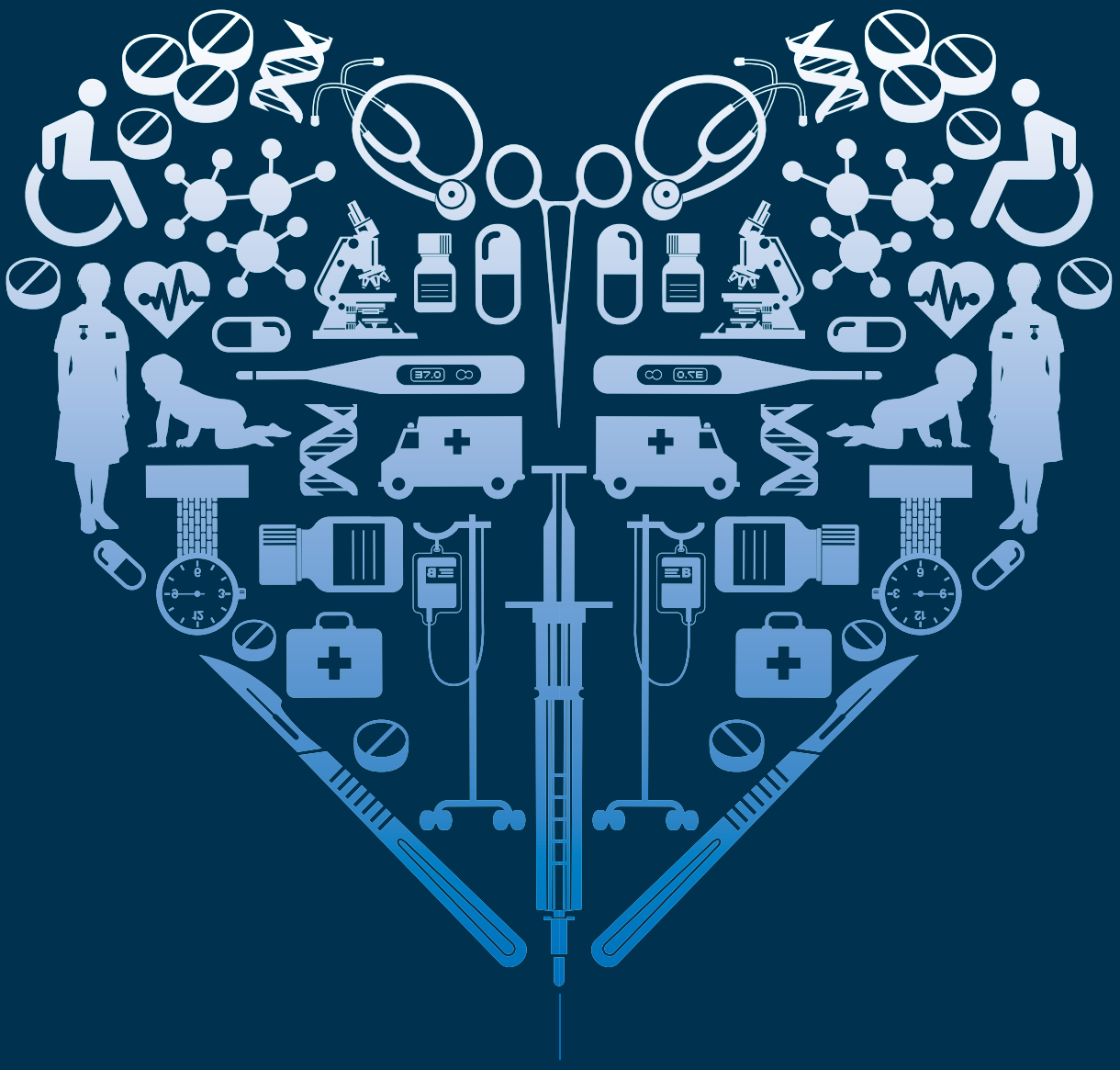
Luton and Dunstable University Hospital
NHS Foundation Trust



Annual Report and Accounts

for the period April 2017 to March 2018
incorporating Quality Account

Luton and Dunstable
University Hospital
NHS Foundation Trust

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

Contents

Introduction

Awards and Congratulations

Official Opening of The Rahul Joshi Unit

Dr Joshi was a much loved and well respected doctor here at the Luton and Dunstable University Hospital who sadly died, aged 46. He is greatly missed but will always be remembered.

In dedication of his hard work and incredible achievements, the new haematology Unit was dedicated in his name. The Rahul Joshi Unit was officially opened by Dr Joshi's family on Wednesday 20th September. The unit is open for patients with Haematology and oncology related illnesses and will enable a team of specialist medical and nursing staff to support these patients in the best possible environment.

Our staff

Luton and Dunstable University Hospital Foundation Trust were announced as the only Hospital to meet all three performance targets on the BBC NHS tracker. In November 2017, the L&D CEO informed all staff saying:

'We are very proud of all L&D staff for their contribution towards our performance achievements that have been announced this week. We know that it hasn't been easy to hit these targets and we know that the coming few months are going to be extremely challenging as we head into winter (Monday was our busiest ever day in A&E with 359 attendances) but we are confident that, working together, we will be able to meet this challenge and continue to provide our patients with the best possible care.'

Engagement 2017 – Good, Better, Best Events

The Trust held two lots of staff engagement events in 2017, one in July and one in December. Staff were invited to attend one of numerous sessions during the week long events to hear about the L&Ds current news and aims for the next few months. Staff were also encouraged to participate in work to help shape the future plans of the L&D. They also gave the Board an opportunity to thank staff for their hard work. The events were very well attended and feedback from staff was extremely positive.

Engagement 2017

Luton Community Service Awards - Healthcare Hero, Farida Parker

The L&D is very proud that Farida Parker, a Respiratory Nurse here at the hospital won the Healthcare Hero Award at the annual Luton Community Awards in October 2017.

Farida Parkar was nominated by a group of grateful patients, who are seen on a regular basis in outpatients or when they are admitted into Hospital. She said "I felt very humbled to be nominated and honoured to receive the award on behalf of the Respiratory team who all play a big part in the service we provide".

Nursing Awards

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

Student Nurse of the Year – Danielle McLaughan

Clinical Support Staff of the Year – Charles Addai
Most Promising New Graduate (The Aimee Varney Award) – Daniella Lehotska

Mentor of the year – Laura Cruise

Innovation in Care – Community Midwifery Team

Team of the Year – EAU 1

Nurse of the Year (The Erma Bristol Miller Award) – Martha Simango

Midwifery Awards

At the Annual Midwifery Conference held on 5 May - International Day of the Midwife – Award Winners were:

- Mary Edmondson
- Jayne McLean
- Piper Carla-Louise
- Michelle Causer
- Giselle Cook
- Elizabeth Godwin
- Kelly Belcher
- Christine Mcmahon
- Tina Mccann
- Emma Sherwood
- Ward 32

UCL Medical School Awards

Name and Proclaim Award
Throughout the academic year, UCL Medical School students and staff have the opportunity to acknowledge people who have impressed and inspired them at UCL Medical School. We are very pleased that Dr Samia Nesar was commended by a student. We would like to thank Dr Nesar for her hard work and contribution.

Top Administrator Award
Throughout the academic year, the students are asked, via the online evaluation questionnaires, to nominate teachers and administrators who have made an especially positive contribution to their learning and experience at UCL Medical School. Ms Su Gill has received an award as a Top Administrator and we would like to thank her for all the support she gives medical students at the L&D.

Annual Nursing conference award winners

Annual Midwifery conference award winners

Our volunteers

Luton's Best 'Service with a Smile' Award– Pearl Hinds

We are very proud that one of our wonderful volunteers, Pearl Hinds, was recognised locally at the Luton's Best Awards ceremony when she won the 'Service with a Smile' award.

Pearl was nominated by staff on our Children's Unit. They said: "Pearl and her smile are infectious! She is one of the team and just gives so much. She's always happy and cheerful and brightens the day of all of us. The children benefit so much from her happy disposition, her time and her caring nature - it certainly goes a long way to making them feel more at ease and supporting their recovery. We treasure her and truly cannot thank her enough for what she does. We are so pleased that she has won this award."

Pearl Hinds - Service with a Smile' Award

Volunteer Long Service Awards

On 3 January 2018, more than 100 volunteers attended our Annual Thank You and Volunteer Long Service Awards which were hosted by Trust Chair Simon Linnett. High Sheriff of Bedfordshire, Vinod Tailor presented the awards, including a very special award to recognise 30 years of voluntary service to the L&D.

Award recipients were:

5 Years Awards
Alwiya Aboudi
Kay Crossland
Margaret Duffy
Beverly Campbell
Janet Graham and John Graham
Ester Jackson
Matt James
Oliver Pena
Colin Rutter

10 Year Awards
Dianne Foyle
Wendy Harding
Icilda Mayhew
Frisco Smith
Daphne Venstone
Vivienne Whitton

15 Year Awards
Beryl Barclay
Judy Tungate
Judy Fleckney
Susmita Shah

A special award was also presented to Bernadette Lana for an amazing 30 years service to volunteering at the L&D. Bernadette is one of those people who it is impossible to praise highly enough. She has been a Roman Catholic visitor and Eucharistic Minister for 30 years and she now co-ordinates a team of people who ensure that people are visited and receive the support that they need.

Thank you to all our volunteers. They provide such an invaluable service and support to our patients and staff.

Volunteer long service all Award Winners

Our Governors

The L&D became a Foundation Trust with a Council of Governors in 2006. Each Governor is able to stay for a maximum of three terms of office and during 2017, one of our Governors, Mr John Harris reached the end of their third term which equated to nine years' service on the Council of Governors.

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

Mr John Harris


Epilim
Epilim
DELL

About this Report

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

The report is structured as follows:

Introduction

Statements from the Chairman and the Chief Executive

Strategy

The Trust strategic vision, performance against 2017/18 objectives and the corporate objectives for 2018/19

Operational Performance Report

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

Our Patients, Our Staff and Our Partners

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

Governance Report

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

Financial Performance Report

Includes performance against financial targets and any risks for the future

Annual Governance Statement and Annual Accounts

Includes the Annual Governance Statement and the annual accounts

Quality Account

Includes details of the progress against quality objectives for 2017/18, the plans for 2018/19 and the annual quality statements..

Chief Executive Introduction

Dear Colleagues

It is a great honour to have led the L&D over the past year, and firstly I have to pay tribute to the legacy I have inherited from Dame Pauline Philip who did so much to create an organisation of strength and confidence, capable of delivering fantastic care to our patients.

However, it has been both an exciting and challenging year. Our proposed partnership with Bedford Hospital has dominated our strategic agenda and we continue to put all our efforts into making that proposal come to fruition. It has been encouraging to see the communications and engagement which have taken place between the clinicians across our two hospitals and the ideas and the opportunities which are starting to be developed.

Whilst we have been working hard on our long term objectives we have also had to deal with the immediate challenges of a very difficult winter period. The risks on our local population and the increase in the complexity and acuity of the patients we saw resulted in a need for extraordinary efforts to maintain our growth and performance.

The need to use contingency areas of the hospital on a regular basis meant a large number of elective cancellations and we are now in the process of implementing the recovery plan for our 18 week performance which suffered as a result. As we plan for next winter, we are hopeful that primary and community services are better equipped to cope with the peaks in activity. We are implementing our Needs Based Care programme which has the intention of reducing our length of stay for medical patients by ensuring that patients are seen by the right consultant team and receive continuity of care. This will contribute to giving us extra capacity in future.

Finally, we have been giving more thought to the Trust's vision and values as we enter this new period in the Trust's development with the Bedford proposal, the STP agenda and our capital ambitions all changing the context in which we work. We have based our vision around the recruitment and retention of the best people with the right values, and our commitment to retain and support the teams they work in to provide outstanding care to our population

David Carter
Chief Executive

Chairman's Statement

As you will all know, last year ended with terrible weather overlaid by flu and challenges of access to the hospital causing activity pressures, the like of which we have never before experienced. I, on behalf of the Board and Governors, would like to pay our tribute to all our staff who have worked tirelessly and timelessly to keep the hospital delivering excellent care when needed to those who needed it - to paraphrase Churchill, never in the history of NHS care was so much expected by so many of so few. They were all remarkable and deserve your unreserved gratitude. Only now, after a month of the new year, is activity beginning to return to something resembling normality.

A large part of the hospital's resilience and ability to cope with all those pressures, is down to the excellent foundations laid down by Dame Pauline Philip (honoured in the Summer) who left as our CEO at the beginning of the 2017/18 financial year to take on a national role coordinating delivery from NHS England. We owe her a great debt and have been pleased to support her in her national role by offering access to other hospitals to learn about the way in which the L&D achieves effective emergency flow. Sadly over the year, we have said goodbye to our Chief Nurse, Pat Reid to Poole Hospital, Marion Collict, Director of Operations, Risk and Governance, to supporting Pauline at NHSE, Jill Robinson, Non-Executive Director and Mark England to become Chief of Staff of the STP.

It is a great tribute to David and to Cathy Jones, Deputy Chief Executive, that, with all these significant changes, they have worked together so well to maintain performance and make a very positive contribution to the "spirit" of the hospital.

David will address the year in some greater detail but it has brought on three connected challenges and opportunities:

- We have a very tired estate which is required to meet the health demands of a growing population. Our STP estimated that this is likely to run at 3% per year for the next five years. We have made no significant investment on the site for some 20 years since St Mary's was opened at the turn of the millennium. We have submitted an application to NHS to invest £100m in the estate merely to keep up with demand, decay and modern health standards.

- This need for capital is exacerbated by the wish to merge with Bedford Hospital; that merger will place some strains on our finances and it is essential that the estate is refreshed ahead of that additional challenge so that we can take proper advantage of that union and secure the benefits in patient care and efficiency we have offered.

- Increasingly over the year, the role of the Sustainability and Transformation Partnership (STP) has grown. Increasingly we are being encouraged to work together even to the extent of sharing some element of financial performance. These new structures, while to be encouraged in their purpose of greater health integration, will require adjustment in working patterns and practices.

During the year we have also seen some changes to the Board. In particular, we said goodbye at the end of the year to Cliff Bygrave. Cliff has been a Non-Executive Director of the Hospital for the majority of the period since 2001. During which time he spent four months as Acting Chair in 2014. Cliff's enduring commitment to the hospital has been an example to us all and we are pleased that he remains as Chair of the Committee that oversees the hospital charity.

These are challenging times but I have every confidence that the L&D Hospital will continue to improve its health delivery as we enter the year of the NHS' 70th Birthday.

Simon Linnett
Chair


BARBADOS
Event Pack

Strategy

Annual Report Executive Summary

Strategy for 2018/19

The Luton and Dunstable Hospital's strategy has been developed to reflect its context and position. It serves a highly diverse geography close to London, is a highly performing Trust with flagship emergency services and a reputation for consistent operational and financial delivery.

However, the context and structures are changing with the development of new networks for care (Sustainability and Transformation Plans, Integrated Care Systems, Accountable Care Organisations) but also with the needs and expectations of our population.

We will continue to participate actively in these changes whilst at the same time focussing our energy on maintaining our record of delivering the best care to our community.

Corporate Objectives 2018/19

The Board of Directors have reviewed the Corporate Objectives for 2018/19 that ensures they reflect the strategic vision of the organisation. The Trust's Quality Strategy directs our plans for the year and the detail of this is in the quality account. The five objectives are:

1. Deliver the Quality Priorities outlined in the Quality Account.

2. Deliver National Quality and Performance Targets.

3. Implement our Strategic Plan, including working collaboratively with the Local Health System to improve Clinical Outcomes and Sustainability.

4. Secure and Develop a Workforce to meet the needs of our patients.

5. Optimise our Financial Plan.

Service Developments 2018/19

The Trust and the Divisions have outlined their plans for the year. This is a combination of service redesign, new service provision and managing additional capacity. We have also been successful in receiving a Global Digital Excellence Award of £10m which is a demanding 3 year development programme, Trustwide, to improve clinical efficiency, effectiveness and communication through the use of technology.

Performance in 2017/18

Performance against Objectives 2017/18

The Trust made significant progress against the objectives for the year.

- We improved our Hospital Standardised Mortality Rate and implemented a review tool for reviewing all deaths at the hospital. HSMR reduced from statistically high 110 in February 2017 to currently 101.9. This information is also reported to each public Board.

- We consistently achieved 98% harm free care despite the capacity challenges at the hospital. However, we have seen an increase in avoidable pressure ulcers which is the subject of additional training and review. We reduced the falls rate and increased compliance with VTE assessments by the end of the year.

- We maintained a low rate of C Difficile which is one of the lowest in the country and continue to put processes in place to reduce it further.

- We have seen an increase in the number of patients who would recommend the hospital to their friends and family. However, the national inpatient surveys continue to report that we need to make more progress. The Quality Strategy that was launched in 2017 focuses on patient experience as well as patient safety, clinical outcomes and prevention of ill health.

- We continued to achieve the national targets for A&E and Cancer. We were only one of three Trusts that met the A&E target in March 2018. However, in December 2017 due to the unprecedented winter pressures, we have not met the 18 week target. A recovery plan is in place. Similarly, delivery of the six week diagnostic target proved challenging during the year but has now been recovered and is back on track.

- We have continued to develop services to support our strategic vision and provide services in line with our population. We have also collaborated with our partners in the STP, in particular around improving clinical outcomes and sustainability of secondary care, resulting in the announcement to pursue a merger with Bedford Hospital NHS Trust as detailed in the strategic vision above.

- We have continued to recruit and support staff throughout the year and achieved excellent engagement scores through our bi-annual Engagement Events where over 2000 staff attend each event.

- We have achieved our financial target for 2017/18 and established a Service Line Performance Framework to maximise devolution of authority with accountability, while maintaining strong governance and assurance by the Board of Directors.

Maintaining Performance

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

Improving Quality

Staff and stakeholders were engaged in the development of the strategy and this is reflected in the priorities for the next few years and an investment in training for our staff in Quality Improvement methodologies that accelerate our 'Journey to Outstanding' through improving staff experience and engaging and enthusing staff in promoting a culture of continuous learning and quality improvement.

Staff and stakeholders engaged in this process and the result identifies the priorities for the next few years and an investment in training for our staff in Quality Improvement methodologies that accelerate our 'Journey to Outstanding' through improving staff experience and engaging and enthusing staff in promoting a culture of continuous learning and quality improvement

Operational Performance

The Trust has continued to deliver performance in line with the best hospitals in the country, notwithstanding the unprecedented winter pressures experienced at the end of 2017 and beginning of 2018. We have worked hard to turn around challenged departments to achieve key indicators. However from December 2017, we have not achieved the 18 week target. We have a recovery plan in place but are challenged by the continued pressures and our aging estate. The activity at the L&D has increased 7% this year which impacts on the staffing requirements and our ability to provide services. The Trust has managed to deliver against this increase. However, this will be under constant review across our partner organisations to determine actions to safely improve efficiency.

