ensure they are completed. However, it should be noted that not all comments are negative and a large number either make no comment or praise the staff for their care. There were no particular trends or themes noted from the information collected. This is one of the challenges associated with the FFT and the outcome of a review by NHS England will be reported in April 2019.

As a result of sharing the scores every week Inpatient and Day Case Patient scores have maintained higher scores than the national average. The Emergency Department has significantly increased scores in the latter half of the year, and like Inpatient results these are notably higher than national scores.

All aspects of the FFT remains the same from last year, however following consultation and review by NHS England there will be announcement made in Q1 2019/20 with changes anticipated in Q3.

"How likely are you to recommend our ward to friends and family if they needed similar care or treatment?"

We continue to collect information from the following clinical areas;

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

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.

Table One: shows the comparison between the Trust and the national average by quarter for inpatients completing the FFT.

Table Two: shows the comparison between the Trust and the national average by quarter for ED patients completing the FFT.

Tables 3-6 show the percentage recommend scores across all areas of the Trust. These statistics are reported monthly to NHS England.

Table One: Trust Comparisons to National Inpatient Recommend FFT Results

Comparison	Total Responses	Total Eligible	Response Rate	Percentage Recommend	Percentage Not Recommend
England excluding independent providers (Q1)	659,865	2,663,926	24.7%	96%	2%
Trust (Q1)	6,109	18,287	33.4%	95.6%	1.3%
England excluding independent providers (Q2)	655,123	2,663,320	24.6%	96%	2%
Trust (Q2)	6,575	17,550	37.4%	95.3%	1.3%
England excluding independent providers (Q3)	647,118	2,744,234	23.5%	95%	2%
Trust (Q3)	5942	16,387	36.4%	95%	2%
England excluding independent providers (Q4)	647,684	2,697,767	24%	95.6%	2%
Trust (Q4)	5,776	16,440	35.1%	94%	1.7%

Table Two: Trust Comparisons to National ED patient Recommend FFT Results

Comparison	Total Responses	Total Eligible	Response Rate	Percentage Recommend	Percentage Not Recommend
England excluding independent providers (Q1)	431,778	3,387,374	12.7%	87%	7.3%
Trust (Q1)	2,139	20,382	10.3%	98%	0.3%
England excluding independent providers (Q2)	432,663	3,430,340	12.6%	87%	7.6%
Trust (Q2)	2,752	6,831	13.7%	99.3%	0.3%
England excluding independent providers (Q3)	402,892	3,385,867	11.9%	86.6%	8%
Trust (Q3)	6,092	19,584	31.9%	98%	0.6%
England excluding independent providers (Q4)	412,235	3.396,696	12.1%	85.7%	8.3%
Trust (Q4)	6,511	19,636	33.2%	98%	1%