Our last CQC Inspection report was received in June 2016 and the Trust received a 'Good'. There have been no inspections from the CQC since that date. The Trust continues to have processes in place to maintain Board to Ward reviews of clinical areas and seek assurance about performance.

The Trust also reports to NHS Improvement and follows the Single Oversight Framework. This reviews quality, finance, operational targets, strategic change and leadership. With the data they receive they place the Trust in a segment and '1' reflects providers with maximum autonomy. The L&D is in segment 1 which demonstrates excellent performance.

Education and Performance

The Trust continues to work closely with the Deanery to support medical students. Any issues identified have been actioned throughout the year and we continue to oversee performance.

Medical and Nursing staff are required to undergo annual re-validation and we ensure that these deadlines are complied with throughout the year.

We have continued to recruit throughout the year for all staff groups (including from overseas) and this will support the increasing demand on the hospital resources. This is also supported by professional development opportunities and new roles such as apprentices.

Sustainability

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

We are successfully reducing our carbon emissions year on year and water volume is remaining static following a significant reduction in 2013/14.

Emergency Preparedness, Resilience and Response Performance

All NHS organisations need to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety.

The Trust has measured itself as substantially compliant against the 2017/18 EPRR Core Assurance Standards; this rating has been confirmed and upheld by NHS England and Bedfordshire Local Health Resilience Partnership. This is an improvement on the Trust's 2016/17 assessment of partially compliant.

Our Patients

Patient feedback continues to be a valuable source of intelligence for us to help drive quality improvement and develop services. We review friends and family cards, national patient surveys, complaints, information from the Patient Advice and Liaison Service (PALS), feedback from local stakeholders such as Healthwatch.

We received 601 formal complaints in 2017/18 but are challenged with responding to the complaints within the 35 day standard. The Board receives assurance that the quality of the responses is good as very few are re-opened. Ongoing action is being taken to improve compliance with the standard. We also receive many compliments from our patients that outweigh the complaints and in 2017/18 we received 4,840.

Safeguarding

We continue to have safeguarding processes in place for vulnerable adults, children and young people.

Our staff

We continue to recruit and support our staff throughout the year. We approved a Needs Based Care business case which has increased recruitment of consultants and other front line staff. This will support our patient to receive the right care, in the right place and at the right time based on their clinical need.

We have continued our staff engagement events throughout 2017 holding one in the summer and one at Christmas. Over 2000 staff come to each event and this has made a significant impact on our staff engagement scores and communication between managers and staff.

Our Volunteer Strategy focuses on maximising the potential of volunteering here at the Luton and Dunstable Hospital, making sure that we are utilising the vast and diverse array of talent in the local community and doing all that we can to bring that into the Trust. We aim to achieve our objectives by delivering a high quality volunteer journey that maximises the reciprocal benefits for both the Trust and our volunteers. We increased our volunteers by 8% during 2017/18 and they continue to be a vital support to our staff and patients.

Equality and Diversity

During 2017/18 further progress has been made on the work being done to help embed Equality, Diversity and Human Rights (EDHR) areas into corporate strategies and thinking.

The umbrella framework document that was created in 2017 to deliver an embedded EDHR Strategy has supported this along with the EDHR committee, having a long term NED Champion and Chair, and EDHR featuring on Board level and committee reports and presentations.

Governance

The Trust has in place a Board of Directors comprising of Executive and Non-Executive Directors. This is supported by the Council of Governors.

The Trust committee and reporting structures in place support appropriate challenge and decision making. The Trust has met the statutory requirements for the Board and has sought assurance from internal and external audit.

Finance

A financial surplus for the 19th successive year was achieved with a 2017/18 surplus of £15.4m. Whilst our surplus is in line with our Annual Plan, delivering it relied on non-recurrent items to offset the additional costs of temporary staffing required to deliver unplanned and unprecedented demand. It should be noted that the £15.4m surplus includes a £13.3m performance bonus (known as Sustainability & Transformation Funding) which recognised the achievement of agreed performance and financial targets.

Fundraising and Charitable Donations

During the 2017/18 financial year the Luton and Dunstable Hospital Charitable Fund received £1,029,294 from 1245 donations from grant-giving trusts, companies, individuals, community groups and legacies.

The Fundraising Team have been central in supporting the hospital charity and have been extremely successful during the year. Key activities have been around the helipad and children's oncology room's appeals.

Top 5 Risks

A summary of the key risks and mitigations facing the Trust is detailed below:

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Clinical Operational	1. Workforce Pressures 2. Capacity pressures and responding to demand 3. The need for robust and whole system working & integrated care	High	High	Workforce plans in place Action plans with Trust partners & work with Local Health system, i Needs Based Care initiative	Weekly Executive meetings Monthly Clinical Outcomes, Safety & Quality Committee Board of Directors strategic oversight
Finance	Delivering financial challenge in 2018/19	High	High	Monthly financial & performance review meetings with Divisions led by Executive Directors	Monthly Finance, Investment & Performance committee (FIP) review Introduction of Monthly Service Line Executive Review Framework
Present Hospital Campus	Going forward the Trust site will not be consistent for capacity or clinical requirements for good patient care. Backlog Maintenance	High	High	Robust governance to manage ongoing risks FIP oversight of backlog maintenance and strategy Progression of Business Case for Acute Services Block via BLMK STP	Board review of Full Business Case and approval of actions arising from STP applications process and through the Merger process with NHSI Finance, Investment & Performance committee review
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legalisation	High	Moderate	Board approved action plans in place	Regular monitoring / Assurance from Board Sub-Committees
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event	High	Low	Ensure that the Emergency and Business Continuity plans are frequently reviewed, communicated and understood by key staff	Ongoing review and testing of Business Continuity plan relevant adaptation of plans Oversight by Board Sub group

Economy, Efficiency and Effectiveness

The Trust ensures the adoption of governance and processes that drive financial and clinical efficiency and effectiveness. The Trust demonstrates strong performance against national benchmarks.

2018/19 Strategic Approach

This section of the annual report provides a summary of the strategic plans for the Trust. More detail is contained within the Operational Plan 2018/19.

The Luton and Dunstable Hospital's strategy has been developed to reflect its context and position. It serves a highly diverse geography close to London, is a highly performing Trust with flagship emergency services and a reputation for consistent operational and financial delivery.

However, the context and structures are changing with the development of new networks for care (STPs, ICSs, ACOs) but also with the needs and expectations of our population.

We will continue to participate actively in these changes whilst at the same time focussing our energy on maintaining our record of delivering the best care to our community.

Against this changing environment the Trust's strategy has a number of different drivers:

- We have a highly deprived young urban population in Luton with a life expectancy of one year less than the average for England, and a dispersed, ageing, more affluent population in Bedfordshire.
- The continued population growth, twice the national average, will have 150,000 (20-25%) more people living in the STP area by 2032.
- We have a national reputation for our delivery of emergency care but there is increasing recognition, locally and nationally, that the future of emergency care is much more integrated between organisations and needs to be more focussed on the complete emergency pathway.
- As a medium sized Trust we are increasingly identifying the need to develop critical mass to deliver the care that is required, e.g. services over seven days, consultants in-reaching into admission wards, sufficient elective work within a specialty to service efficient theatre lists and to allow sub-specialisation).
- We are in an area of the South East which has the most acute workforce challenges and we are disadvantaged by being positioned just beyond the area which receives outer London weighting.
- We are at the forefront of IM&T developments in the NHS.
- We have a poor estate that needs redevelopment to support the significant growth in demand and address high backlog maintenance.
- We have a complex geography serving three CCGs, three local authorities over two STPs with three community providers and two mental health providers.

Our strategy represents a response to these drivers.

Our staff are central to our strategic vision and all the evidence suggests that L&D is a place people want to work. However, the need to recruit and retain more high quality staff has never before been so important or urgent as the growth and challenges faced mean workforce shortages continue to open up across all staff groups. The recognition of the importance of putting our people at the heart of the strategic vision has been an emerging theme from the discussions regarding merging with Bedford Hospital and workforce is one of the primary drivers behind the proposed reconfiguration.

This has led to the development of our revised vision statement:

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

This vision statement is based on the idea that we will deliver outstanding care through a sequence of events – we will recruit the best people, we will nurture them when they are here, and we will support them to create high performing teams. Outstanding care will not be delivered without this sequence. Ongoing work in 2017/18 also began a process to develop a revised set of Trust values. Through the 'Good Better Best Event' in July 2017, over 2000 staff were asked to select the words that they identified with the L&D. The value which was most important to our staff was 'teamwork' and this now is a key part of our vision statement.

The vision complements the structures upon which the Trust is built - a commitment to service line management and a belief that high quality services are only possible through decision making close to the frontline and the accountability and responsibility that is devolved in line with this autonomy. To enable this type of approach to flourish, the development of clinical leadership is key.

But, they should feel cared for from when they arrive at the hospital – even – right until they leave.

Our patients – we have launched our Quality Strategy to set out the Trust's path to 'outstanding' and created a new position of Director of Quality to give Board leadership to its delivery. We want to deliver care in the right place (our development of Arndale House is the biggest development outside the hospital walls in its history). We want to deliver that care in a timely way (2018/19 will see our third MRI scanner in place as well as a new SPECT-CT). We want to deliver that care in a safe way (the 'Baywatch' initiative to prevent falls is in its second year). Our communication with our patients needs to be better. The Global Digital Exemplar (GDE) programme will deliver a patient portal allowing patients to better manage their own care. Our medical model needs to meet the changing needs of our patients. We are changing from an age based model of inpatient care to one where the patient is seen by the right specialist team, irrespective of their age, with focus on continuity of clinical staff to the patient.

Our services – our service portfolio (core acute services organised around a major emergency centre and specific tertiary services) meets the needs of our population, makes the Trust an attractive place to work, facilitates recruitment and retention of the best clinical staff and adds scale and resilience to our operations. We will therefore continue to be a provider of core district general hospital services with a major emergency centre but continue with our more specialist services (e.g. hyper acute stroke, bariatric surgery, tier 3 neonatal, head & neck cancer).

Our future – we will create critical mass in the provision of our services by merging with Bedford Hospital to provide a new Trust for the people of Luton and Bedfordshire, creating the scale necessary for efficient, high quality care. This is a proposed merger of two good hospitals and we have committed to maintaining the core services of A&E, paediatrics and maternity on the Bedford site. We have a long history of working together and already provide some joint clinical services to the county and beyond, such as vascular surgery, head and neck cancer services, cervical cancer screening services, neonatal intensive care, and stroke services.

Looking forward, the merger would enable both hospitals to deliver resilient services given the challenges of national workforce shortages and a move towards health services being available seven days a week. At the same time, it is predicted that the demand for healthcare in the area will grow at almost twice the national average over the coming years. These two factors have been a catalyst for the organisations to consider merging to help us make the most of our combined resources by creating single clinical teams, delivering economies of scale and making the case for capital investment to deliver high quality sustainable healthcare.

The proposed merger is supported by a clinical vision for the people of Bedfordshire and beyond:

- A **full range of 'outstanding' hospital services** to be provided to the people of Bedfordshire and surrounding counties.
- **Excellent clinical services** that take the best from each hospital and will deliver consistently high quality standards.
- The **highest standards of clinical leadership and innovation** made possible through responsive and efficient support functions.
- **Integration of care with GP partners** and closer working in specialist teams to support and develop out of hospital care.
- **Specialist services** that are currently delivered elsewhere e.g. plastic surgery and specialist cardiac imaging, to be delivered safely and effectively within Bedfordshire.
- Practices and processes which continue **to focus on delivering safe care** to patients.
- **Common service standards** to be developed to bring equal care to all, based on industry best practice.
- B**etter use of technology and information** to support the delivery of the best possible experience for patients and clinicians.
- Teaching, training and research activities to support **continuous service improvement and employment of the highest quality staff.**

One aim of the merger is to end the uncertainty which has hampered the development of services in the area for many years. However, there are **required enablers** which are necessary to allow services to be delivered to the right standard: transaction costs, including the costs of IT integration, a solution to the accumulated debt at Bedford, an achievable financial target and sufficient capital to ensure the new organisation has solid foundations by improving and extending our current capacity.

Our approach – the L&D has a dynamic and innovative culture. We believe in the need to continue this approach to maintain the levels of high performance and good financial stewardship. Two key enablers are (i) IT, with the Trust at the forefront of technology though the GDE and Fast Follower programmes and (ii) service line management with devolution and autonomy, with accountability, to allow clinically led fast and safe decision-making and drive value. We will continue to give our staff the tools, incentives and support to deliver not just high quality care, but to promote a culture of continuous improvement.

Our community – the Trust recognises that, increasingly, the needs of elderly complex patients can only be met by service provision which is truly integrated across the hospital and community divide. There is more recognition that staying in hospital beyond the time when a patient's medical needs are met is not just sub-optimal but is dangerous and increases the long term cost of care. Our complex geography and multiple partners makes genuine integration more difficult. We have made some early gains, for example the co-location of our hospital based social workers, community nurses and discharge teams, but we need to go much deeper and further.

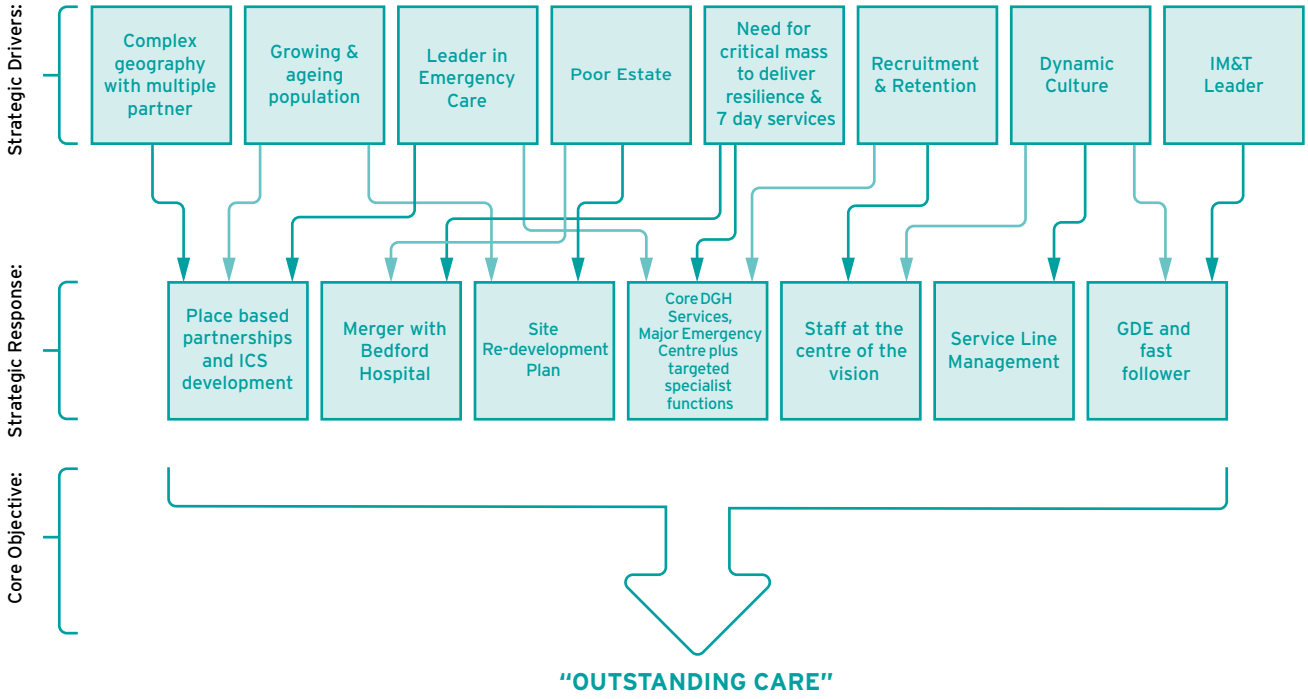
Currently services provided out of hospital have not developed quickly enough to meet the needs of a growing and ageing population. We have seen the consequences of this in recent months over the 2017/18 winter as the hospital has struggled to cope with rising activity (often of inappropriate attendances and admissions).

The Trust fully supports the objectives of the community and primary care programme of the Integrated Care System (ICS), developing more services out of hospital and ensuring that the local populations needs can be met in a different way in future. This will require change: primary care delivered at scale, integration of IT systems, more proactive and reactive community interventions and L&D is determined to play its part in the leadership and delivery of out of hospital care. We will continue to be a full partner in place-based developments (e.g. the Luton Provider Alliance) and the wider STP and ICS programme and look to outreach more of our services (e.g. Arndale House and the proposals for a Dunstable community 'Hub'). The partnership with Bedford Hospital will act as a springboard to a deeper participation in the broader local health economy.

Our estate – the hospital estate has grown up over many decades, responding to changing need through piecemeal development and has now reached a critical juncture where the approach of 'patch and mend' has become a serious impediment to strategic objectives and operational delivery. Clearly a new hospital build would provide the best solution but there is an acceptance that this is not a practical or affordable proposition. We have exhausted all options in the search to find a solution which is deliverable, affordable and makes the most impact on the most pressing needs of the services but also provides the best solution of growth and resilience. The current 'Acute Services block' proposal concentrates on those services on which the ageing deteriorating estate is having most impact but which will need to be provided on the hospital site now, and in the future, maternity delivery suite and theatres, NICU, critical care and operating theatres. We are also developing a strategy to refurbish the wards most in need of development with a linked helipad to further enhance our emergency services.

Summary

We can only succeed in the future if we continue to recruit and retain highly talented individuals that can work as a team and maintain the harmonious, highly committed and professional relationship between staff, management, the Board, Governors, volunteers and Members. The L&D is a collection of such people delivering remarkable things; we are determined to invest all that is necessary to keep it that way as we face and overcome the strategic challenges ahead.


Strategic Drivers:
Complex geography with multiple partner
Growing & ageing population
Leader in Emergency Care
Poor Estate
Need for critical mass to deliver resilience & 7 day services
Recruitment & Retention
Dynamic Culture
IM&T Leader
Strategic Response:
Place based partnerships and ICS development
Merger with Bedford Hospital
Site Re-development Plan
Core DGH Services, Major Emergency Centre plus targeted specialist functions
Staff at the centre of the vision
Service Line Management
GDE and fast follower
Core Objective:
"OUTSTANDING CARE"

Maintaining our Performance

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

Maintain and Develop Key Clinical Specialties

- Ensure continued delivery of core clinical services to secure our future in terms of clinical excellence, financial sustainability and reputation.
- Develop clear annual plans and extend the performance framework at service line level.
- Ensure that specialty plans give consideration to the 'necessary volume' to ensure the economies of scale required for the delivery of seven day services and financial and clinical sustainability.