Table 3: Inpatients Percentage Recommend Scores 2018/19

% of Inpatients who would recommend 2018/19

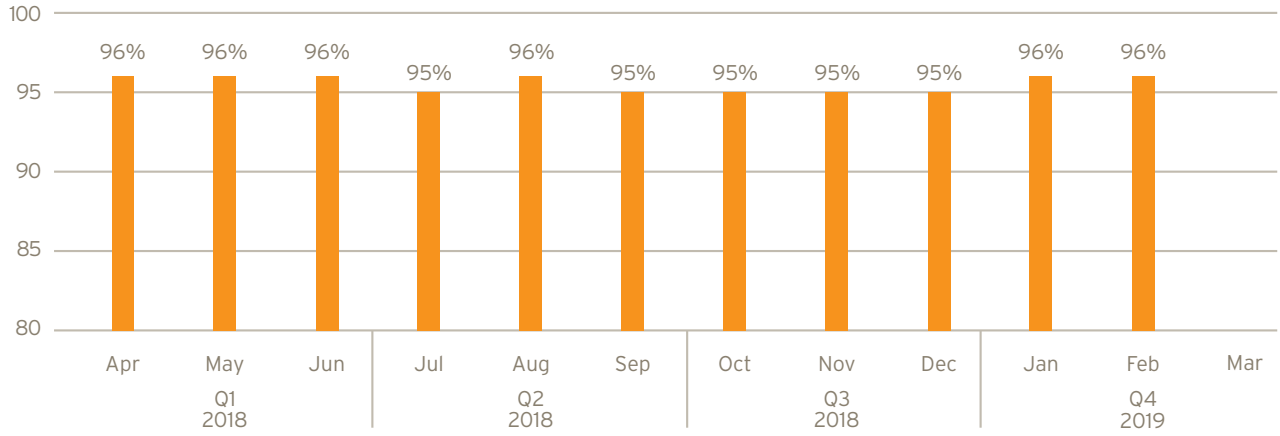


Table 4: Accident and Emergency Percentage Recommend Scores 2018/19

% of A&E patients who would recommend 2018/19

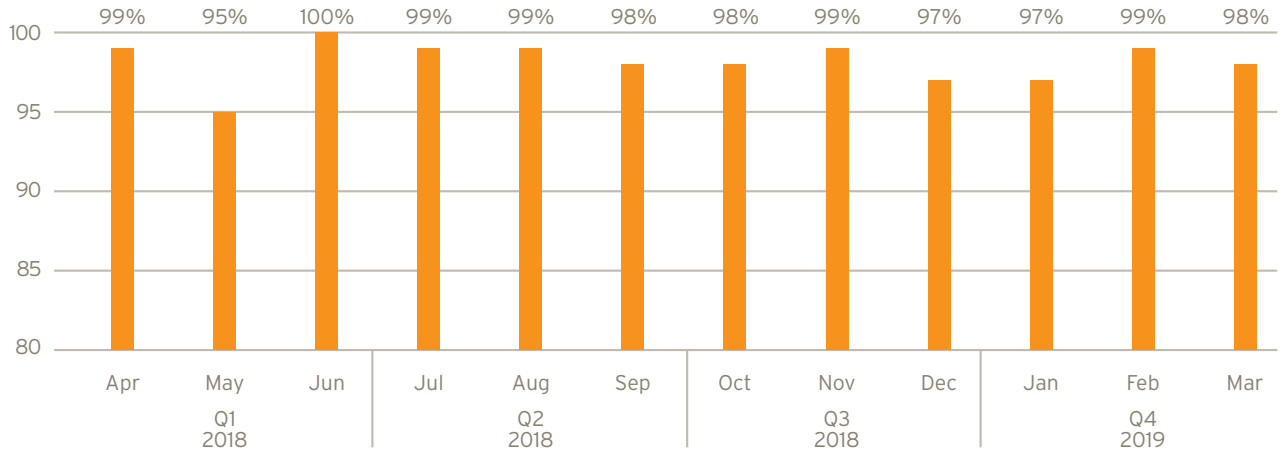


Table 5: Maternity Percentage Recommend Scores 2018/19

% of Maternity Patients who would recommend 2018/19

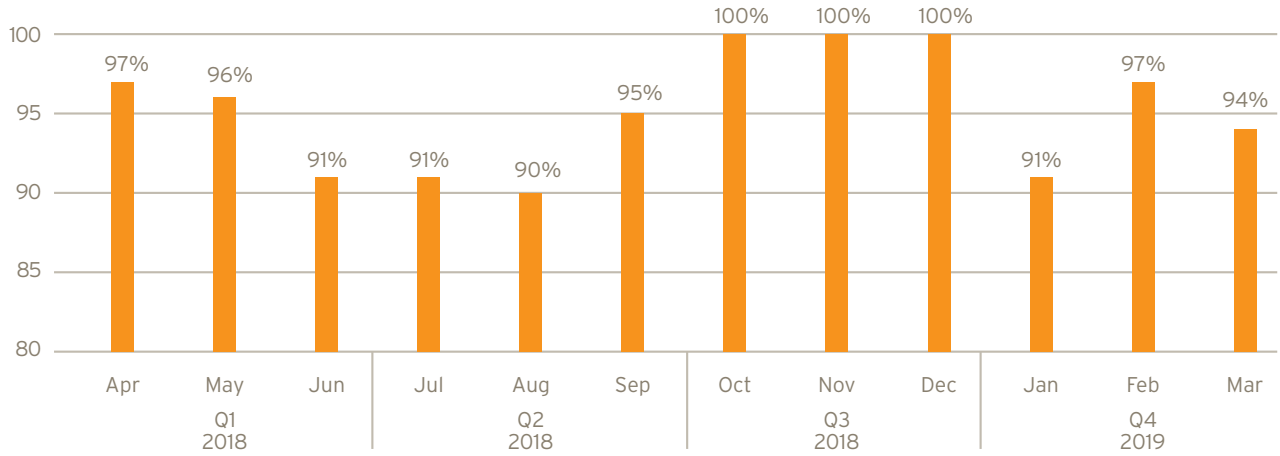
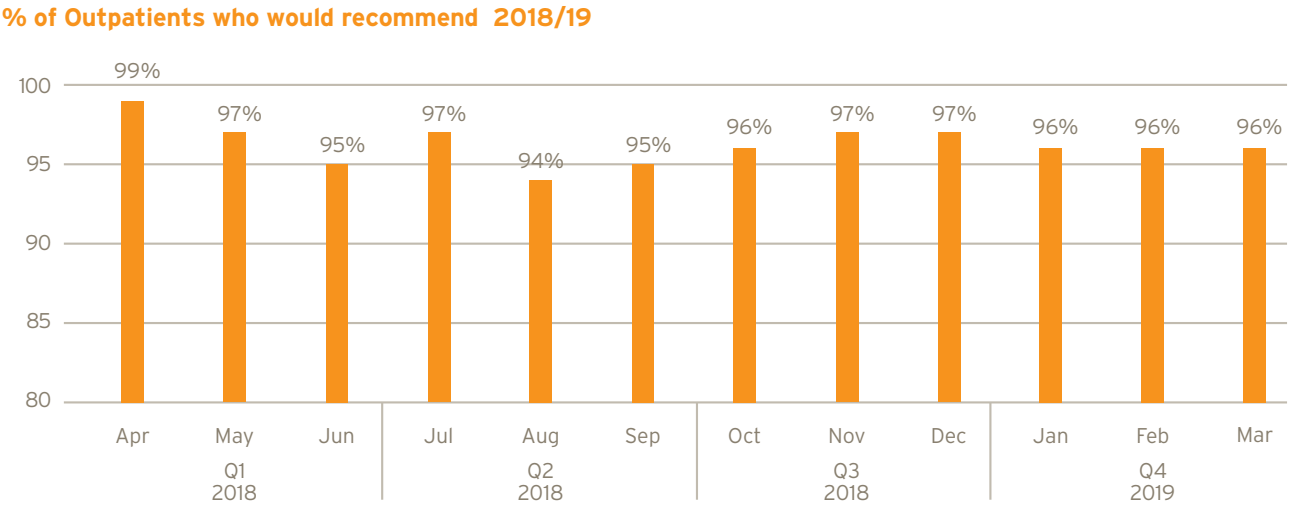


Table 6: Outpatients Percentage Recommend Scores 2017/18



Patient Stories and Improvements following patient feedback.

STORY ONE

Sharing Documentation and Information

KB experienced on-going pain and swelling in her left leg. She was seen at the hospital and via Ambulatory Care scans and tests were planned. However, the tests were not requested properly which resulted in a 2 hour delay for the test to be carried out. The test results did not arrive with her GP and she requested twice that they been sent again, as they contained information vital to receiving treatment to prevent a venous thrombolytic embolism. A Doppler scan was requested but for the wrong leg and despite the patient telling the staff they continued to scan the wrong leg as they said without a request they could not scan the other leg. They did not call down to the doctor to verify the change and because there was not a sonographer trained in Doppler available later in the day, the scan was delayed until the following day. Precautionary injections were prescribed but had all tests be carried out in a timely fashion this course of treatment would not have been necessary

The patient reported not all additional tests were explained and she also found worrying information on her discharge letter, which she had not been given at the time of other tests. She 'googled' the results to get the information she needed

Lesson learned;

1. Correct tests should be recorded and requested in patient records. Staff should be prepared to challenge and check with the patient if they state there is an inaccuracy.
2. Give opportunities for GPs to have access to the results system so that if they do not receive tests they can be followed up.
3. Ensure sonographers need to check with base ward/unit if there an discrepancies with requests
4. Availability of sonographers needs to be communicated so that requesters know when the services us available
5. Ensure medical staff give patients information in a timely fashion and a way they understand.

Overall Outcome:
Additional tests have now been added to the critical escalation list for GPs. The merging of Pathology Services with Bedford Hospital will also facilitate access to the ICE reporting system for GPs. In order to ensure other teams are aware of the availability of relevantly trained staff the Radiology Services Manager has circulated this to PALS team so that they can advise patients of this information. Also sonographers have been encouraged to question discrepancies with tests by ringing the ward/unit to prevent wasted tests and delay undertaking the correct one. As safety brief is now carried out every Monday morning in the Ambulatory Care Unit to enable staff to share key safety information as the medical teams frequently rotate.

STORY TWO

Early Onset Dementia

JB is a 55 year old former teacher with early onset dementia. As part of the National Bowel Screening Programme he was asked to attend the Endoscopy

Unit to undergo a screening sigmoidoscopy. JB also has visual issues and is registered severed visually impaired and has to wear special glasses at all times. His wife attended with him to support him as she does with all hospital appointments. Despite giving the staff information about his early onset dementia his wife was not allowed to assist him with his journey throughout the unit. This left him disorientated and scared as he struggled to retain the information given to him by staff. Some staff did not accept the diagnosis of dementia upsetting him and his wife. He relied on other patients to reinforce information given. He was asked to remove his glasses before he got onto the procedure trolley, which again not only disorientated him but also rendered him blind. He felt this could have been left until he was settled on the trolley. As his wife's phone was on silent as per instruction it took a considerable time for word to get to her that her husband's procedure had been completed and she could take him home.

Lessons Learned:

1. Better acknowledgement and awareness of early onset dementia. Training for staff to address this.
2. When a patient is identified with dementia discrete identification should be added to their records
3. People attending with them should be allowed to accompany them through most of journey to help reinforce instructions and allay fears. This would not include access to the procedure room.
4. There should be better signage throughout the unit to ensure that any patient can easily find their way around.