Explore Opportunities for Integration and Partnership with:

- Provider Alliance
- STP
- Bedford Merger

Ensure Sustainability

- Continue to improve the patient experience and safety, for example, through improving communication and the provision of information to patients and greater access to consultant-led care.
- Ensuring the maximum use of information to deliver safe and efficient care by using an electronic patient record, and support information systems at all levels of the organisation.
- Directing our capital resources at those service changes which will allow sustainability of performance
- Maintain financial sustainability, delivering a comprehensive programme of efficiency projects which meet the need for tariff efficiency and the financing of the redevelopment programme.
- Embed the new structures in the medical and surgical divisions to allow greater focus at specialty level in order to benefit fully from service line management and bring forward a new generation of clinical leaders.
- Continue to review and strengthen performance by the use of internal and external expert review.
- Obtain and evaluate an up to date External assessment of significant Estate Infrastructure backlog maintenance and develop a plan to address the priority issues either through redevelopment or replacement.
- Continue to progress update of business continuity accountabilities, processes and mitigations ensuring they are still current and fit for purpose.

Corporate Objectives

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

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 Bedford, Luton and Milton Keynes (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.

Service Developments Planned

Strategic and Corporate:

- ***Implement the Centre of Global Digital Excellence (GDE) agreed plan*** - The Trust is now engaged in delivering the plan that will encourage more clinical engagement to perfect and improve the clinical platforms to enable us to progress to HIMMS level 7. Level 7 is a closed loop paper free environment, an environment that optimises the IT hardware it sits on and the various devices we utilise to manage patient care.

- ***Support the Trust towards General Data Protection Regulations (GDPR) implementation*** – The Trust is implementing Cyber Security readiness and the GDPR plans. GDPR becomes mandated on the 25th May 2018 and changes the way we manage data for patients and stakeholders.

- ***Support Bedford Hospital in becoming a Fast Follower of the Luton GDE Programme*** – The Trust is working closely with Bedford Hospital NHS Trust to support their technology portfolio. The L&D will offer technical and clinical support to enable them to deploy new technologies already adopted at Luton faster and more efficiently. This will bring many benefits for Bedfordshire patients, but also support the potential merger aspirations of both Trusts, as Information, management and Technology (IM&T) is a crucial enabler to a hospital merger.

- ***Continue to extend our digital footprint in the community*** – The Trust will link with our Strategic partners as part of the digitisation work being carried out under the STP. This will particularly focus on the Shared Care Portal, the Patient Portal, the Unified Communications platform and the Patient Monitoring system which aims to extend the patient monitoring beyond the boundaries of the Trust.

Surgical Division:

- ***Implement Trans Urethral Laser Ablation (TULA) in Urology Outpatient*** - The first bladder cancer laser outpatient cases are to be performed in early 2018/19 in the Urology One Stop Outpatient clinic. This will have a considerable impact on the patient experience as compared to the 90 minutes surgical time for a conventional method, TULA is undertaken under local anaesthesia and takes about 30 minutes.

- ***Recruit Middle Grade Doctors in Urology*** - Due to the success of the Urology One Stop model we are looking to expand and develop the service further with recruitment of additional middle grade staff that will support the existing consultants with new service developments whilst also supporting Urology on-call

- ***Implement Mitomycin Hyperthermia (MMC-H) Urology*** – Mitomycin hyperthermia (MMC-H) is a treatment for bladder cancer. It has been agreed that the L&D should be the regional centre for delivery of MMC-H and patients requiring MMC-H will be referred in from neighbouring hospitals in the network.

- ***Implement a new model for Pre-operative assessment*** - The Trust plans to create a Pre-operative assessment hub on the ground floor of the surgical block this will ensure that any patients cancelled on the day of their surgery is kept to a minimum which will benefit clinical outcomes, patient experience, utilisation of theatres and financial performance.

- ***Refurbish the discharge lounge*** – Following the success of the discharge lounge in 2017/18 the unit is being refurbished to support a better patient experience.

- ***Put in place a new doctor's room*** – Following feedback from medical trainees we are building a new doctors room that will be co-located with the discharge lounge to offer better facilities for the doctors and improved clinical adjacencies.

- ***Implement a Pharmacy Hub*** – The pharmacy hub is to be co-located next to the discharge lounge and will be improved so it contains controlled drugs and a more comprehensive range of drugs to dramatically reduce the medicines dispensing time.

- ***Implement Critical Care follow up clinics*** - Patients admitted into critical care can suffer from post-traumatic stress disorder and suffer ongoing psychological after effects following their admission. The Critical Care follow up service will provide patients with the opportunity to come back to the hospital and to discuss and work through their experiences.

- ***Begin to deliver restorative dentistry*** - we have now been formally commissioned by NHS England to deliver a Restorative Dentistry service at the L&D. This will provide crucial support to the regional Head and Neck Cancer Treatment service provided at the Trust. Recruitment is ongoing for two part time Consultants- one post has been offered and the second is out to advert.

- ***Launch a new Referral Management Service in Oral Maxillofacial (OMFS) and Orthodontics*** - A new service will be launched by NHS England from the 1st April 2018, with a rapid independent triage of all routine referrals to OMFS and Orthodontics from Dentists. This is designed to reduce inappropriate referrals that would be better placed to be seen in Community.

- ***Develop new clinic rooms for Ophthalmology***- From September 2018 Ophthalmology will utilise the four outpatient clinic rooms vacated by Rheumatology to create a new suite of rooms for patients under the care of the Medical Retina team. This will provide much needed additional capacity for Ophthalmology, enabling a second treatment room for intravitreal injection treatment as well as freeing up existing rooms to be used by other Ophthalmology sub-specialties such as Glaucoma.

- ***Provide an additional Bariatric Clinical Fellow*** - Due to high demand of the service we are looking to recruit a bariatric clinic fellow, working closely with existing consultants, to be trained in all aspects of bariatric surgery, running clinics, and will initiate the research projects and support bariatric MDT.

- ***Implement an Orthopaedic elective ward*** - In the late summer of 2018 the development of a designated 14 bedded orthopaedic elective surgical ward will be completed. This will allow a reduced length of stay, better patient experience and improved outcomes for patients. This is in line with the GIRFT program recommendations

Medicine Division:

- ***Implement Needs Based Care (NBC)*** - Following approval of the full business case an aggressive recruitment schedule has commenced across all workforce groups in line with a gateway schedule. Further development of pathways and standard operating procedures are underway to deliver the NBC project and length of stay benefits. This will be subject to ongoing monitoring and assurance through the Programme Board.

- ***Greater utilisation of service line management/ reporting*** – Continued refinement of Service Line Reporting will support financial planning and assurance, including Cost Improvement Plans.

- ***Introduce Dementia Support Apprentices*** – the Division, where a requirement has been identified for a higher need of enhanced levels of observation, will implement Dementia Support Apprentices. This innovative approach is an alternative model of staffing for nursing that provides Medicine with an opportunity to reduce its additional requests for unqualified staff.

- ***Relocate Luton Sexual Health Services*** - The service will move off-site to a town centre location in Arndale House in May 2018. This new facility will provide greater opportunities to deliver a fully integrated Sexual Health Service.

- ***Relocate Dermatology Services*** - The service will move alongside Luton Sexual Health to Arndale House in late May 2018. Following a successful business case for additional specialist nurses alongside substantive Consultant recruitment, additional capacity will be realised including an expanded phototherapy service.

- ***Provide additional outpatient capacity*** - Following Luton Sexual Health and Dermatology services moving to Arndale House, additional on-site outpatient accommodation will be available. This will support speciality medicine to expand their existing elective capacity as identified in the Needs Based Care Business Case

- ***Consider the introduction of a Therapies Led Rehabilitation Unit*** – The Division aims to deliver a Therapies Led Rehabilitation Unit supported by NHS England. This unit will enable appropriate level of skill mix and release nurses back into the complex medical arena.

- ***Further develop Ambulatory Care services*** – A 7 day pilot commenced at the end of 2016/17 which demonstrated the need for a seven day model which has now been implemented successfully. Additional enhanced pathways, in line with Needs Based Care, will now be developed to ensure the right patients are accessing the right services to gain the most benefit.

- ***Plan appointments for GP Heralded Referrals*** – Work is commencing with East of England Ambulance Service, the Acute team and Cambridge Community Services around a planned approach for booking of GP referrals to ensure earlier presentation of those patients who require secondary care input and greater ability to avoid admission where appropriate.

- ***Continue Overseas Medical Recruitment*** – To continue to build on the good relationship already established with the University of Colombo in providing Sri Lankan doctors. These doctors successfully fill vacancies. We are considering

adopting this model for Emergency Doctors from India.

- ***Establish a Frailty Unit*** – Further development in line with the CCG plan for admission avoidance by supporting an Integrated Community MDT and establish a telephone support hotline for complex patients.

- ***Introduce Emergency Department Technicians*** – This role has been piloted in the last quarter of 2017/18 which has demonstrated improvement in patient safety and the flow of patients through ED. Following a detailed review approval will be sought to include these roles within the Emergency Department establishment. Further expansion into the acute areas will also be considered.

- ***Implement a new Decontamination Facility*** - The site for the new decontamination unit has been agreed and anticipated to be operational during 2018/19. This will support additional endoscopy activity following the opening of a fourth procedure room during 2017/18 and a further procedural room planned in 2018/19.

- ***Undertake Clinical engagement with Medical specialities at Bedford Hospital NHS Trust prior to the proposed merger*** - Work continues with individual medical specialties across both sites around the planning and development of future services. The Lead Endoscopy Nurse from Bedford Hospital working across sites is an example of collaborative working arising from these conversations.

- ***Continue to monitor, assure and learn from mortality case reviews*** - Quarterly mortality forums will continue, with the aim of identifying contributing factors and themes. The aim is to increase awareness, reduce variability and share areas of best practice. This is supported by the implementation of primary case reviews of all deaths and the introduction of structured peer reviews.

Women & Children's Division:

- ***Make further improvements to the Neonatal unit*** – The Division aim is to enhance parental communication enabling parents to be as actively involved in the care of their baby whilst in the unit and to review our options around visiting enabling supported visiting for siblings now we have improved facilities for them to use.

- D***evelop the GP/Consultant connect service*** – The Division will continue to work with Primary care and community care to review pathways for children with conditions such as viral Wheeze and Asthma to ensure they can get the right support as early as possible to prevent exacerbation of the condition and to avoid where possible the need to come to hospital. For example we will be working with Pharmacies, GP's and the community rapid response teams to ensure we are giving consistent advice and teaching to parents on the use of inhalers.

- ***Develop an ambulatory service for patients in early pregnancy*** – During the year, Gynaecology outpatient clinics will be relocated into vacated space within the main hospital outpatients area. This will separate it from the current Maternity clinic. This is in response to feedback from women and was a recommendation following our CQC review. The new space will allow us to take forward some of the ambulatory pathways we had planned.

- ***Further develop the scanning access within the fertility service*** – The Division are looking to support the role of Sonographers in the imaging team through the training of Midwives and Medics to be able work alongside the imaging team to provide gynaecology and maternity scanning to support resilience and skill mix across the services.

- ***Initiate work on the Children's Oncology Unit*** – The Division have been working with the local community individuals, staff and local businesses to raise the funds needed to start the work this summer on the redesigned specialist Oncology cubicles on the Children's ward. The money has been successfully raised and work will being this year.

- ***Continue to hold events to raise awareness of the services provided*** - Last summer the maternity services ran a 'MAMA' event which showcased Maternity and Neonatal services to families expecting or planning babies. This was very successful and attended by over 60 local service users. Maternity will continue this work throughout 2018/19 and will be holding another 'MAMA' event this summer to which families are encouraged come along.

Diagnostics, Therapeutics & Outpatients Division:

- ***Consolidate pathology services*** – The Trust has plans to consolidate pathology services across L&D and Bedford Hospitals, as well as GP practices, in line with national and STP strategic objectives to deliver optimally effective and efficient, integrated pathology services.

- ***Introduce antibiotic sensitivity testing*** – The Division are planning to introduce antibiotic sensitivity testing equipment in Microbiology to meet new regulatory standards. The increased automation of this technology will best support faster diagnostic turnaround times to improve timely and appropriate patient treatment and management in terms of admission and / or discharge.

- ***Complete a successful bid for the Central Beds tender for mortuary and post mortem services to the Coroner's Office*** - This service development will further support the closer collaboration between L&D and Bedford Hospital in delivering a local, sustainable and resilient mortuary and post mortem service.

- ***Support the strategic implementation of specific outpatient services moving in to the community*** – The Division will support the opening of Arndale House, providing access to GP phlebotomy and outpatient anti-coagulation services.

- ***Further phased improvements to Zone B outpatient facilities*** – This plan will include refurbishment and expansion of the current waiting area to meet service growth, and provision of expanded outpatient-based phlebotomy services to best meet patient need.

- ***Complete the paper switch off to GP referrals*** – The Division is working across the Trust to fully implement the electronic referral system in line with national strategic objectives and contractual requirements.

- ***Implement the MRI expansion and redevelopment*** – the Division is replacing two existing scanners and providing an additional 3rd MRI scanner to meet continued service growth and to ensure timely access to inpatient and outpatient diagnostic services, development of improved patient pathways and to best support cancer pathways.

- ***Develop the CT SPECT service*** – This will replace the old technology gamma camera equipment in Nuclear Medicine with CT SPECT technology that will improve service resilience and efficiency while also enabling a wider range of scanning functionality, and improved image quality.

- ***Invest in Radiologist on-call*** – The Division is developing this service and consultants to best support safety, quality and sustainability of in-house 7-day emergency and inpatient reporting services to the Trust.

- ***Develop Radiographer led fluoroscopy services*** – This service will deliver enhanced staffing skill mix and professional development, whilst improving service capacity and resilience, as well as reducing patient waiting times. The service will also continue to support training of an expanded cohort of reporting radiographers and sonographers.

- ***Develop a therapies led rehabilitation / discharge unit*** – This unit will be providing an AHP managed ward, delivering a rehabilitation and enablement approach 7 days a week, 24 hours a day. Breast Screening aim to develop tomosynthesis CT breast scanning, to improve diagnostics in relation to breast cancer.

- ***Implement pharmacy and therapy wide access to system one community-based IT system*** – Linking to this system will improve information flows and best support patient clinical management pathways between primary and secondary care.

- ***Consider an Allied Health Professional / therapies strategy for the Trust*** – This strategy will enable the Division to best support professional leadership, representation, recruitment and retention and professional development of this important staff group both within the Trust and across the STP.

- ***Pharmacy will continue the support of Needs Based Care inpatient management*** – This support will be with a Monday – Friday, ward-based pharmacy service at admission delivering medicines reconciliation, optimising patient medicines and supporting medication adherence, information on medicines use / side effects, attendance on post-take ward rounds and supporting fast appropriate discharge through use of prescribing pharmacists.

- ***Continue to support the Trust's GDE ePharmacy agenda*** - The Division will support the Trust to improve medicines security, upgrade pharmacy IT systems to meet NHSE digital requirements, meet the national medicines value programme and ensure compliance with the Falsified Medicines Directive by February 2019.

Performance against Corporate Objectives 2017/18

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

Objective 1: Deliver Excellent Clinical Outcomes

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

- The Trust Mortality Board has overseen the development and publication of the Trust Mortality Review Policy. The first draft was published on the Trust website before the September deadline set out in the Learning From Deaths agenda.
- We have changed the methodology of our mortality reviews, from one adapted from the East of England Mortality Review Tool, to the Structured Judgement Review introduced by the Royal College of Physicians. This entailed training all consultants in the new methodology, and supporting their first few notes reviews. The process is now embedded, and teams are familiar with the Potential Avoidability score being used as the end-point of the review.
- We now have an established two-stage process for reviewing notes of deceased patients. In the first two months of the final quarter of 2017-18, we have achieved a primary review in 97% of all deaths (275/284). From these, we requested 74 full mortality reviews, of which to date, 51 (69%) have been completed. This is significant progress from the previous quarter, where only 35% of requests were completed. The data being collated is now much more robust, and learning themes are being presented to governance meetings to improve system performance.
- We have referred all Learning Disability deaths to the LeDeR co-ordinators since the scheme was launched in October 2017, and Child, Maternal and Neonatal deaths continue to be reported and investigated through the appropriate national review programmes.
- Our HSMR has improved from a statistically significant high of 110 in Feb 2017 to its current level of 101.9, moving us out of lower quartile performance.

Objective 2: Improve Patient Safety

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

- We consistently achieved 98% harm free care
- We have had a challenging year with an increase in avoidable grade 3 pressure ulcers. However, we have had no hospital acquired grade 4 pressure ulcers.
- We have reduced the falls rate from 4.06 to 3.97 per 1,000 bed days (which is below the national average) with continued challenges from an ageing and more frail population with complex health needs.
- We have achieved the 95% or greater target compliance of all VTE assessments and at the end of the year reached 99.8% compliance.

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

- We had one of the lowest C. Difficile infection rates in the country (nine in total compared to eight in 2016/17) and are assured that none of these were due to cross contamination.
- We have maintained a low rate of MRSA bacteraemias with only one case during 2017/18.

Objective 3: Improve Patient Experience

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

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

The feedback tells us that between 91-97% (90-95% for 2016/17) of our inpatients would recommend the Trust and between 93-96% (90-98% for 2016/17) of outpatients which is demonstrating an improving picture of consistency overall.

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

The annual national patient survey is demonstrating steady progress and some improvement. We are within the normal range when benchmarked against other hospitals nationally.

Objective 4: Deliver National Quality and Performance Targets

Delivering sustained performance with all CQC outcome measures

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

No enforcement action has been taken against the Trust during the reporting period April 1st 2017 and 31st March 2018 and we have not participated in special reviews or investigations by the CQC during the reporting period.

The Trust continued with the programme of CQC Domain reviews throughout the year reporting back to the Clinical Outcome, Safety and Quality Committee.

Delivering nationally mandated waiting times and other indicators

During 2017/18, the L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.

- Met the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in the first two thirds of the year. However, due to unprecedented winter pressures and the Department of Health directive to cancel surgery, the Trust has been unable to achieve the target since December 2017. A recovery plan is in place.

- Met all of the cancer targets for the year. The Trust has delivered one of the most consistent cancer performances in the country.

- Had excellent performance for C Difficile maintaining a low rate of 9 (one of the lowest in the country and below the de minimis of 12) but this did exceed the agreed contract threshold of 6.