Overall Outcome: As part of John's Campaign the team in the unit have worked closely with the Dementia Specialist Nurse to improve the experience of patients with dementia. Work is in progress to improve the layout of patient waiting areas and improved signage on-going. Dementia awareness training has be made available to update staff and a new dementia champion has been identified

3.18 National Inpatient Survey 2018

(At time of writing contemporary data remains embargoed)

The report of the L&D inpatient survey was received in June 2019 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 2018 were surveyed. The Trust had a response rate of 40% against a national average of 45%, compared to 38% and 41 % respectively from 2017

Results of the national in-patient survey 2018 compared to the previous 5 years

Category	2013	2014	2015	2016	2017	2018	Trust year on year comparison with 2017	Comparison other NHS hospitals
The emergency / A&E department, answered by emergency patients only	8.4	8.2	8.6	8.5	8.7			
Waiting lists and planned admission, answered by those referred to hospital	9.1	8.9	8.8	8.8	9.0			
Waiting to get to a bed on a ward	6.5	7.1	7.3	6.7	7.1			
The hospital and ward	8.1	8.0	8.0	7.6	6.3			
Doctors	8.4	8.4	8.3	8.3	8.5			
Nurses	8.2	8.1	8.3	7.7	8.0			
Care and treatment	7.6	7.6	7.7	7.5	8.0			
Operations and procedures, answered by patients who had an operation or procedure	8.2	8.4	8.4	8.5	8.1			
Leaving hospital	7.1	6.8	6.8	6.8	*		*	*
Overall views and experiences	5.5	5.5	5.3	5.2	4.4			

Note all scores out of 10
* No score available for 2017 due to issue with questions.

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.

3.19 NATIONAL STAFF SURVEY 2018

NHS staff survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.
The response rate to the 2018 survey among trust staff was 52 % (2017: 54%). Scores for each indicator together with that of the survey benchmarking

Group 'Acute Trusts' are presented below.

	Trust	Benchmarking Group -average	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.0	9.1	8.9	9.1	9.0	9.2
Health and Wellbeing	6.0	5.9	6.1	6.0	6.2	6.1
Immediate Managers	6.9	6.7	6.9	6.7	6.8	6.7
Morale	6.1	6.1		Not measured		Not measured
Quality of Appraisals	6.0	5.4	5.8	5.3	5.9	5.3
Quality of care	7.6	7.4	7.6	7.5	7.6	7.6
Safe environment – bullying and Harassment	7.9	7.9	7.9	8.0	7.7	8.0
Safe environment – violence	9.5	9.4	9.3	9.4	9.3	9.4
Safety culture	6.8	6.6	6.7	6.6	6.7	6.6
Staff engagement	7.2	7.0	7.2	7.0	7.3	7.0

Commentary

A sample survey was conducted in 2018 and this sought the opinion of 1250 of our staff. The response rate was 52% and although slightly lower than the 2017 response rate it was still higher when compared to the average of all Acute Trusts.

We have seen a number of positive trends including staff motivation at work and the support that they receive from their immediate managers which is also reflected in the positive feedback on appraisal. The visibility of senior managers continues to be raised through the work that is being undertaken during the twice-yearly week-long staff engagement events: 'Good – Better – Best'.

We are pleased to see that staff feel optimistic about patient safety and consider that the Trust takes concerns raised by staff and patients seriously and where necessary action is taken to improve learning to prevent future incidents. Staff are also satisfied with the quality of care they give to patients and believe that they can deliver the care they aspire to.

Areas for improvement

We recognised that there is still more work to do in relation to harassment, bullying and abuse from some patients and service users and we will continue to support staff in dealing with these difficult situations. There is a downward trend of physical violence from patients and service users though 15% of the staff who completed the survey indicated that they have suffered some violence in the previous 12 months.

Stress in the workplace remains higher than we would like, however, it appears that it is high across all Acute Trusts where the average was over 3% higher than the Trust at 39%. This figure represents how staff responded in relation to a question about having felt unwell as a result of work-related stress. As an organisation, we cannot be complacent and we take steps through our health and wellbeing activities to mitigate the impact of stress in a highly pressurised, busy hospital.

Finally, we are still concerned about the feedback from the survey that suggests that staff have experienced musculoskeletal (MSK) problems as a result of work activities. The trend is upward since 2014 with 32% indicating that this is an issue which is 3% above the average. Taking steps to improve this will form part of our action plan for this year.

Future priorities

The Trust is implementing a suite of improvement

priorities for our staff and these include:

- Embedding our new policy on preventing harassment and bullying of our staff from members of the public reinforcing the action that will be taken against the very small minority who behave in an aggressive manner towards our staff.
- The training on Prevention of Bullying and Harassment will be reviewed to ensure it still meets the needs of the Trust.
- We offer a range of training to support staff who experience stress and this will be promoted and we will ensure that there are enough places on offer.
- Where there is evidence of local MSK concerns, we will offer further advice and guidance as well as local training with our Moving and Handling Trainers.
- As we now have a full set of new organisational Values with behaviours that describe what staff like to see and what they do not, we will ensure that these are fully embedded through annual appraisal and Values-Based Recruitment. We will also promote these Values to all our external stakeholders to ensure that they are aware of how we wish to conduct our services and what we expect from everyone.

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 2018/19 the Trust has continued with initiatives, to promote opportunities for staff to adopt a healthier lifestyle either on site or by promoting external facilities that are conducive to good health.

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 a number of awareness raising events.

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

Annual Health and wellbeing event

In June 2018, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place. Attendance levels have increased year on year, and we had over 300 members of staff attend, with many participating in the activities. Awareness raising stands and activities included: Chair based fitness exercise demonstrations by Active Luton, Latin infusion dance demonstrations, Laughter yoga, Batak reaction game, smoking cessation, smoothie bikes, Blood pressures, Heights/weights and Body Mass Index, healthy eating, a nutritionist performing health snacks demonstrations, table tennis and a skipping challenges, and a company promoting ergonomic posture correction and active working products.

This year, 76.5% of our frontline staff were vaccinated against flu, which was marginally higher than the year previous and amongst the highest uptakes when compared to other NHS Acute Trusts.

Employee Assistance Programme

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

Health Checks for staff

The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. A company commissioned by Luton Borough Council provides 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 580 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 onward 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. Whilst this initiative was primarily for staff, it has also been welcomed by patients and visitors to the Trust alike.

Since September 2015, the stall has been on site one day a week. In April 2016 we introduced a new activity entitled 'Apples and Pears to take the stairs'. This activity takes place on a monthly basis to encourage staff to use the stairs more, increase levels of fitness and also to raise awareness of the fruit and veg stall. The interest in this event has increased over time and we now have on average 30 members of staff participate in this challenge which is held over a 45 minute period.

Wednesday Walking
These '30 minute' walks have been held every Wednesday since 2009. Numbers attending are generally quite low, however the initiative has led to groups of staff holding their own walking sessions at times that fit in with their individual work routines.

On site Eye tests
Following requests from staff, we invited a specialist company to come on site, for the purpose of providing free comprehensive eye tests to our staff.
They were on site from early December 2018 to early February 2019, for a total of 34 'testing' days. During this time 602 members of staff were seen, 61% were advised the need for vision correction.

3.21 Performance against Core Indicators 2018/19

Summary Hospital level mortality indicator (SHMI)
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			2
	Published Jul 13 (Jan 12 - Dec 12)	As expected	As expected			2
	Published Oct 13 (Apr 12 -Mar 13)	As expected	As expected			2
	Published Jan 14 (Jul 12 - Jun 13)	As expected	As expected			2
	Published Oct 14 (Apr 13 -Mar 14)	As expected	As expected			2
	Published Jan 15 (Jul 13 - Jun 14)	As expected	As expected			2
	Published Mar 16 (Sep 14 -Sep 15)	As expected	As expected			2
	Published Mar 17 (Sep 15 -Sep 16)	As expected	As expected			2

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
	Published Mar 18 (Oct 16 – Sept 17)	As expected	As expected			2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level (The palliative care indicator is a contextual indicator)	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
	Published Mar 18 (Sep 16 –Sep 17)	32.8%	31.6%	11.5%	59.8%	N/A
	Published Feb 19 (Oct 17 –Sep 18)	36.1%	33.6%	59.5%	14.3%	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:
- On-going Use of "Structured Judgement" as a methodology for mortality reviews with these fed through to the regular morbidity and mortality learning meetings held within each of the organisational Divisions and services
- We have appointed a Board-level Executive lead for the Mortality Review Process, and we have a non-Executive lead charged with oversight and challenge.
- The outcomes from Mortality Reviews are shared quarterly through a Board level quality report as from September 2017.
- Membership of our Mortality Board has been broadened to include representation from external stakeholders; including our lead Clinical Commissioning Group this allows oversight to ensure that any deaths that require a community review are subject to a consistent process.

Readmission Rates
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 Trust during 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*
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2018/19	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*
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2018/19	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:
- Continued work with our external partners to prevent unnecessary readmissions to hospital via 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 NHS Digital is 2011/12 uploaded in December 2013.

Patient Reported Outcomes Measures (Proms)
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 (worst)	Lowest score (best)
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*	0.078	0.08	0.14	0.06
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

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Varicose vein surgery	2015/16	**	0.1	0.13	0.037
	2016/17*	**	0.099	0.152	0.016

PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
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	0.38	0.44	0.53	0.33
	2017/18*	0.43	0.46	0.55	0.36
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	0.30	0.32	0.39	0.24
	2017/18*	0.31	0.34	0.41	0.25

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

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

*Relates to data available through NHS Digital
**score not available due to low returns

Responsiveness To The Personal Needs Of Patients During The Reported Period
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 (worst)	Lowest score (best)
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	71.6	76.7	88	70.7
	2017/18	66.2	68.6	86.2	54.4
	2018/19	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:
- The PALs service continued to provide the first contact and support the collection of ongoing friends and family feedback.
- Improved access to interpreters.
- Implemented recommendations following Healthwatch visits including improved awareness of translation services.
- Reviewed the complaints process and have initiated recommendations to streamline the responses.
- Themes from complaints identified discharge from hospital as a concern. Therefore this was included as a Quality Account Priority for 2018/19.

Staff Recommendation
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 (worst)	Lowest score (best)
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%
	2017/18	72%	70%	87%	60%
	2018/19	70%	71.3%	87%	40%

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:
- Engaged with staff about the vision, values and behaviours and have embedded them within the appraisal process.
- Provided information and training at the Staff Engagement Event in July 2018 to over 2500 staff, on how to deal with challenging situations.
- Supported fast track physiotherapy access to staff.