- Reported 1 MRSA Bacteraemia which is also under the de minimis of six for reporting to Monitor.

- In 2017/18 the NHS Improvement Single Oversight Framework included the six week diagnostic target as a new part of the assurance process. This was challenging during the year. However, the position was recovered by the end of the year.

Objective 5: Implement our Strategic Plan

During 2017/18 a number of key strategic developments supported the delivery of the Trust's Strategic Vision.

a) Delivering new service models:

Emergency Hospital

- ***Continued the transition to a Needs Based Care model*** – There was considerable work during 2017/18 to refine the proposition for delivering care in relation to the patients need. The business case was approved in November 2017 and since then recruitment and job planning has been ongoing and a responsive in reach pilot took place.

- ***Further progress towards becoming a Hyper Acute Stroke Unit*** – There has been an increase in speech and language therapies support that improved the service and there are links to the community provision of psychological care for this patient group. The Trust is now achieving all targets for stroke care on the ward 90% of the time and TIA treatment within 24 hours.

Women's & Children's Hospital

- ***Further improved community based services*** - The gynaecology service has continued to work with the Local CCG's to support gynaecology provision in the community. We have hosted GP awareness events and jointly reviewed referral pathways to ensure timely care and one stop clinics where possible.

- ***Developed the GP/Consultant connect service*** - The Consultant connect service has been fully implemented across Luton and South Bedfordshire GP practices. Offering access primary care to Paediatric advice and clarity on treatment plans and when it is necessary to come to the assessment unit for an urgent review. This had enabled families to be supported by GP's to safely manage their child at home where they are most comfortable.

Elective Centre

- ***Expanded Oral and Maxillofacial Surgery*** - Work was completed in September 2017 to expand the Oral and Maxillofacial Surgery (OMFS) department. This created five new clinical rooms providing much needed capacity for the service and enabling the L&D to continue to act as the centre for the OMFS network.

- ***Developed Paediatric Surgical Services*** – We have recruited a substantive paediatric orthopaedic surgeon and a consultant paediatric general surgeon. This enables links with Great Ormond Street Hospital to offer more complex surgical treatment for children closer to home.

- ***Developed Haemato-oncology services*** – the dedicated unit was opened in July 2017, providing purpose-built facilities for both in-patients and patients attending for procedures and infusions. The unit has successfully recruited an additional substantive consultant and two SpRs from Sri-Lanka.

- ***Expanded and invested in new scanning equipment*** – One new and two refurbished MRI scanners have been procured, including the addition of a third scanner to meet increasing service need, and the redevelopment of the MRI suite has commenced to provide improved in-patient waiting facilities. Construction of a fourth ultrasound room has also been completed, providing improved access and facilities.

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

- Re-development proposals for the site are set out in an Outline Business Case approved by the Trust Board in October 2015. An Outline Business Case for development of the Acute Services block, which was one of the key elements of the re-development proposals, was completed in December 2017. This was a key element to support the Full Business Case for the proposed merger with Bedford hospital. The Trust continues to pursue funding from NHSI for an Acute Services Block via BLMK STP with a further submission due in July 2018.

- The proposed merger supports one of the key priorities within the BLMK STP to support Secondary Care Transformation through the development of sustainable secondary care plans for services to reflect new models of care.

- The work to refurbish some old administration offices to provide an extension to the Oral and Maxillo Facial department was completed in September 2017.

- The Trust has entered into a lease for the first floor of Arndale House, an old office building in the centre of Luton. This is now being refurbished to provide accommodation for the Sexual Health Services team, Dermatology and part of the Phlebotomy service and will be completed in May 18. This releases space on the main site for expansion of outpatient services.

- The refurbishment of the MR suite was approved in 2017 and is underway. A third MR scanner will be commissioned in June 18. This will be followed by a complete refurbishment of the existing scanners.

- Work was approved for the construction of a new Endoscope Decontamination Unit. This will release more space within the Endoscopy suite to support increased activity within this service.

- A design team has been commissioned to prepare proposals to provide a major upgrade to the electrical distribution and standby generation facilities on the site. This will address some of the key risks on services on the estate, and will significantly decrease the exposure to power failures. This work will start in 2019. In parallel with this, the Trust is pursuing a procurement to identify an Energy Services company to develop proposals to address the current issues with energy consumption, primarily through replacement of ageing boiler plant.

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

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

- In light of the ongoing national skills challenges facing the NHS the Trust has maintained its focus on recruitment across all staff groups. The Trust has continued to attend career fairs at local schools, Universities and other organised events to promote the various careers available within the NHS.

- The Trust have also implemented a new applicant tracking and recruitment software system which has reduced time to hire and improved the recruitment experience for both applicants and recruiting managers.

- The national shortage of registered nurses remains a key challenge for the Trust. During the past year the Trust introduced a designated nurse recruitment team to ensure a proactive and effective response to demand. As well as continuing with cohort recruitment, regular advertising the Trust has continued to deliver its strategy to recruit both EU and non EU nurses.

- Building on the previous year's successful use of band 4 Assistant Practitioners (AP) these roles have been incorporated into teams across the Trust. The staff are vital in supporting our registered nursing staff to deliver safe, quality patient care. The band 4 AP's are supported to move through the registered nurse training pathway to help the Trust to 'grow our own' which goes some way towards mitigating the national shortfall of newly qualified nurses. The Trust has 35 expressions of interest from staff to undertake their nurse training as part of this scheme.

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

- At the heart of L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important are the large scale, Trust wide 'Good, Better, Best events'. The events were held over a week and over 80% of our staff attended each event in July and December. Both events engaged with our staff to provide them with key information about the Trust and gather their feedback about what the Trust does well and any areas for improvement with clear actions identified.

- The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2017 Staff Survey showed that the Trust scored above average for its overall staff engagement score. The percentage of staff reporting good communication between senior management and staff, placed us in the top (best) 20% of Trusts.

- Organisation and Management interest in and action on health and wellbeing, also placed us in the top (best) 20% of Trusts.

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

- Medical Education continues to be a priority for the Trust. Over 2017/18 we have provided a high standard of both undergraduate and postgraduate training. All of our Educational Supervisors have attended formal training to be appointed as Educators and have had an annual appraisal for their educational role. This process has strengthened the standard of training and the governance of the process which has had a positive impact on feedback.

Undergraduate

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

Postgraduate

- Health Education England introduced a Quality Framework which replaced the previous annual Dean's report and quality performance review. The Trust's first submission highlighted the following risk areas: winter pressures, lack of rest space and lack of simulator facilities.

- In 2017/18 Health Education England undertook a table top review of Dental training and exploratory visits for Anaesthetics and Surgery and the surgical specialties. Actions plans following these reviews/visits have been submitted as per the required timelines and the Trust continues to implement the recommendations made.

- From August 2019, changes to core medical training will be implemented and the Trust is currently reviewing the core medical posts and placements to ensure that we are in a position to meet the recommendations set out in the 'Shape of Training' report. The new training pathway will be known as Internal Medicine Stage 1.

- The Trust has also been notified of future anticipated changes to core surgery posts where training posts will only be allocated to Trusts who are not only able to demonstrate that their posts meet the JCST quality indicators but that trainees are guaranteed to be with their surgical trainers during normal working hours 65% of the time. The Surgical Tutors, trainees and General Managers have reviewed the three posts and the rota commitment and have identified that additional resources in the form of Physician Associates/Nurse Practitioners are required to reduce the trainees on-call rota commitments. They are preparing a business case to support this recruitment so that the Trust can continue to host core surgical training.

Objective 7: Optimise the Financial position

Delivering our financial plan

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

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

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

Service Developments 2017/18

During 2017/18, the Division of Surgery including Cancer:

- ***Further developed Ear, Nose and Throat (ENT) services*** - ENT installed two new workstations in two of its Outpatient clinical rooms with modern workstations. This enables clinicians to be able to conduct procedures such as ear micro suction and flexible nasendoscopy in the clinic room, rather than having to use a separate treatment room. This has enabled better flow through clinics.

- ***Improved Surgical Flow*** – The Division has established a surgical discharge lounge to reduce length of stay and improve patient experience. This has resulted in patients going home earlier in the day, improving the productivity of theatres. The number of cancellations due to bed availability was well below 2016/17 levels until January 2018.

- ***Introduced e-referral in Urology*** – This commenced on Monday 26th February 2018. The first surgical service to go live with e-referral is Urology. Early days still but this will allow faster turnaround of referrals. It will also streamline the outpatient element of the pathway by enabling consultants to easily order tests in advance of the first appointment.

- ***Initiated the HoLEP Fellowship Urology*** – Our first Registrar HoLEP Fellowship 'student' commenced in October 2017 and has since been successful in securing a consultant post within the London region. Therefore, this has demonstrated its success for clinical development with HoLEP surgery. A post we will hope to recruit into for 2018.

- ***Introduced the Urology TURBT Blue Light*** – Successful implementation of the Blue Light stack in Theatres in 2017, Mr Barrass and the Urology team can now identify Bladder cancer cells by colour using the chemical Hexyl Aminolevulinate that is inserted into the catheter 30mins to 60mins prior to operation that has a high success rate of full removal of bladder cancer cells.

- ***Introduced the Urolift in Urology*** – First Urolift procedure completed in November 2017. Prostatic urethral lift for the treatment of lower urinary tract symptoms (LUTS) in men with benign prostate hyperplasia (BPH) . Mr Barrass and the Urology team now offer this minimally invasive approach to BPH that many patients request over more invasive surgical procedures.

- ***Developed an Integrated Pain Service*** – The development of a multi-disciplinary triage service for chronic pain referrals was developed. This team triage and stream all pain referrals received by the Trust to the most appropriate service for individual patients, including consultant and nurse led pain services as well as physiotherapy and psychology services in order to minimise unnecessary appointments for patients. This ensures all referrals are seen by the most appropriate clinical team first time and has resulted in a much reduced waiting time for patients.

During 2017/18, the Division of Medicine:

- ***Continued to develop support for performance monitoring and decision making*** – The Division continued development of directorate dashboards. This included appropriate escalation through Medicine Executive and Clinical Operational Board for executive guidance to support strategy and decision making.

- ***Further implemented service line management/ reporting*** – Work was progressed that refined Service Line Reporting for financial planning including Cost Improvement and Finance Recovery Plans.

- ***Commenced reviews of the Integrated Sexual Health Services for Luton Borough Council*** – The Division worked throughout the year to re-provision the service at an offsite location in Luton.

- ***Continued the implementation of all case mortality reviews*** – Quarterly mortality forums continued to identify contributing factors and themes for improvement and to increase awareness, reduce variability and share areas of best practice. A policy for reviews was completed and published on the Trust website.

- ***Continued to develop the Rheumatology service*** – As part of the Needs Based Care programme additional recruitment has been undertaken to support increasing demand and capacity.

- ***Further developed the Ambulatory Care services*** – A 7 day pilot was delivered into a permanent expansion to a 7 day model in 2017/18.

- ***Approved new decontamination equipment*** – New decontamination equipment for Endoscopy was approved during 2017/18. This is integral to diagnoses and ongoing surveillance of gastro-intestinal cancers and a wide range of non-cancer related conditions.

- ***Continued clinical engagement with Medicine across the STP*** – The Division has engaged in STP dialogues throughout the year and actively participated in the clinical vision as part of the merger with Bedford Hospital.

During 2017/18, the Division of Women and Children's Division:

- ***Made further improvements to the Neonatal unit*** – The Division have successfully made the improvements to the neonatal unit as planned and all areas are open and being fully used feedback from parents and staff has been very positive.

- ***Continued to implement the Better Births and Saving Babies Lives programmes*** - This work is ongoing and has come together across the BLMK area supported by a Local Maternity Services Board ensuring consistency across the area. Support collaborative working and sharing of best practice across the local maternity units.

- ***Continued to develop an ambulatory service for patients in early pregnancy*** – This work is continuing to be developed we have not been able to commence the community Hyperemisis service as yet but with planned redesign of services it is hoped we can take this forward.

- ***Developed the gynaecology nursing roles*** – The Division is very proud of the support and dedication teams and individual nurses have given to develop nurse led services across gynaecology. Both these services now have dedicated nurse led clinics.

- ***Further developed the scanning access within the fertility service*** – The Division have excellent fertility nurses who have worked tirelessly to complete their training with the support of the fertility consultants to support the service.

- ***Recruited a paediatric nurse specialist for haematology*** - The paediatric team successfully appointed one of the Trust's experienced paediatric nurses into this valuable post. The role is working closely with the clinical teams and parents to ensure patient experience is enhanced and we are working effectively to provide streamlined and consistent care to this vulnerable group of children and young people

- ***Worked closely with the Five to Thrive team*** - The Baby buddy app has been in use in Luton throughout 2017/18. It has been well used by families. The Division are looking at ways in which this can be used to support families further with more information and guidance.

During 2017/18, the Diagnostics, Therapeutics and Outpatients Division:

- ***Continued to improve 7-day services*** – Further investment in radiographer and radiologist staffing has enabled expansion of MRI and outpatient x-ray service provision at weekends, whilst commissioning of the mobile MRI unit has supported timely access and continued service growth over the course of the last year. The Trust has also improved local access to non-vascular consultant led interventional procedures Monday-Friday.

- ***Continued improvements to outpatient facilities*** – in order to support the growth of outpatient services, additional room facilities have been constructed within Zone B, as the first part of a phased approach to improving the outpatient environment in Zone B. The outpatient administration service was also successfully relocated in to new facilities, with the benefit of a new call centre.

- ***Improved therapy services to patients*** – The Division has continued the strategy to consolidate the provision of therapy services to the Trust, with in-sourcing of speech and language staff to provide improved resilience, continuity and professional development. The Trust has also been successful in being awarded the LCCG commissioned community contract for SLT services, commencing in April 2018.

- ***Improved mortuary services*** – the hospital mortuary has undergone both expansion and refurbishment during the course of the year, to provide new and expanded storage facilities, improving service resilience to meet both hospital and community needs.

- ***Implemented the Pathology Laboratory Information System*** – the new laboratory information system (LIMS) implementation was successfully completed to schedule in November 2017, providing the platform for further Pathology service developments and improvements.

- ***Implemented new technologies in Microbiology*** - new PCR technology has been introduced, delivering faster and more accurate diagnostics to best support timely and effective treatment of patients

- ***Supported sustainable transformation (STP)*** – the Division has continued involvement in the BLMK STP programme, to progress opportunities for collaborative working for improving the effective and efficient use of resources across Pathology, Imaging Pharmacy and Therapies.

Improving Quality

During 2017/18 the L&D launched its Quality Strategy. In response to the need for an improvement in the safety domain during our CQC inspection, we asked the Institute for Health Improvement (IHI) to work with us to identify opportunities to improve safety and quality. Many of the recommendations made, have been included in the development of this strategy.

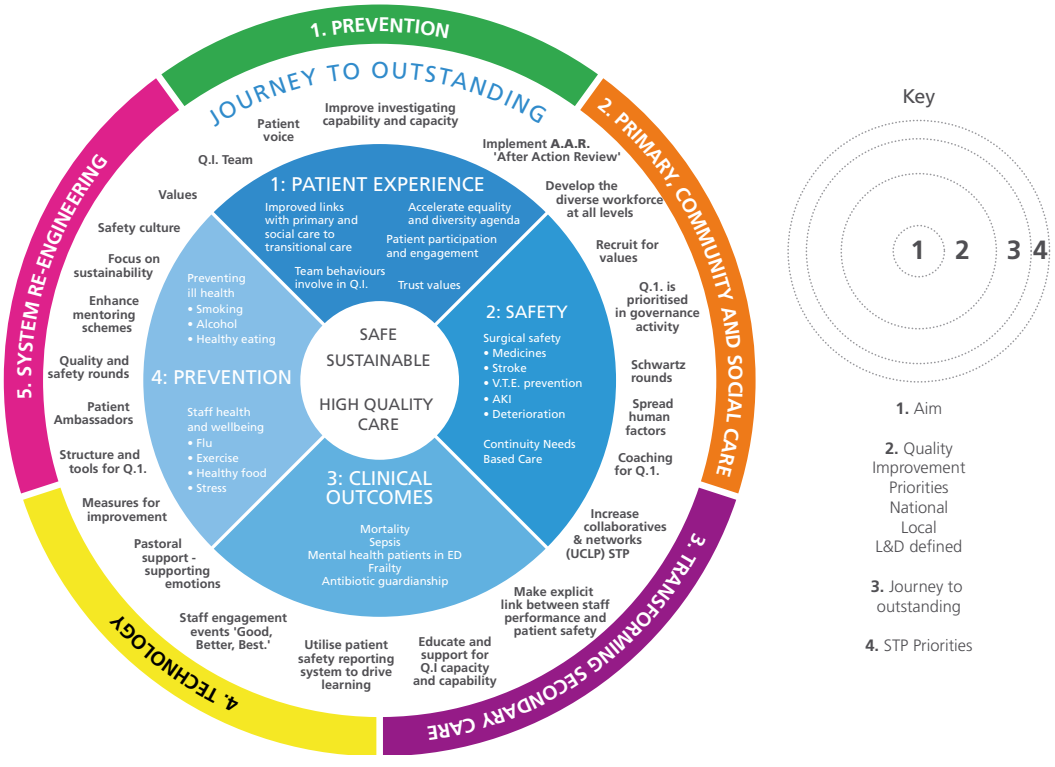
A number of events to engage with staff and service users has enabled a better understanding of the support and resources required to create a culture and proactive environment for Quality Improvement (QI), both through our Good Better Best event (bi-annual Trust-wide staff engagement event) and at an interactive workshop considering QI in more detail. The feedback from our staff and patients is that they want to become more involved in improving quality within the Trust and that they need the support to do so.

The L&D prides itself on the delivery of high quality, safe and sustainable services to our diverse, local community and those for whom we provide tertiary services. We aim to be the first choice provider for people who need to use local, acute hospital services. As a Trust with a track record for achieving success in our performance measures and targets, we have taken time since our 'good' CQC inspection to reflect on how we can grow in a different way to help create and build a hospital where quality, and the advancement of quality, is everyone's business. We commissioned a safety diagnostic from the IHI to assist us in doing this.

The anticipated merger with Bedford Hospital, provides a bigger opportunity to deliver 'outstanding' acute hospital services for Bedfordshire. We believe that, under the umbrella of a single NHS Foundation Trust, we can create greater momentum for improvement to benefit our community. This is a strategy for all and embraces the delivery and improvement of services from pre-conception and maternity, through children's services and into old age and the end of life.

To achieve this, we will continue to put the needs of our patients, their carers and their families first and we will place greater priority to listening to the patient voice. We will expand our portfolio of projects that improve peoples' experiences of the Trust (patients, carers and staff), including those that improve on delivery of dignity and respect, fair treatment, access and inclusion, whilst we continue with our endeavours to further improve patient safety.