Risk Assessment For Venous Thromboembolism (VTE)

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 (worst)	Lowest score (best)
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%
	2017/18 - Q3	95.91%	95.3%	100%	76.08%
	2018/19 - Q1	99.34%	95.64%	100%	52.66%
	2018/19 - Q2	98.2%	95.7%	100%	74.8%
	2018/19 - Q3	99.17%	95.73%	100%	55.6%

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:
- Introduction of an electronic VTE risk assessment tool, this mandates risk assessments on admission and prompts our clinicians to consider prescribing thromboprophylaxis at the same time.
- We ran an organisational wide "Stop the Clot" campaign aimed at raising awareness around the risks of VTE with education and training opportunities for our staff.
- We continued with a review and audit process for those patients who may have developed a HAT with a full root cause analysis where any patient was identified as acquiring a thrombosis which was potentially avoidable.

Clostridium Difficile Rate
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	3.6	13.2	82.7	0
	2017/18	4.0	14.0	91.0	0
	2018/19	2.1	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 5 C.difficile for 2018/19

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.

Patient Safety Incident Rate
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	Highest score (worst)	Lowest 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	23.3	41.1	23.1	69.0
	2017/18	32.2	42.6	24.2	124
	2018/19	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	0.06	0.2	0.53	0.01
	2017/18	0.13	0.16	0.55	0
	2018/19	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

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.

3.22 Performance Against National Priorities

		2015/16	2016/17	2017/18	2018/19	Target 18/19
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	11	8	9	5	6
MRSA	To achieve contracted level of 0 cases per annum	1	1	1	1	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	100%	99.9%	100%	100%**	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	88.4%	88.6%	89.2%	87.6%**	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.8%	96.4	96.3%	95.8%**	93%
Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	98.6%	100%	100%**	100%**	94%
	Anti-cancer Drugs	99.8%	100%	100%**	100%**	98%
Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	96.3%	93.2%	91.9%	91.1%**	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.6%	98.8%	98.4%	98.1%	95%
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	N/A	0.7%	3.4%	0.8%	<1%

Glossary

Term	Description
Acute Kidney Infection (AKI)	A painful and unpleasant illness caused by bacteria travelling from your bladder into one or both of your kidneys
Antimicrobial	An agent that kills microorganisms or stop their growth
BAUS	British Association of Urological Surgeons
BRA	Breast Reconstruction Evaluation
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
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.
Delirium	Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment.
DME	Division of Medicine for the Elderly
DNACPR	In the right circumstances, a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order helps ensure that a patient's death is dignified and peaceful.
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.
Frailty	Frailty is a common geriatric syndrome that embodies an elevated risk of catastrophic declines in health and function among older adults
GIRFT	The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow.
HES	Hospital Episode Statistics

Term	Description
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.
ICNARC	Intensive Care National Audit and Research Centre
Laparoscopic	Key hole surgery
Learning Disability	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
LIG	Local Implementation Group
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Needs Based Care	Inpatient adult wards are organised by patient need rather than age for example a cardiac ward, respiratory ward.
NELA	National Emergency Laparotomy Audit
Neonatal	New-born – includes the first six weeks after birth
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 patient's journey. If it is red, the patient has not progressed, green they have.
QSIR	Quality, Service Improvement and Redesign The QSIR programmes are delivered in a variety of formats to suit different levels of improvement experience and are supported by publications that guide participants in the use of tried and tested improvement tools, and featured approaches, as well as encouraging reflective learning.
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.

Term	Description
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
Somatosensory	The somatosensory system is a part of the sensory nervous system. The somatosensory system is a complex system of sensory neurons and pathways that responds to changes at the surface or inside the body.
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit.
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply A review methodology based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.
Structured Judgement Review	A review methodology based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.
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
WHO	World Health Organisation

Research – Glossary of terms

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

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

Statement of Directors responsibilities for Quality Account

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018-19 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 2018 to May 2019; papers relating to quality reported to the Board over the period April 2018 to May 2019;
  - feedback from commissioners dated [not received at time of signing];
  - feedback from governors dated 27 February 2019 ;
  - feedback from local Health watch organisations dated 16th May 2019 from Bedfordshire Healthwatch [Luton Healthwatch not received at time of signing]
  - feedback from Overview and Scrutiny Committee - Central Bedfordshire dated 20th May 2019
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21 May 2019;
  - the latest national patient survey [not received at time of signing];
  - the latest national staff survey dated March 2019;
  - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2019;
  - CQC inspection report dated 7 December 2018.

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

22nd May 2019
Simon Linnett
Chair

22nd May 2019
David Carter
Chief Executive

Stakeholder Feedback

healthwatch Central Bedfordshire

L&D University Hospital Quality Account 2018/19 Review by Healthwatch Central Bedfordshire

Healthwatch Central Bedfordshire recognises that Luton ft Dunstable University Hospital serves a population made up primarily of patients from both Luton Borough and areas of Central Bedfordshire and notes that last year it provided healthcare to over 90,000 admitted patients and 400,000 outpatients, including the delivery of 5,300 babies.