The Quality Wheel (figure 1) was initially presented to staff attending the Good, Better, Best Event in December 2016. The central aim is to deliver safe, sustainable, high quality care. Our Quality Wheel seeks to depict an 'at a glance' overview of our approach to Quality. Our quality priorities are articulated surrounded by a collection of enablers which will support our 'journey to outstanding'.



Around this aim sits four quality priorities:
- Patient Experience
- Patient Safety
- Delivering excellent clinical outcomes
- Prevention of ill health

To achieve the above we must also:
- Accelerate our 'Journey to Outstanding' through improving staff experience and engaging and enthusing staff in promoting a culture of continuous learning and quality improvement

These four priorities encompass a broad range of work streams, many of which are already in progress or soon to begin – the work to be undertaken is detailed in the Quality Priorities 2018/19 contained within this report. A number of enablers or building blocks are required to support the quality improvement to maximise benefit for patients, staff and the organisation. It is vital to get these in place and right for staff so that they are supported in their endeavours. It is also important that staff energy is directed towards quality improvement priorities and objectives that have been agreed by the Trust. By developing a culture of collaboration within and between teams and a collective leadership approach, we want our staff to be involved in agreeing our priorities and objectives.

Our Quality Impact Assessment process

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

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

The Trust's position for undertaking risk assessment is outlined in the Risk Management Framework. The Trust's top 5 risks for 2018-19 are detailed in the Annual Governance Statement. With regards to the risk assessment of CIPs and associated QIAs, this includes an outline of the programme in detail and the associated assessment of the likely quality impact and financial impact, in line with NHS Improvement recommendations. The Executive Board oversees the programme and assurance is provided to the quality sub-committee (Clinical Outcome, Safety and Quality Committee) of the Board. Internal Audit periodically review the process.

The triangulation of quality with workforce and finance

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

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

The Trust continues to consider how information can be better presented to articulate more clearly to our Board and the public, the actions in place to address any areas requiring improvement. The Trust uses the information collated to effectively make informed, evidence based decisions about future developments.

Our Quality Improvement Implementation

A healthcare organisation's culture shapes the behaviour of everyone in the organisation and so affects the quality of care that together they provide. Research shows that the most powerful factor influencing culture is leadership.

Collective leadership - ***"leadership of all, by all and for all"*** – provides the type of culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across trusts (NHSI 2017).

The Trust strives to provide the culture for the delivery of high quality care and which fosters continual improvement. Our feedback from the IHI recommended that we use a safety culture tool. We will use a culture assessment tool, such as the King's Fund CAT currently being rolled at Bedford Hospital and we will work to address any identified needs. Our aim is to provide an environment which enables staff to show compassion, to speak up, to continuously improve and an environment where people are always treated with dignity and respect, where there is learning and a clearer focus on listening and responding to the voices of our patients and staff.

The Trust will continue to deliver Human Factors education to support more effectively learning and quality improvement. We intend to strengthen the Human Factors offering to a number of staff within each Division and use this expertise to identify stronger solutions to problems when developing improvement/ action plans.

We will continue to deliver the Quality, Service Improvement and Redesign programme (QSIR) and develop a range of shorter courses and faster sessions as well as ensuring that all staff receive an introduction as part of their induction to the Trust.

The QSIR programme is just one element of a wide range of 'enablers' which have been built into our new quality strategy to support us on our journey to becoming an outstanding organisation for our patients and our staff. The programme engages our staff by harnessing local skills, knowledge and experience to improve the service delivered and builds our improvement capability. We want all staff to be able to identify opportunities for quality improvement and to be skilled in using a common language and processes to do so.

The Trust is now one year into our QSIR journey and we have trained 33 staff as QSIR practitioners since January 2017. The staff span the whole range of multi-disciplinary teams. Another 25 staff are currently on the programme (Cohort 3). In order to build up our faculty of teachers, two of our staff have attended the national ACT academy (NHSI arm of QSIR).

The QSIR programme is delivered in 5 days over 4 months covering 8 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

Until we have our own full complement of facilitators, we are fortunate to benefit from the support of our experienced QSIR trainer colleagues from UCL. The collaboration has been a real asset; the team have lent their valuable experience and ensured the success of the first two cohorts.

On October 2nd we brought QSIR practitioners together to share their quality improvement stories and to celebrate their successes. It was really inspiring to hear about the really positive contributions our staff had made. Guest speakers included Stephanie Reid from NHSI ACT Academy, Mark England the Director of Transformation at the STP and our own CEO, David Carter. We hope to make this a regular feature in the Trust's celebration events.

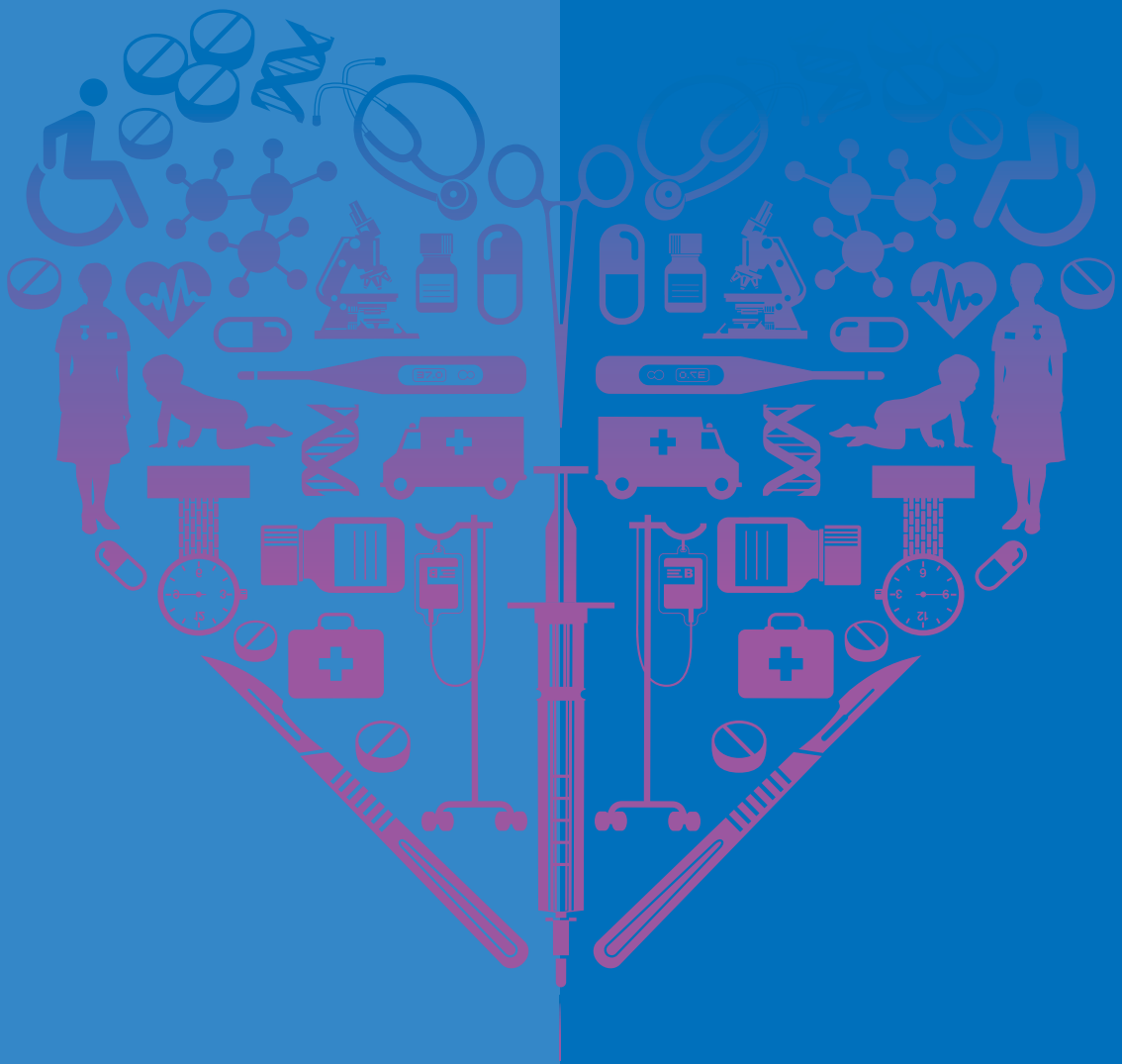
Engagement Events – 'Good Better Best'

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

Raising Concerns and Freedom to Speak Up Guardian

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

Operational performance report



Principal activities of the Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 90,000 admitted patients, over 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 newborn babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

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

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

Division	Specialties		
Medicine	Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine	Respiratory Medicine Diabetes and Endocrinology Gastroenterology Cardiology Dermatology Heptology Neurology	Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery - Colorectal - Upper Gastrointestinal - Vascular - Bariatric Surgery Urology Paediatric Surgery	Trauma & Orthopaedic Hospital at home Critical Care Plastic Surgery ENT Cancer Services Medical Oncology	Ophthalmology Oral & Maxillofacial Surgery Anaesthetics Pain Management Orthodontics Audiology
Women and Children's	Obstetrics Community Midwifery Early Pregnancy General Gynaecology	Gynae-oncology Paediatrics Fertility Neonatal Intensive Care Unit	Uro-gynaecology Ambulatory Gynaecology

Diagnostics, Therapeutics & Outpatients	Pathology Services - Blood Sciences - Cellular Pathology - Microbiology - Phlebotomy Haematology Care	Pharmacy Physiotherapy and Occupational Therapy Imaging Musculoskeletal Services Dietetics	Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2017/18 Divisional Directors, General Managers and Executive Directors met in the Executive Board.

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

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

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

Review of Operational Performance

Key performance targets 2017/18

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

Activity

During 2017/18, the L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- Met the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in the first two thirds of the year. However, due to unprecedented winter pressures and the Department of Health directive to cancel surgery, the Trust has been unable to achieve the target since December 2017. A recovery plan is in place to reach compliance within 2018/19.
- Met all of the cancer targets for the year. The Trust has delivered one of the most consistent cancer performances in the country.
- Had excellent performance for C Difficile maintaining a low rate of 9 (one of the lowest in the country and below the de minimis of 12) but this did exceed the agreed contract threshold of 6.
- Reported 1 MRSA Bacteraemia which is also under the de minimis of six for reporting to Monitor.
- In 2017/18 the NHS Improvement Single Oversight Framework included the six week diagnostic target as a new part of the assurance process. This was challenging during the year. However, the position was recovered by the end of the financial year.

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

L&D Performance against CQC and NHS Improvement Targets

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

Achieved

Regulatory Quality CQC Performance

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

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

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

No enforcement action has been taken against the Trust during the reporting period April 1st 2017 and 31st March 2018 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

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

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example, are people getting MRSA because of poor hygiene?

- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example, is there an effective 'enhanced recovery' programme?

- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.

- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.

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

The last CQC inspection was January 2016 and the report received in June 2016 gave the Foundation Trust and Hospital a rating of 'Good'. The Trust did not receive any further inspections during 2017/18.

Transforming Quality Leadership 'Buddy' System

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

Non-Executive Assessments (3x3)

The assessment process is further enhanced by Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards. Our Clinical Outcome, Safety and Quality Committee (COSQ) receive these assurance reports.

Quality of Governance

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

Regulatory Performance Ratings

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

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

Single Oversight Framework

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

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

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

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

Segmentation

The Trust is in segment 1. This segmentation information is the trust's position as at 20th April 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2017/18 Scores	2016/17 Scores
		Q4	Q4
Financial sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	2	1
	Agency spend	4	3
Overall scoring before overrides		**2**	1
Score of 4 override		**Yes**	n/a
Overall scoring after override		**3**	1

We had no formal interventions.

Activity Performance Analysis

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

Point of Delivery	Currency	17/18Plan	17/18 Outturn	18/19 Plan
Elective	Spells	37,505	35,664	38,035
Emergency	Spells	38,979	40,904	41,735
Non Elective (incl. BPT)	Spells	21,765	22,066	22,282
A&E	Attendances	107,061	105,216	107,523
Maternity Pathway	Pathway	11,393	11,098	11,088
Critical Care	Days	20,794	19,467	19,392
Outpatients -Firsts	Attendances	66,586	74,002	82,660
Outpatients -Follow Ups	Attendances	146,866	158,381	173,769
Outpatient- Multi-professional lsts	Attendances	3,028	1,977	2,225
Outpatient- Multi-professional FU	Attendances	7,734	5,515	5,848
Outpatient Procedures	Procedures	65,390	70,879	79,092
Outpatients -Non PbR	Attendances	60,050	60,878	68,084
Pre-assessment	Attendances	14,872	13,641	14,846
Telephone contacts	Contacts	11,394	6,890	6,981
One-stop	Attendances	5,089	5,159	5,729
Non-Prebooked outpatients	Attendances	1,123	771	899
Breast Screening	Screens	59,603	52,126	55,475
Unbundled Imaging	Images	36,652	44,947	47,559
Direct Access Pathology	Tests	1,107,687	1,102,347	1,116,690
Direct Access Radiology	Images	64,835	61,905	61,833
Same Day Chemotherapy	Attendances	3,978	4,176	4,339
Non PbR -Elective	Spells	2,085	2,391	2,358
Non PbR -Non-Elective	Spells	3,861	7,283	7,412

In 2017/18 our commissioners anticipated substantial CIP reductions. Despite their endeavours planned reductions on activity did not occur and emergency activity, in particular, has shown a significant increase in non-elective work. In the latter stages of the year we have seen a reduction in elective referrals, although referrals from Hertfordshire continue to rise.

The Hospital performed well to accommodate this unplanned activity without compromising a range of national target indicators with the exception of 18 weeks due to the cancellation of elective patients to accommodate A&E attendance as per national instructions, increasingly services such as hospital at home and ambulatory care to absorb the demand. However, this activity could not be provided within existing employed staffing levels and consequently the Trust incurred substantial temporary staffing costs.

Research Performance

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

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

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

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

This practical support includes:

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

Recruitment to NIHR Portfolio studies at the L&D for 2017/18 was **809**. In CRN North Thames the bar is set high in respect of recruitment and quality but we are confident we are up to the challenge, particularly with the funding from CRN North Thames to appoint research nurses.

Research issues and studies approved to be undertaken at the Trust (via the Research & Development Department) are presented at the quarterly Division of Medical Education and Research (DMER) Committee meetings. During 2017/18 there were 154 NIHR Portfolio studies and 31 Non-Portfolio studies ongoing in which 36% of our consultants are involved.

The Trust's Annual Academic Report for 2017/18 will be available from September 2018. However, the Annual Academic Report for 2016/17 reported that, in addition to the 173 ongoing research studies during that year, publications by Trust staff included 98 Scientific Papers; 75 Abstracts and 13 Books or Chapters in Books.

Education and Performance

Medical Education

Medical Education continues to be a priority for the Trust. Over 2017/18 we have provided a high standard of both undergraduate and postgraduate training. All of our Educational Supervisors have attended formal training to be appointed as Educators and have had an annual appraisal for their educational role. This process has strengthened the standard of training and the governance of the process which has had a positive impact on feedback.

Undergraduate

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

Postgraduate

Health Education England introduced a Quality Framework which replaced the previous annual Dean's report and quality performance review. The Trust's first submission highlighted the following risk areas: winter pressures, lack of rest space and lack of simulator facilities. These are being addressed in 2018/19.

In 2017/18 Health Education England undertook a table top review of Dental training and exploratory visits for Anaesthetics and Surgery and the surgical specialties. Actions plans following these reviews/visits have been submitted as per the required timelines and the Trust continues to implement the recommendations made.

From August 2019, changes to core medical training will be implemented and the Trust is currently reviewing the core medical posts and placements to ensure that we are in a position to meet the recommendations set out in the 'Shape of Training' report. The new training pathway will be known as Internal Medicine Stage 1.

The Trust has also been notified of future anticipated changes to core surgery posts where training posts will only be allocated to Trusts who are not only able to demonstrate that their posts meet the JCST quality indicators but that trainees are guaranteed to be with their surgical trainers during normal working hours 65% of the time. The Surgical Tutors, trainees and General Managers have reviewed the three posts and the rota commitment and have identified that additional resources in the form of Physician Associates/Nurse Practitioners are required to reduce the trainees on-call rota commitments. They are preparing a business case to support this recruitment so that the Trust can continue to host core surgical training.

Medical Revalidation

There are over 425 doctors within General Medical Council (GMC) Connect who have identified the Trust as their designated body for Revalidation. We support all doctors to prepare for their individual revalidation with the GMC which is required every 5 years. We offer access to 360° feedback at least once in every 5 years and doctors are enrolled onto a customised website which holds a portfolio of evidence in preparation for appraisal each year. This online web-based portfolio of evidence is a full record of the doctor's whole practice and provides comprehensive information towards revalidation.

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

Pre-Registration Education for Nurses and Midwives

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

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

To monitor quality, we undertake a formal assessment of the performance of the University of Bedfordshire and the University of Hertfordshire using nursing education quality indicators as a benchmark. Annually, 160 nurses and 60 midwives are trained in partnership with the University and the Trust. However, due to the current government changes to student bursaries from September 2017, it is unclear what impact changes in funding will have on student numbers during 2017-2018.

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

Career Pathways into Nursing

The Foundation Degree (FD) is the qualification required of our Assistant Practitioners currently being employed in specialist areas of the Trust and more recently on general elderly care and medical wards. In March 2017 the Trust took part in the pilot of a new role of Nursing Associates. The training of the new role is similar to the FD, participants undertake a 2 year programme equating to the first year of the pre-registration nursing programme whilst remaining employees of the Trust. There are 9 support workers currently on the programme from a variety of departments.

5 members of staff commenced a shortened 18 month pre-registration nurse training programme in September 2016 and have now completed the programme. They have all commenced work as staff nurses across the hospital. We have 2 HCAs currently on 18 month flexible nursing course who start their sign off placement in May.

Moving forward in line with the draft workforce strategy published by HEE at the end of 2017 more staff need to take up the FD or nursing associate programmes in order to increase the number able to apply for the flexible nursing (FN), programme. We encourage this flexible approach to provide as many opportunities to staff and to boost the number of registered staff.

Pre-Professional Workforce

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

Nurse Revalidation

All nurse and midwifery registrants are now required to demonstrate they remain fit to practise to another 3rd party every three years in accordance with The Code, 'Professional standards of practice and behaviour for nurses and midwives', updated in March 2015. The start date for the process formally commenced 1st April 2016. As a Trust we have achieved 100% compliance as of January 2018.

Overseas Nurses

We continue to recruit overseas nurses into the Trust. They all have a tailor-made induction programme which incorporates assessment of their prior learning and skills and time on their wards. The nurses then have the preceptorship competencies to complete which assesses their knowledge and skills in practice.

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

All EU nurses now have to provide evidence to the NMC that they meet the English language requirements they set. It is only once these are met that their registration proceeds. To ensure that all the nurses have a reasonable standard of English, they are assessed at interview as part of the screening process prior to submitting their documentation to the NMC. Prior to commencing employment our EU appointed nurses attend a residential placement and sit their International English Language Testing System IELTS) exam with the aim of them obtaining the required level for registration. The NMC has recently ratified an alternative language test which is deemed to be more relevant to health care so we are exploring using this in future to assess the language skills of our overseas nurses.

Mandatory Training across the Region

The Trust submitted a declaration of alignment to the Skills for Health Core Skills Mandatory Training Framework (CSTF) providing assurance that our training is sufficiently comprehensive and standardised across the East of England. Work continues towards greater transference of CSTF aligned training across organisations on recruitment. We have reviewed our approach to Induction for those staff already holding CSTF competencies, with a view to streamlining their pathway through commencement and out into clinical practice, whilst still maintaining high standards of training compliance and safety. This will lead to savings in time undertaking training when clinical staff move roles between NHS organisations, reducing duplication and increasing efficiency.

Personal and Continuing Professional Development

An annual training needs analysis informs our plans for continuing education. It also enables managers to prioritise staff development that meets services needs as well as the professional development of individual staff. This complements discussions at appraisal when individual personal development plans are developed with staff and their career aspirations discussed as part of a talent management conversation. Each year, we develop and publish our comprehensive training brochure which covers a wide range of programmes including mandatory training; health and safety, clinical skills, leadership and management development, apprenticeship qualifications, communication skills and IT training.

We continue to actively promote e-learning for mandatory training as we want to progress towards a more blended approach with classroom-based training and supervised sessions for staff to undertake their e-learning, where required. We have increased our resources for e-learning in partnership with Library Services which benefits all staff including junior doctors who are required to complete on-line learning prior to starting their placement here.

Registered staff update their clinical knowledge and skills through attending advanced specialist education courses which have been funded by Health Education East of England. We also fund specialised courses for clinical professionals at appropriate national centres of excellence such as Great Ormond Street Hospital. The outlook for funding remains unclear for the future but we are actively engaging with external partners to ensure that we can access any opportunities.

Apprenticeships

The 1 April 2017 saw changes to the way that apprenticeship qualifications were procured and paid for. The Apprenticeship Levy is a mandatory requirement and was introduced by the government on the 1 April 2017 at the very start of the financial year. The Levy changed the way in which apprenticeship qualifications were procured and paid for and was imposed upon all organisations with a payroll obligation greater than £3m. For the Trust this meant its Levy obligation was around £880k. To ensure that we make best use of the funds, the Trust would need to enrol approximately 88 apprentices this financial year.

We have enrolled over 120 new apprentices since April 2017. This has not been achieved without hard work, and a committed Apprentice Team. Apprenticeship enrolments have been in a wide range of subjects including Healthcare, Pharmacy, Business Administration, Customer Service, Team Leading and Management.

The Apprentice Team works closely with departments across the Trust and is forging close links with wider Bedford, Luton and Milton Keynes colleagues. Furthermore, we were the first NHS hospital nationally to procure our Apprenticeship provision through a series of small scale competitions and continue to support other Trusts to do the same.

The Trust continues to broaden the range and level of apprenticeship qualifications that are available, and to offer apprenticeship qualifications at levels 2, 3, 4 and 5. New apprenticeship standards are being launched all the time and the Trust is developing its strategic plans for the Nursing Associate Apprenticeship and Nursing Apprenticeships, both of which will give individuals the chance to gain qualifications without the need to attend university full-time. This will contribute to attracting students in training and then retaining them post qualification as employed staff which in turn, should address the shortage of qualified nurses at a regional level.

Leadership Development

We encourage development through our talent management process which is embedded in appraisals and we continue to support the development of future leaders across the Trust. Staff survey results for 2017 indicate that staff appreciate the quality of appraisals and non-mandatory training that they receive.

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

A new leadership programme for Band 6 nurses has been launched with a focus on managing individuals and teams effectively, understanding and improving performance, risk management and quality improvement.

The customised programme for newly appointed consultants to support them in their new role has been running for a year and it is being evaluated. The programme offered provision of specialist on-line training, a New Consultants' Forum with regular sessions in a range of useful topics and the offer of a senior consultant as a mentor. Early analysis of the feedback indicates that new consultants appreciate the opportunity for development and support.

In addition we have worked with senior medical leaders to identify their development needs in senior management roles and a number of opportunities including coaching, workshops, master classes and one-to-one personal development to support doctors working in a challenging leadership role have been offered. This initiative is also currently being evaluated.

The NHS Healthcare Leadership Model continues to be promoted internally and we have increased the number of feedback facilitators in the Trust. Uptake of the 360º feedback model is increasing as staff see the benefit of receiving in-depth feedback on their performance as managers and leaders. We offer multi-source feedback to all our senior consultants and it is an integral part of leadership programmes for Band 7 staff. This has a positive impact on the culture of the organisation as it offers an opportunity for facilitated discussion of a leader's impact in their team as well as with their colleagues.

Coaching takes place regularly for senior staff, where appropriate and helpful, and this supports the development of a culture where leaders model effective dialogue and are able to reflect on how they interact with colleagues across the organisation.

Sustainability/Climate Change Performance

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

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

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

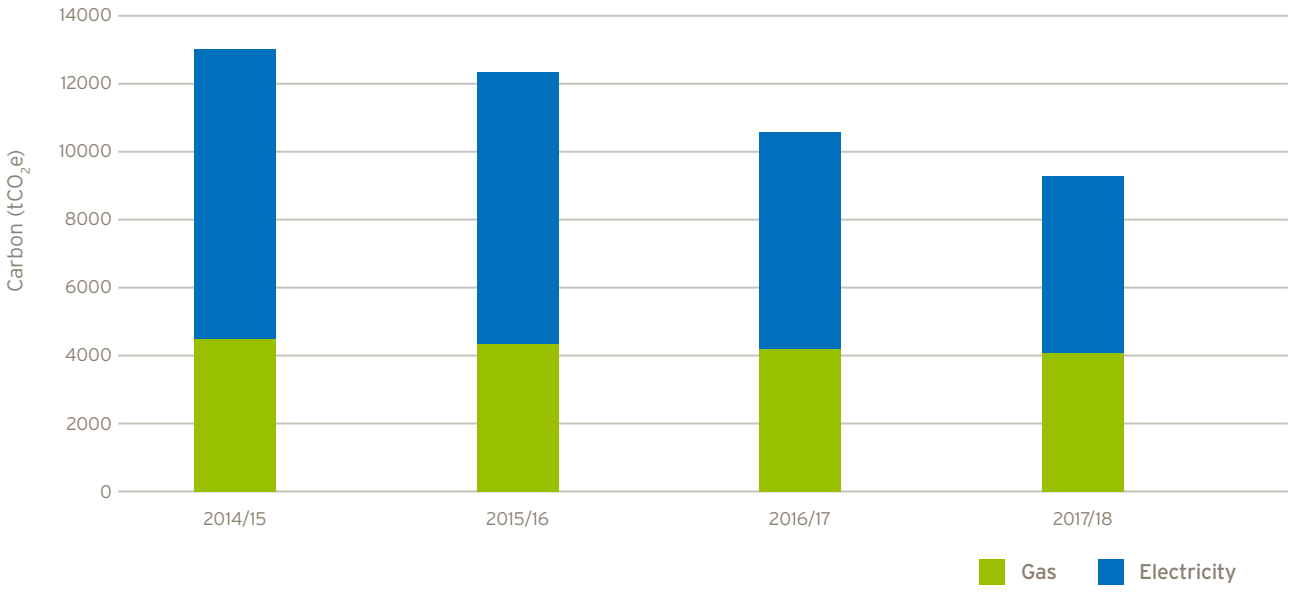
Performance

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

Energy

We have spent £2,148,162 on energy in 2017/18, which is a 33.8% increase on energy spend from last year due to large increases in commodity costs.

Carbon emissions - energy use



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

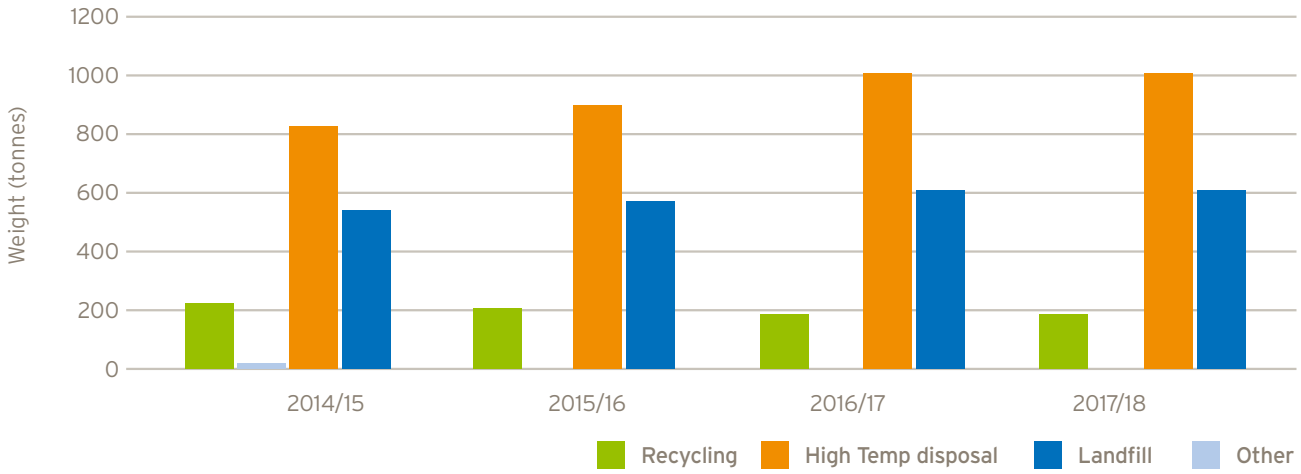
The consumption of both utilities is influenced by the seasons and has remained fairly constant over the last four years with minor reductions in gas due to boiler improvements and thermal efficiency schemes. Electrical consumption has seen a steady decrease due to the fitting of LED lighting and improved plant control. A large reduction has been made during 2017/18 by recharging consumption from other organisations

Gross expenditure on the CRC Energy Efficiency Scheme to cover emissions generated in 2017/18 is £170,000.

Waste

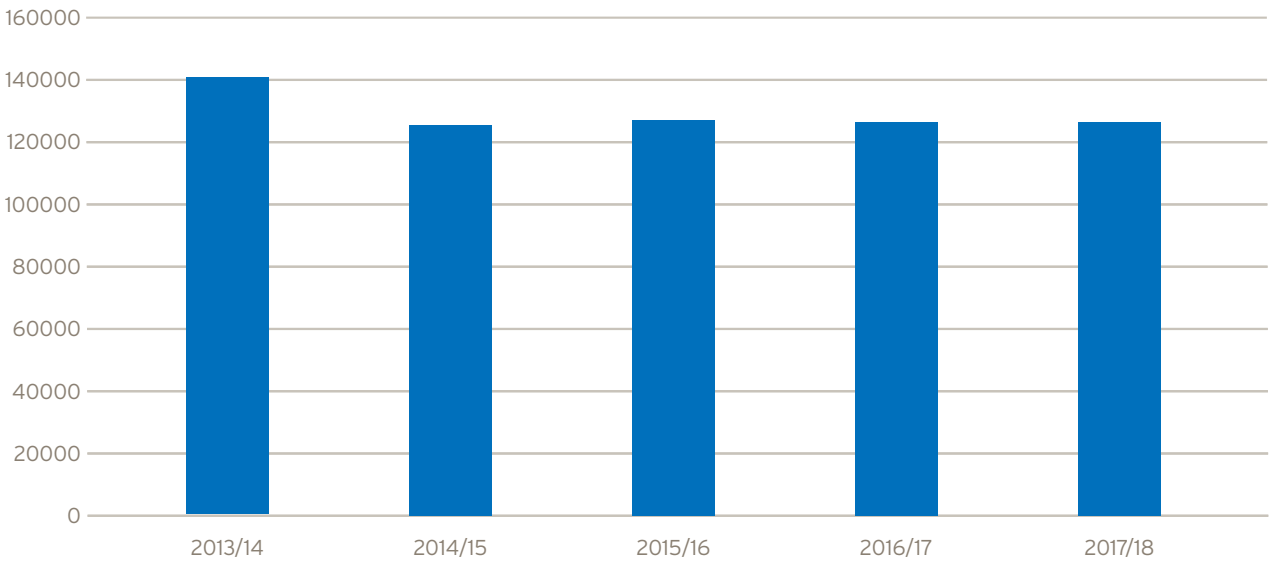
Waste has continued to increase due to refurbishment, reorganisation and increased activity. Recycled volume has remained steady and there has been a large increase in high temperature disposal. All waste going to high temperature disposal is incinerated in waste to energy plants so the CO2 produced is partially offset by the energy produced.

Waste breakdown



Water

Consumption (m³)



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

Water consumption has remained relatively constant and is fairly low when compared with organisations of comparable size and activity.

Transport

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

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

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

Looking Forward

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

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

Energy centre

Work is underway on strengthening our electrical infrastructure in preparation for a future energy centre. The Energy Centre is at an early stage but is progressing and should be completed during 2020.

Improved controls

BMS controls have been upgraded to ensure that all heating and ventilation plant is controlled in the most efficient manner. Further upgrade works are planned for the coming year.

Energy efficient equipment

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

Emergency Preparedness, Resilience and Response Performance

Introduction

All NHS organisations need to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety.

The NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) set out clearly the minimum standards which NHS organisations and providers of NHS funded care must meet. These standards are in accordance with the Civil Contingencies Act 2004, the NHS Act 2006 (as amended) and the Cabinet Office Expectations and Indicators of Good Practice set for Category 1 and 2 Responders.

Acute Trust's are required to self-asses compliance annually against the NHS England Core Standards for Emergency Preparedness Resilience and Response. The self-assessment is signed off by the Trust Board each year. The Trust's Director Level Accountable Emergency Officer (AEO) is responsible for ensuring these standards are met.

Summary of Core Standard requirements

In accordance with the Civil Contingencies Act 2004, the Trust is recognised as a Category 1 responder and subject to the relevant related governance and legislation. The core standards are divided into the following categories:

- Governance
- Duty to asses risk
- Duty to maintain plans
- Command & Control
- Duty to communicate
- Information sharing
- Co operation
- Training & Exercise

HAZMAT/CBRN

- Preparedness
- Decontamination Equipment
- Training

The Trust is required to state an overall assurance rating measured against 66 core standards. The definitions of these ratings are detailed below:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-Compliant	Arrangements in place do not fully address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

Performance

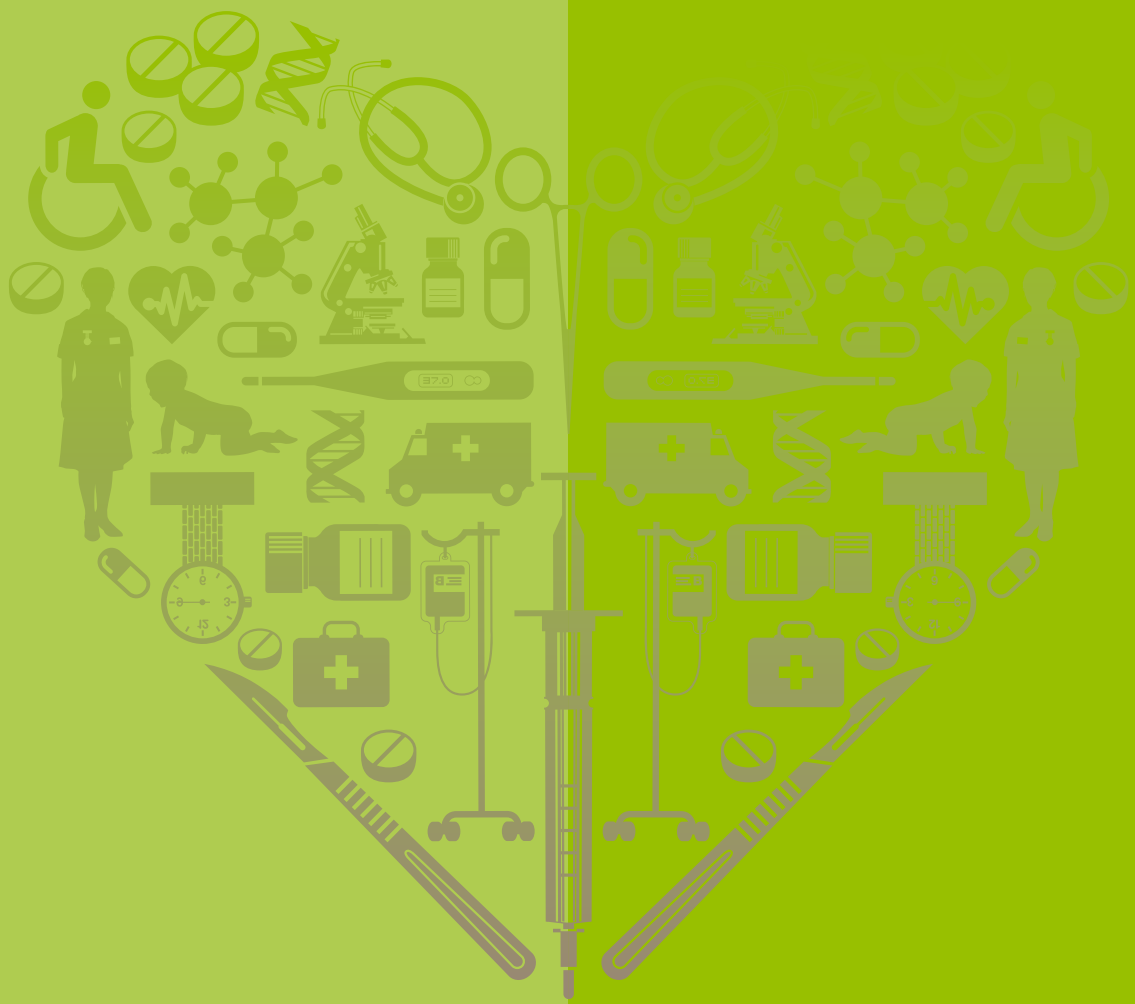
The Trust has measured itself as substantially compliant against the 2017/18 EPRR Core Assurance Standards; this rating has been confirmed and upheld by NHS England and Bedfordshire Local Health Resilience Partnership. This is an improvement on the Trust's 2016/17 assessment of partially compliant.