Healthwatch Central Bedfordshire (HWCB) has noted the continuing focus on patient safety, the effectiveness of treatments and the over-arching goal of improving patient experience and in considering the data in this report also recognises the positive steps taken by the hospital to ensure that the patient experience is as good as it might be.

In particular we reference the positive way that the hospital encourages 'Always Events' (P10 of the report), Front Door in Reach (P14), the Frailty Unit (P15 ft30) and the use of the Pharmacy Team (P15). The 'Needs Based Care' initiative appears to be generally reducing the length of stay in hospital of patients and we also see that appreciating the particular needs of those with Mental Health has reduced their repeat attendances considerably during the past year (31 particular patients with 464 attendances in 17/18 down to 139 attendances last year).

We note that falls within the hospital are below the national average and recognise the continued efforts being made to make these events even less than that, the ongoing work re preventing cardiac arrests and VTE Risk Assessment compliance which are all producing positive results.

Clearly the hospital is set up to learn from both complaints, that continue to fall year on year (P69), and from the work of the Hospital Mortality Board (P27) and has introduced 1421 patients into research projects last year (PSS).

CQC regards Luton ft Dunstable University Hospital as 'Good' and the results of the Family and Friends Test are also excellent. We note the Quality Improvem,ent Plan, but also see that the response to the internal staff survey still only attracts a response of just over 50%. One other initiative that caught the eye were those that related to healthy eating and lifestyles and the examples that they set (P34/35).

Inspected and rated
Good
Care Quality Commission

The Trust is one of a number of organisations developing the Integrated Care System (ICS) and we would like to have seen more in the report about the progress within this report, but overall Healthwatch Central Bedfordshire notes the report and the positive messages within it.

Diana Blackmun
Chief Executive
Officer Healthwatch Central Bedfordshire
Capability House,
Wrest Park
Silsoe
MK45 4HR

Email: diana. blackmun@healthwatch-centralbedfordshire.org. uk
Mobile: 07881 108967
Tel: 0300 303 8554

https: //healthwatch-centralbedfordshire.org. uk

Central Bedfordshire comment on the Luton and Dunstable University Hospital NHS Foundation Trust Quality Account 2018/19

"The Social Care Health and Housing Overview and Scrutiny Committee has been reviewing quality accounts from the various hospitals used by Central Bedfordshire Council residents and intends to continue to do so.

This year the accounts fall at the time of local elections and it has not been possible to arrange a special meeting, there will also be a change of Chairman of the OSC and some new members. The first meeting of the scrutiny committee of the new Council does not take place until 3 June, in the meantime, the quality accounts that have been presented, some feedback will be given. It would appear that given the deadline of others, it will not be possible to meet these. However, it is proposed that when the new committee is formed, Members will have the opportunity to scrutinise the remaining QA's".

'Overall a great deal of improvement is evidenced in this report of which all personnel should be proud. The fact that staff are markedly more likely to recommend their hospital than prior years is a sure sign of improvement and areas such as harassment and bullying are showing a decline, all of which bears witness to a real effort to improve across the board.

At the outset of the report we see reference to the success of common values training and integration into the ethos of the hospital. This has to be of extreme importance when managing such vast numbers of people and differing skill sets/responsibilities and I cannot help but feel that this drive to achieve a recognised set of common goals/language has played a big part in the overarching improvements the hospital is able to report. I might venture so far as to suggest this remains a priority rather than be relegated to 'business as usual' status in the ensuing year.

Section 1.2 deals with the adoption of 'always events' thinking which is a sound programme given the diversity of employees, it being good to spell out what must always happen though this might need to be balanced with 'never events' for the same reason and if this is the case then the report does not make that clear.

Section 1.3 End of Life: some really good work is apparent here and the outcome of specialist palliative consultancy I feel sure will show a positive influence on future performance in this area. There is no surprise that family feedback may not always be positive given all the emotional issues surrounding the loss of a loved one but the improved communications efforts and getting discharge right should go a long way to mitigating the experience for those close to the deceased.

Priority 2: Patient Safety
Some encouraging work is evidenced here in terms of frail elderly front door experience and falls as well as the coaching on how to talk to families where patients are deteriorating. Also some good progress on thrombosis avoidance and meds errors. Maybe a simple chart for those administering meds might help reduce human error in this area.

Priority 3: Clinical Outcomes
Again, some very encouraging signs. Counter sepsis measures are bound to show improvements in patient health and broadening the debate around patient mortality is likewise bound to help with improvement through broadening the reach of exploration by involving a wider pool of stakeholders. The work being done on Advice and Guidance is commendable although this must put extra pressure on an already burdened and limited expert resource. More work will need to be done to spread that burden without compromising the outcome.

The work on staff wellbeing is paying dividends in the context of the entire account and while work related stress and injury cannot be removed completely it is obvious from staff feedback that the L&D are getting it right given the marked improvements of employee enthusiasm for the quality of their workplace and the evidence of performance improvement.

The only fly in the ointment is a rise in recorded pressure ulcers which, despite the excellent work on embedding values, are increasing and are a sure sign of neglect that belies staff comprehension of what those values accrue. While not a huge number, they are a key indicator of nursing care or lack of but in overall terms, the L&D is showing favourably on a wide spectrum of indicators and residents of Central Beds can be reassured that their hospital is improving and indeed bettering many statistical neighbours in the process'.