Going forward

A comprehensive work programme for 2017/18 will address the four substantially compliant core standards, progress will be tracked through the Emergency Preparedness and Business Continuity committee, with an aim of being fully compliant in the 2018/19 Core Assurance Assessment.


A3

Our patients, our staff and our partners



Our Patients

Patient feedback continues to be a valuable source of intelligence for us to help drive quality improvement and develop services. The Friends and Family test (FFT) along with the national patient surveys continue to be indicators of what our patients tell us about their experiences and we collect feedback regularly from the following groups to gather this information;

- Adult inpatients (FFT and National Survey)
- Maternity (FFT and National Survey)
- Outpatients (FFT only)
- Emergency Department (FFT and National Survey)
- Children and Young People's Services (National Survey only)
- Cancer Services (National Survey only)

In the 2017 National Inpatient Survey the feedback our patients demonstrated an overall improvement in their experiences compared to 2016. 55 questions recorded an improved score compared to the 2016 survey, 22 of which had a percentage increase of more than 5%. In contrast only four questions recorded a score lower than the 2016 survey, of which two showed a greater than 5% decrease.

In the 2017 Maternity Survey, new mothers told us that we continue to provide a similar quality of services compared to 2015. Both the inpatient and maternity surveys are now conducted annually so we will be able to compare what our patients tell us year on year.

When our patients complete the FFT survey in all areas they tell us that they are more likely to recommend our services compared to the national average. We collect the information weekly and feed this back to teams so that, where necessary, they can look at ways to make improvements quickly rather than waiting for monthly results.

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

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

The PALS Team currently co-ordinate access to the Interpreting Service, which is available for our patients. The service is contracted from an external provider and the quality of service provided is under constant review to ensure that we are able to fully meet the needs of our patients. Outpatients and Maternity Services are the highest user of interpreting services. The top four requested languages are Polish, Romania, Bengali and Urdu which account for over 80% of requests made.

The PALS office is open to the public Monday to Friday from 10am to 12.30 and 13.30 to 16.00, and is situated next to Reception at the Main Entrance to the hospital.

Local Involvement Networks - Healthwatch

Healthwatch Luton undertake announced 'Enter and View' visits in health and social care establishments and the team visited two wards in the hospital in January 2018. The visit included interviews with staff, patients and family/carers and the overall feedback from the team was positive with some recommendations for improvements. It is useful to get feedback from Healthwatch Luton as sometimes patients and staff may be more likely to give honest and open feedback to someone who does not work at the hospital.

NHS Choices

We continue to review feedback left on the NHS Choices Website as another measure of what our patients tell us about our services. To date this year there have been 265 reviews posted on the NHS Choices website. The overall star rating for the Trust was 4 stars, which have been retained since last year. There are five subgroups, cleanliness, staff co-operation, dignity and respect, involvement in decisions and same sex accommodation. We scored 4 stars in each category.

Patient and Public Participation Group (PPPG)

The PPPG has continued to be active in 2017/18. In line with the Trust values and objectives the terms of reference have been revised. Throughout the year there have been focus groups and meetings looking at key aspects of patient experience. With lay people and external stakeholder members the group has given feedback and suggested changes to the Patient Welcome Booklet and the Patient Experience section on the Trust website.

Service User Groups

There are number of service user groups in the organisation and the Patient Experience Team has helped to facilitate a number of them, in particular the

Breast Care Support Group and the Integrated Pain Management Meeting. The Integrated Pain Management Team set up the new group this year, which not only gathers feedback from patients who have been through the service, they have also helped with suggestions for service improvements. The group is multi disciplinary, including external stakeholders such as local GPs and the Clinical Commissioning Group (CCG), as well as service users.

Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. During the reporting period we received **601 Formal Complaints**. A breakdown of complaints (by month, by category) is contained within the Quality Account.

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

The majority of complaints were resolved at local level. Some Service Managers were pro-active in resolving some of the complaints by contacting the complainants to resolve their issues without the need of a written response, therefore they were resolved informally. Some of the complaints were resolved at Local Resolution level, whereby meetings were held by either the General Managers, the Director of Nursing, Director of Transformation, or Deputy Chief Executive and the Chief Executive. However, 6 complainants asked the Parliamentary and Health Service Ombudsman (PHSO) to review their complaints. Following this process, 1 complaint was partially upheld, 2 complaints are not upheld (we have a draft report from the PHSO) awaiting final report. 3 complaints are waiting for a decision.

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

We have continued to make improvements to our complaints process, for example:

- We are making contact with complainants early in the process to ensure we address the pertinent issues and that the complainants are happy with the investigation direction.
- If people are not happy with their response they are invited to come for a Local Resolution Meeting to discuss their concerns.
- Gathering ongoing feedback from complainants about the process.
- Continued with weekly updates about overdue complaints for every division and this is escalated to senior managers.

Compliments

During the reporting period over approximately 4,840 compliments were received directly by the staff or service, and cascaded to the staff and/or service involved by the respective manager.

Below are some of the compliments we received:

Thanks to everyone in A&E

Last Friday morning my elderly mother was brought to you having fallen in the night and cut her arm, which wouldn't stop bleeding. Everyone in the Accident department was kind and patient with her -even to the extent of over-hearing Mum saying she was hungry and appearing with a choice of sandwiches! I've been to a number of A&E's with Mum over the years, the treatment has always been 1st class but the kindness you all showed her last week was amazing - thank you.

Excellent handling of my case (breast cancer)

My experience of the breast cancer services at the L&D is second to none. From detection through a routine breast screening test to biopsy, further investigation in November/December, mastectomy in January and offer of immediate breast reconstruction I have experienced nothing but excellence. All the nurses involved were very competent, efficient and always cheerful which, I am sure, helped me recover more quickly. I feel extremely lucky to live near and have easy access to what I would class as a 5 star NHS service provided by its hard-working, very competent and dedicated staff.

Thank you

I would like to say a big thank you to all the staff who work in the maternity department of the hospital. From the early weeks of pregnancy to the safe delivery of my son this week, every member of staff involved has been amazing.

Thank You to the Cardiology Department

Two days ago I had a pacemaker fitted and I would like to express my thanks to the wonderful staff for their care and attention whilst in the unit. The attitude of everyone was exemplary and the care second to none and I would like you to convey my deepest thanks to everyone in the Cardiac Unit. As a hospital, you should be very proud of them. Many thanks.

Compliments to catering department

I've been an inpatient since Wednesday and have been pleasantly surprised by the high quality of the food I have been offered. Of note, the food has always been well presented and I have been particularly surprised that it has always been piping hot. Of particular note I had the chicken curry one evening which was absolutely delicious. Your ward housekeepers have been helpful and courteous. So thank you to all the team and congratulations on a high standard.

The Chaplaincy Service

This has been a year of change and development for the Chaplaincy, our Team Chaplain left to take up a Lead Chaplain's post in Hampshire which has enabled us to review and reconfigure with the appointment of two part time team Chaplains and in an exciting development we have also been able to create a new Muslim Chaplain post. These appointments will allow us to better meet the needs of the Trust and the communities we serve. We are continuing to focus on developing spiritual care and support at the end of life and ensuring that our care meets the spiritual, religious and cultural needs of the diverse communities we serve.

We have continued to enlarge our team of volunteers and have welcomed new people from a variety of faith and community groups into the team and the team were once again able to offer support to over 27,000 people – patients, visitors and staff – over the past year.

We have been exploring how we can work more closely with the Chaplaincy team at Bedford Hospital and have identified a number of ways that we can support and help one another and bring our teams closer together.

Safeguarding Children and Adults

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

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

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

Actions taken and measures in place are as follows:

- Reports are presented to the Clinical Outcome, Safety and Quality Committee annually on safeguarding children and young people and there is a clear reporting structure in place to raise issues throughout the year.
- Audits and reviews are carried out to check and satisfy us that our systems and processes are effective.
- Clear procedures are in place in the Emergency Department (A&E) and staff receive regular update training on safeguarding.
- Clear procedures are in place to ensure that the Trust is working with other organisations to safeguard children and adults.
- Disclosure and Disbarring (DBS) checks are made on all new staff adhering to the NHS Employer guidelines and the Trust is compliant with safeguarding guidelines.
- Training in safeguarding children and young people and adults is one of the key components of the corporate induction programme for all new starters and is included in the annual mandatory refresher training which is being made available as e-learning.
- All training arrangements have been reviewed.
- A Named Nurse, Named Midwife and Named Doctor have specific responsibility for safeguarding children and young people across all parts of our hospital – they are clear about their roles and are given sufficient time to enable them to fulfil their responsibilities.
- A Named Nurse and Named Doctor have specific responsibility for safeguarding adults.


NICU
19 of 20

Our Staff

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

Recruitment and Resourcing

In light of the ongoing national skills challenges facing the NHS the Trust has maintained its focus on recruitment across all staff groups. The Trust has continued to attend career fairs at local schools, Universities and other organised events to promote the various careers available within the NHS.

The Trust have also implemented a new applicant tracking and recruitment software system which has reduced time to hire and improved the recruitment experience for both applicants and recruiting managers.

Registered Nurses

The national shortage of registered nurses remains a key challenge for the Trust. During the past year the Trust introduced a designated nurse recruitment team to ensure a proactive and effective response to demand. As well as continuing with cohort recruitment, regular advertising the Trust has continued to deliver its strategy to recruit both EU and non EU nurses. However, this method of recruitment provides challenges around the International English Language test (IELTS) and OSCE (Observed Structured Clinical Examination) which overseas nurses need to pass before they can gain their NMC registration. Subsequently the length of time for these nurses to commence in post remains protracted due to the amount of time it takes for all the stages to be completed and for the Nursing and Midwifery Council to process the applications for registration. The Trust has developed a fast track OSCE training programme which has reduced the length of time to gain NMC registration

Recruitment of newly qualified nurses continues bi-annually, and we remain the main source of employment for Bedfordshire University nursing students. The Trust also welcomes applications from nursing students who have trained at other Universities.

Acorn Preceptorship Programme

After three years training student nurses and midwives qualify and then face many challenges as they manage the transition into a Registered Nursing (RN) or Midwifery (RM) role. The Trust recognises that this can be quite daunting, one day they are classified as a student and the next as a registered practitioner, Within the Trust there is excellent provision to support the newly qualified RN/RM with the practical skill training as well as guidance and advice that form the detailed well established preceptorship programme. From September 2017, newly qualified staff are presented with a commemorative acorn badge as part of their preceptorship journey to thank them for choosing to start their careers with the L&D. When they complete the preceptorship programme this is formally recognised with presentation of a certificate marking the transition to registered practitioner.

Assistant Practitioners

Building on the previous year's successful use of band 4 Assistant Practitioners (AP) these roles have been incorporated into teams across the Trust .The staff are vital in supporting our registered nursing staff to deliver safe, quality patient care. The band 4 AP's are supported to move through the registered nurse training pathway to help the Trust to 'grow our own' which goes some way towards mitigating the national shortfall of newly qualified nurses. The Trust has 35 expressions of interest from staff to undertake their nurse training as part of this scheme.

Healthcare Assistants

The Trust has undertaken more frequent recruitment campaigns over the past 12 months to ensure that all vacancies are kept to a minimum. Cohort based recruitment involve assessments and interviews on the same day to maintain the high calibre of new recruits and to streamline the recruitment process.

Needs Based Care

The Trust has commenced recruitment to posts that enable the transition to a Needs Based Care (NBC) model of delivery that has continuity of care as its key principle. This has resulted in the introduction of a number of new consultant, specialist and other front line posts. Recruitment to these posts will continue up to October 2018 in order to ensure our patients receive the right care, in the right place and at the right time based on their clinical need.

Agency Collaboration

The Trust has continued to work collaboratively with trusts across Bedfordshire and Hertfordshire on joint

tendering and common processes to ensure best value for the use of agency staff without risks to patient safety. The project continues to deliver savings to the Trust and provide consistency within the local agency market.

Consultant Job Planning

The Trust recognises the importance of ensuring alignment between meeting patient demand and the availability of senior medical staff. Following last year's project to ensure consultant job plans are up to date and representative of service needs, work has continued to embed related processes and to ensure job plans remain fit for purpose in the context of 7 day, 24 hour working. The Trust's Job Planning Assurance Group has continued to meet regularly to provide oversight and scrutiny of all job plans and a final approval process which has been designed to ensure a fair and consistent approach across the Trust. Job Planning work has also been extended, this year, to embrace a team based approach where appropriate.

Communicating and engaging with our staff

The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2017 Staff Survey showed that the Trust scored above average for its overall staff engagement score. The percentage of staff reporting good communication between senior management and staff, placed us in the top (best) 20% of Trusts
Organisation and Management interest in and action on health and wellbeing, also placed us in the top (best) 20% of Trusts.

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

Examples of staff communications and engagement include:

- Monthly staff briefings are led by our Chief Executive. We share information on key operational issues and gain feedback from staff
- Executive Team present to new staff at induction monthly.
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets quarterly with our Council of Governors, which includes nine elected staff governors
- Quarterly public Trust Board meetings
- Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust
- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

Staff Involvement Group

The focus of this group is on developing a culture of staff involvement, open communication and partnership working with factors that have a real impact on staff such as reward and recognition, security, health and wellbeing. The membership of the group is diverse and members are active in taking forward themes from the staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.

Staff Involvement Group Newsletter

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

Engagement events 2017

Our third 'Good, Better, Best'' staff engagement event was a great success. More than 80% of our staff participated during the week in July 2017. The focus of the event was Quality Improvement Patient Safety and Patient Experience. The Quality Improvement faculty was launched and the Trust development of the Quality Strategy and sought feedback from staff attending on the Trust values that would be developed.

The Quality Strategy was launched at the Good, Better, Best Christmas staff engagement event was held in December 2017 with more than 2000 members of staff attending the sessions. Themes this Christmas included presentations on the Quality Strategy, the launch of the new Trust vision and progress towards the values, an update on the collaboration with Bedford Hospital and gave us an opportunity to thank staff for their hard work and dedication over the year.

Our Volunteers

Our Volunteer Strategy focuses on maximising the potential of volunteering here at the Luton and Dunstable Hospital, making sure that we are utilising the vast and diverse array of talent in the local community and doing all that we can to bring that into the Trust. We aim to achieve our objectives by delivering a high quality volunteer journey that maximises the reciprocal benefits for both the Trust and our volunteers.

The Voluntary Services Manager is responsible for overseeing external organisations such as the RVS, Carers in Bedfordshire, Hospital Radio and also organisations or businesses wishing to offer one day volunteering. She is a member of the National Executive Committee of NAVSM (The National Association of Voluntary Services Managers – NHS) and contributes to the Special Projects team, which has recently published and distributed their 'Good Practice Guide' to VSMs across the NHS. She also assists in organising the NAVSM annual training seminar.

We currently have 272 volunteers working alongside our paid staff in a variety of roles.

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

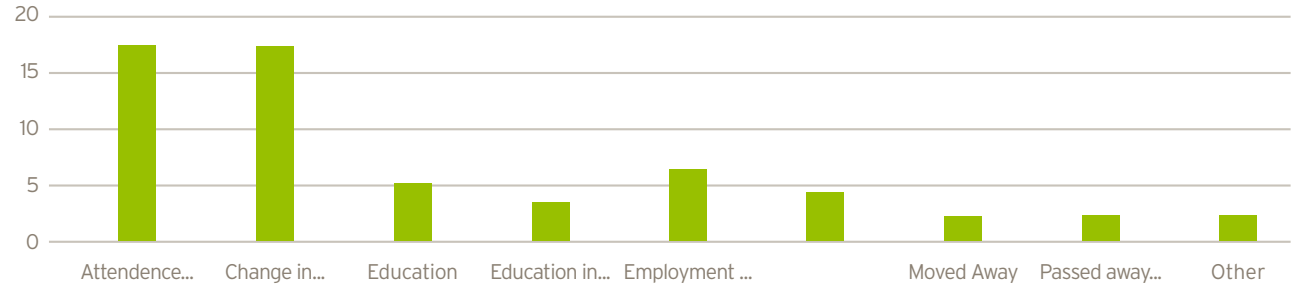
Our volunteer base is made up as follows:

Age (years) 2017/2018	Number of volunteers	%
80 and over	16	5.90
66 - 79	128	47.23
50 - 65	58	21.40
25 – 49	49	18.08
18 - 24	18	6.64

This very much reflects previous years but this year saw an 8% rise in the number of volunteers registered.

Generally, those in the 18 – 24 age category use their volunteering experience to help them gain an insight into healthcare which in turn supports their applications for health related courses. We see a higher number of younger volunteers at the beginning of each academic year, and by the summer the numbers are reduced. Of a total of 58 leavers in 2017 /2018, 8 went on to further education. A further 4 of those leavers secured employment in the Trust.

Leavers



29.88% of volunteers are from a BME background, which is an increase of 4.51 % from last year - although it is still slightly under representative of our local community. An opportunity in 2017 to work with a local Imam to engage our Muslim community resulted in the recruitment of three further Muslim Chaplaincy volunteers.

During 2017 / 2018:

- Our Trust volunteers gave us a total of over 23,000 hours, which is the equivalent to 12.3 full time band 2 staff.

- 74 new volunteers were recruited and there were a total of 58 Leavers.

A number of external organisations joined us to give their support as part of their Employee Volunteering Programmes. In May, Nationwide Building Society returned and they transformed the Wilmot Dixon Courtyard Garden into a useable area for staff to relax away from the busy stresses of everyday life. In July we were joined by Employees from TUI who gave the garden in the NICU parents' bungalow a much needed makeover, and also by Allianz whose staff braved torrential rain to repaint the walkways outside the pre-assessment unit.

Volunteer Support for the Medical Education OSCS Exams has resulted in a sizeable donation to Voluntary Services. This will be used to support the cost of Uniforms and Volunteer 'Thank You' Events.

Two of our volunteers were externally recognised for their support and contribution to the patient experience. David Macdonald (Main Reception Volunteer) was invited to attend the Queens Garden Party in May as a result of the award he received at last year's Cheering Volunteering Awards Ceremony. Pearl Hinds (Children's Playroom Volunteer) was the recipient of a 'Luton's Best Award'.

New roles this year include the Introduction of a PAT Dog to provide therapeutic intervention for patients requiring Occupational Therapy and also those with Dementia. Also new in 2017 we have a volunteer supporting staff in the post room and have recruited a gardener to help maintain outside areas designated for staff relaxation. We continue to expand the areas in which we have admin support and now have 51 admin volunteers in 40 different areas

We held our annual Long Service Awards event in December which was attended by 100 Volunteers. A sit down meal was followed by 5, 10 and 15 year awards which were presented by the Trust Chairman, Simon Linnett and then a 30 year Long Service Award presented by the High Sheriff of Bedfordshire, Vinod Tailor, to Bernadette Lana, one of our Chaplaincy volunteers.