Comments from:
Luton CCG
Healthwatch Luton
OSC Luton
Not received at the time of sending to NHSI

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 (LDUH) on Quality Account 2018- 2019

Luton Clinical Commissioning Group (LCCG) and Bedfordshire Clinical Commissioning Group (BCCG) welcome the opportunity to comment on the 2018/19 Draft Quality Account for Luton and Dunstable University Hospital NHS Foundation Trust (LDUH). The Quality Account was shared with CCG Board Lay Members (lead for patient safety),Clinical Chair , Medical Director Executive Directors, Performance, and Quality Teams. The Quality Account and Response from the CCGs will be shared for the attention of the respective Boards. The LCCG Patient and Safety Quality Committee (PSQC) and Bedfordshire CCG Integrated Commissioning and Quality Committee (ICQC representatives) reviewed the account to enable development of our commissioning statement. We are disappointed that this draft has omissions and is therefore not yet complete and look forward to receiving and reviewing the complete document that will be submitted to NHSI.

Both CCG's have continued to work closely with the Trust during the past year to gain assurance on the delivery of safe, effective and responsive services. LCCG and BCCG have reviewed the information contained within the LDUH quality account and checked this against data sources, where this is available to us as part of our existing monitoring discussions, and confirm this to be accurate. This has been undertaken in accordance with the NHS (Quality Accounts) Regulations 2011, and the Amended Regulations 2017,

The CCG welcomes and commends the Trusts overarching Quality strategy that was updated and launched for 2018-2021. In particular it welcomes the focus on the four key priority areas of Improving patient experience, improving patient safety, delivering excellent clinical outcomes and the prevention of ill health. The CCG welcomes the development of Always events based on NHS England's Always Event and the continuous improvement in End of Life care. We acknowledge the above average scores in 6 out of 8 categories of the NACEL audit and look forward to this improvement continuing across all aspects of the Audit. In addition we also look forward to reviewing the results from the 2018 Patient Experience Survey.

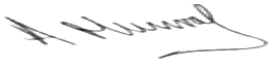
In the past year the Trust has made advances to the development of 7 day services across the organisation in line with NHSI guidance for Quality Accounts for 2018/19. Furthermore the CCG acknowledges the service redesign and Quality improvement initiatives regarding respiratory services, the development of a frailty unit, the introduction of a pharmacy team based between ED and EAU and the evolving therapy model all of which has resulted in a decreased length of stay. We also acknowledge the continued work around reducing falls and whilst we are pleased to see the improvements made in reducing the prevalence of falls with harm we look forward to a further reduction in the overall falls rate.

The CCGs are pleased to have seen the improvements made regarding mortality across the Trust. We acknowledge the reduction in the HSMR the ongoing mortality review process and in particular the significant reduction in the crude mortality rate. We acknowledge the continued work across the Trust in improving the identification and timely treatment of sepsis and look forward to seeing continued improvements in the forthcoming year. We also look forward to receiving the validated data relating to the learning from deaths. The CCG also acknowledges the further development of the advice and guidance services and are pleased to see its effectiveness.

The CCGs e acknowledge the improvement in flu vaccine uptake from its staff and look forward to this improvement being maintained against the new targets set by NHSI for 2019/2020. We are happy to see the continued work to improve patient's lifestyles in relation to smoking and alcohol intake and healthy eating. We were also pleased with the development of freedom to speak up champions across the Trust to support their staff in raising concerns. However it was disappointing to note the reduction in performance in relation the NHS staff survey in respect of stress and musculo-skeletal disorders.

Luton CCG and other associate CCGs support the Trust's quality priorities and indicators for 2019/2020 as set out in the annual account and also the Quality strategy for 2018-2021. In particular the improvements in the fractured neck of femur pathway and the continued developments of the seven day services assurance board framework. We also support the trusts vision to improve the patient's experience by improving the complaints service and the discharge process. Luton CCG will monitor the progress of the Trust robustly in driving forward the 2019/2020 initiatives and improvements to ensure high quality healthcare and outcomes for the population of Luton and Bedfordshire.

Anne Murray
Chief Nurse



Bedfordshire Luton & Milton Keynes
Commissioning Collaborative

Independent Auditor Assurance Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LUTON AND DUNSTABLE UNIVERSITY 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 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

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 2018/19* (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 Guidance.

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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from local Healthwatch organisations, dated 16 May 2019;
- feedback from Social Care Health and Housing Overview and Scrutiny Committee, dated 26 April 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated January 2019;
- Care Quality Commission Inspection, dated 7 December 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 15 May 2019; 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 Dunstable 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 2019, 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 CISAE 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.

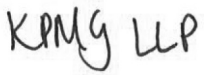
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. 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 2019:

- 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 indicators in the Quality Report subject to limited assurance have 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
Chartered Accountants
London
24 May 2019


PETS AS
THERAPY
visiting volunteer
VOLUNTEER

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