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 2017/18 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 awareness raising events.

In June 2017, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place, which proved to be very popular. Awareness raising stands and activities included: Chair based fitness exercise demonstrations by Active Luton, Chi Kung Tai Chi demonstrations, 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 among other initiatives.

This year, 76.1% of our frontline staff were vaccinated against flu, which was 4.7% higher than the year previous and also a higher uptake than the national average amongst other NHS Acute Trusts.

The Wednesday walking activity (30 minutes of a brisk walk) that first started in 2009 continued to take place every Wednesday lunchtime.

The Occupational Health team were successful in retaining their accreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the

Faculty of Occupational Medicine. SEQOHS accreditation is the formal recognition that an Occupational Health Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

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

Health Checks for staff

The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. 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 520 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary referrals made.

Fruit and Vegetable Market Stall

Following on from a staff suggestion, a fruit and vegetable vendor was asked to set up a stall in an effort to promote healthy eating. 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.

2017 NATIONAL STAFF SURVEY SUMMARY OF RESULTS

1. Introduction

The NHS National Staff Survey was undertaken between September and December 2017. All NHS Hospitals in England are required to participate in the survey. The data collected is used by the CQC for the Benchmark reports across all NHS Acute Trusts.

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

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

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

This year the Trust opted to perform a full survey. 4005 questionnaires were distributed in paper format only.

Completed questionnaires were sent directly to the Trusts independent survey contractor, Quality Health, for analysis.

This report gives an overview of the survey findings. A summary report of the complete results will be made available on the Trust intranet.

The survey report provides vital feedback from staff about working in the Trust.

As in previous years, there are two types of key finding:

- Percentage scores, i.e., percentage of staff giving a particular response to one, or a series of survey questions.

- Scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these summary scores, the minimum score is always 1 (Strongly disagree) and the maximum score is 5 (Strongly agree)

2. Response Rates

2017 National NHS Staff Survey		2016 National NHS Staff Survey		Trust Improvement
Trust	National Average*	Trust	National Average*	
54%	44%	43%	43%	11%

* Acute Trusts

The official sample size for our Trust was 4005, and we had 2126 members of staff take part.

3. Staff Engagement

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

	2017 National NHS Staff Survey		2016 National NHS Staff Survey		Change since 2016 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
Overall Staff Engagement	3.87	3.79	3.90	3.81	No significant change	Above (better than) average
KF 1 Staff recommendation of the Trust as a place to work or receive treatment	3.84	3.75	3.88	3.76	No significant change	Above (better than) average
KF 4 Staff motivation at work	3.99	3.92	4.01	3.94	No significant change	Highest (best) 20%
KF 7 Staff ability to contribute towards improvements at work	72%	70%	75%	70%	No significant change	Above (better than) average%

4. Key Findings

A summary of the key findings from the 2017 National NHS Staff Survey are outlined in the following sections:

4.1 Top Ranking Scores

Top 5 Ranking Scores	2017 National NHS Staff Survey		2016 National NHS Staff Survey		Change since 2016 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 24 Percentage of staff/colleagues reporting most recent experience of violence	79%	66%	72%	67%	No significant change	Highest (best) 20%
KF4 Staff motivation at work	3.99	3.92	4.01	3.94	No significant change	Highest (best) 20%
KF 12 Quality of appraisals	3.33	3.11	3.40	3.11	No significant change	Highest (best) 20%
KF 6 Percentage of staff reporting good communication between senior management and staff	40%	33%	36%	33%	No significant change	Highest (best) 20%
KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abusee	51%	45%	54%	45%	No significant change	Highest (best) 20%

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

The L&D was ranked as being in the top 20% (best) when compared with other Acute Hospital Trusts for the following indicators

- Organisation and Management interest in and action on health and wellbeing
- Staff satisfaction with the quality of work and care they are able to deliver
- Staff satisfaction with level of responsibility and involvement
- % agreeing that their role makes a difference to patients/service users

We were ranked as being above or better than average on the following:-

- Staff recommendation of the organisation as a place to work or receive treatment
- Quality of non-mandatory training, learning or development
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- % of staff feeling unwell due to work related stress in last 12 months
- % of staff attending work in the last 3 months despite feeling unwell because they felt pressure
- % able to contribute towards improvements at work
- Effective team working
- Recognition and value of staff by managers and the organisation
- Support from immediate managers
- Staff satisfaction with resourcing and support

4.2 Bottom Ranking Scores

Bottom 5 Ranking Scores	2017 National NHS Staff Survey		2016 National NHS Staff Survey		Change since 2016 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 16 % of staff working extra hours***	75%	72%	79%	72%	No significant change	Highest (worst) 20%
KF 20 % of staff experiencing discrimination at work in the last 12 months	17%	12%	15%	11%	No significant change	Highest (worst) 20%
KF 22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	15%	18%	15%	No significant change	Highest (worst) 20%
KF 25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	31%	28%	33%	27%	No significant change	Highest (worst) 20%
KF 15 % of staff satisfied with the opportunities for flexible working plan	48%	51%	50%	51%	No significant change	Lower than average

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

	2017 National NHS Staff Survey		2016 National NHS Staff Survey	
	Trust	National Average	Trust	National Average
% working additional paid hours	47%	35%	48%	35%
% working additional unpaid hours	57%	57%	63%	57%

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

- % appraised in the last 12 months
- Effective use of patient/service users feedback
- % witnessing potentially harmful errors, near misses or incidents in the last month
- % experiencing physical violence from staff in last 12 months

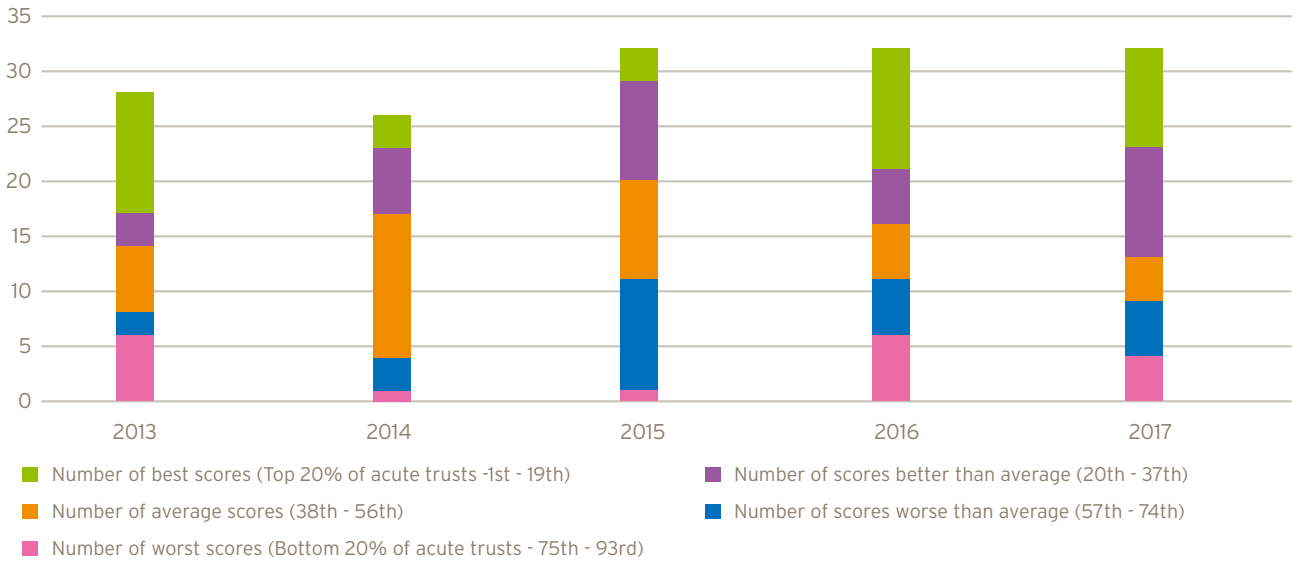
Of the total 32 reported key findings, all 32 can be compared to 2016 and all were deemed by the survey providers as not demonstrating a real statistical change.

Key findings over the past five years

The following graph indicates the key finding ratios over the previous five years. It should be noted that in 2013 there were just 28 key findings and 29 in 2014. From 2015 onwards there have been 32.

There are 93 Acute Trusts, and where our results are reported as placing us within the top 20 % of Trusts, this would give us a ranking of somewhere between 1st and 19th. Better than average, would be 20th – 37th, average 38th and 56th, worse than average 57th and 74th. Where reported as being in the bottom 20% of Trusts, this would place us 75th – 93rd.

Key findings over the past five years



Next Steps

The results will be analysed further to identify areas for improvement and hot spots, to target for action, in particular:

- Discuss the results at the Staff Involvement Group meeting and agree the appropriate action which will include:
  - Concentrating on some successes – with an aim to continue and improve on these;
  - Agree actions for areas where the results are in the bottom 20% of Acute Trusts, the Trusts bottom five ranking scores and other areas of concern
  - A static display of the results will be available in areas where there is evidence of a high staff footfall.
- A summary of the results will be shared with the Executive Team, Trust Board, Council of Governors, General Managers/Divisional Directors and will also be available on the intranet.
- An article and brief summary of the results will appear in the staff newsletter.
- The results will be available on the Intranet and an Everyone e-mail sent with a link to the results

Action

Violence and Harassment

- The Trust reviewed the data and other intelligence that identified there was an issue related to reported incidents involving confused patients on the ward. As a result new training was put in place to support staff dealing patients with cognitive impairment.

- The Trust implemented 'Baywatch' which ensures that the nurses who are observing patients, such as those with dementia, are clearly identified and that patients and visitors are aware that those nurses cannot leave the bay.

- The Managing Conflict Policy has been reviewed and a new scheme including exclusion letters and Action Against Abuse signage is being rolled out and awareness training planned.

- A targeted Trust approach will be presented through the Staff Engagement Event in July 2018 that will equip staff with support mechanisms.

Staff working extra hours

- The Trust reviewed the data and most of the extra hours identified were paid hours. As part of the Trust rolling out the results, outlier departments are being asked to review if there are any concerns in relation to working these extra paid hours.

Flexible Working

- The Trust has a policy in place and each request is considered on a case by case basis.

Discrimination

- The Trust has an Equality, Diversity and Human Rights Committee and have set up a task and finish group specifically looking at these issues. During Equality and Diversity Week (14-18th May) the Trust will be having a weeklong series of activities to raise awareness about the issue.

- The Trust began a process in July 2017 using the Engagement Events, to establish a new set of values.

Equality and Diversity

During 2017/18 further progress has been made on the work being done to help embed Equality, Diversity and Human Rights (EDHR) areas into corporate strategies and thinking.

The umbrella framework document that was created in 2017 to deliver an embedded EDHR Strategy has supported this along with the EDHR committee, having a long term NED Champion and Chair, and EDHR featuring on Board level and committee reports and presentations.

Going forward, the need to know appendices in our EDHR Framework will be updated with the most recent developments within the field of EDHR practice. This includes simple, more engaging guidance to the Gender Pay Gap Reporting and the Workforce Disability Equality Standard.

The Trust published comprehensive reports with analysis of trends for Workforce Equality; Patient Equality and the Workforce Race Equality Scheme WRES on the website at the end of July 2017 to meet our Public Sector Equality Duty and NHS Contract requirements.

In 2018, this will be the Trust's fourth year of comprehensive reporting with valuable data that can be used to make informed decisions about service and workforce changes and objectives. The Trust uses data, service and workforce changes to plan objectives, initiatives and actions that will improved Patient and Workforce experience and Trust performance. Examples of Trust identified objectives in relation to this and to the Equality Delivery System EDS2 for both Patient and Workforce Experience include:

1. Delivering the fourth WRES action Plan - The WRES measures data for any gap in experience in the treatment of White and BME staff, so that any less favourable experience of BME staff can be addressed. For all Trusts, there is a National WRES Report and the Trust analyse, compile and share a summary report of the Trust's position in this benchmarking.

2. Preparing for the Workforce Disability Equality Standard WDES - After the success of the WRES, NHS England have implemented a WDES standard from April 2017 to address disability areas. The Trust has been undertaking initiatives to attain an improved level of declaration from staff / patients. In 2017 data the level of no declaration of disability status of staff changed from 56% to 33% as a result of recruiting processes and the employee self-record system ESR.

3. Tackling data areas with low declaration - In 2018 more actions on equalities areas of low declaration are planned. This includes raising the levels of declaration for disability, religion or belief and sexual orientation for both the workforce and patients. Low declaration effect data validity and having better data will enable better assessment and application of fairer treatment and meeting of needs whilst giving a more accurate picture of performance 3.

4. Transgender - In 2017 the Trust advised that the workforce, services and society has seen an increased presentation of the transgender community. Several patients identified as "other". Actions included the delivery of briefings for key staff; the provision of advice and supporting documents and the development of a policy and guidance for patients and staff including conduct, and confidential handling. Further progress needs to be made in respect of increasing confidence in handing and in declaration of sensitive information.

5. Gender Pay Gap Reporting. It is now mandated that all organisations with 250 staff or more must have collected specific pay data details by gender for the year ending March 31st 2017 and publish the results in a report to a prescribed format that can be nationally benchmarked by March 30th 2018.

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

7. Review of Interpretation and Translation Policy - and contracted provision of Interpretation and Translation Services for patients or their principal carers - This aims to improve the service and the patient and workforce experience. It is particularly important for meeting language and literacy needs, for knowing and understanding options and processes, being able to make informed decisions about best treatment and for being able to give consent to surgery. Without this the quality of experience and performance for the patient and staff member will suffer as will access, inclusion, dignity and respect and fair treatment.

Accessible Information Standard (AIS)

The Trust advised in 2017 that the AIS involves the co-operation and response of all stakeholder organisations in the Trust's services in achieving a consistent approach to meeting information and communication support needs of patients, service users, carers and parents, in relation to disability, impairment or sensory loss. Successful implementation means consistently identifying, recording, flagging, sharing and meeting these needs. Considerable work was done in this area through a working group.

The work being done on translation and interpretation is also part of this as it deals with the language and literacy information and communication needs of diverse groups,

The Trust is ensuring continued stakeholder relationships through the proposed merger with Bedford Hospital and the strategic partnership approach with Milton Keynes Hospital. AIS is a prime consideration in the STP and new IT system planning. Also there will be changes to policy, procedure, practice and electronic systems as applicable.

EDHR is an important part of values and culture – work is underway to identify with the workforce a set of values that will form the basis of our culture and of our expectations of behaviour and conduct for staff.

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

There are planned seminars on EDHR for the Trust Board. This includes actions to improve equal opportunities and reduce discrimination such through annual data and analysis reports, staff survey results and what challenges and responsibilities these bring as well as Trans and Agender Awareness, EDHR. The annual data and analysis reports are also presented to, shared and discussed with the COSQ Committee and Clinical Board.

Equality Diversity and Human Rights Committee EDHR - We have a well-attended broadly representative committee from across the protected characteristics and roles – a key focus of this meeting was the annual reports / staff survey and WRES results. It is chaired by a non-executive director and 2 directors and an associate director attend.

EDHR Task and Finish Committee – an EDHR sub-committee has been set up whose Terms of Reference are to look at four staff survey indicators around discrimination, fair treatment, equal opportunity and conduct areas.

We are also looking at;

- **Access to non- mandatory training and CPD**
- **Pay Bands representation**
- **Recruitment and selection**
- **Board representation**

In addition to this we are using this Committee to roll out:

- **Declaration initiatives to improve disability, sexual orientation, religion or belief data**
- **Disability confidence – for both physical and mental disability**
- **Preparation for the Workforce Disability Equality Standard**
- **Preparation for Gender Pay Gap reporting.**

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

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

Equality and Diversity Data using Employee data as at 31st March 2018

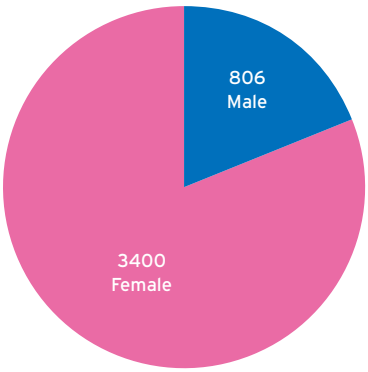
For the last 4 years the Trust has produced comprehensive Annual Equality Data Reports for the Workforce and for Patients. These can be viewed on the Equality and Diversity area of the Trusts website.

The information below shares some of the workforce data with analysis of what this data shows compared to last and previous year's annual reports.

Staff establishment

The number of staff at March 31st 2018 totalled 4206. This is against 3950 in 2017, 3813 in 2016 and 3880 in 2015. Relevant against this data is the fact that patients using the service or attendances accrue by circa 5% each year.

Workforce by Gender

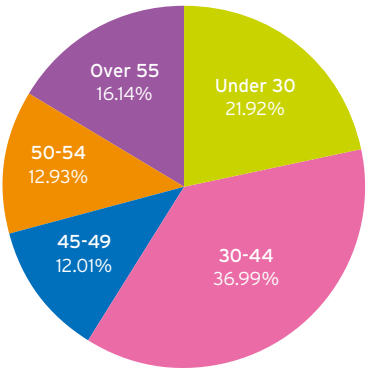


Gender - the ratio of male to female remains constantly close to circa 20% male to 80% female with this year's ratio at 19% : 81%.

Gender Pay Gap Reporting for year end March 31st 2017 - as already mentioned in this annual report, the Trusts first Gender Pay Gap Report was published in March 2018 and can be viewed on the Equality and Diversity Section of the Trusts website.

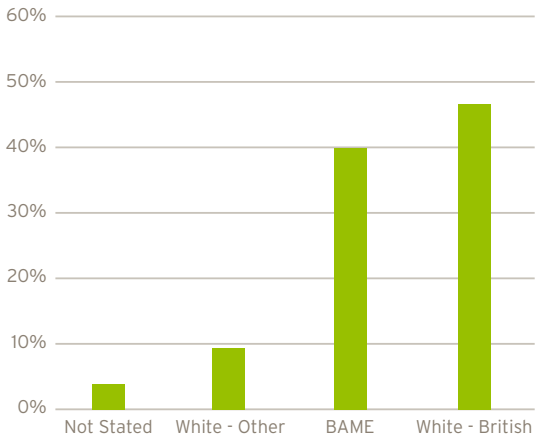
Age Profile - there is very little change in the annual data captured for age. The majority of staff are aged between 30-54 years of age. The challenge for the Trust remains the significant proportion of staff in the over 55 age range who may opt for retirement. Age is an area of high declaration as date of birth is required for all employees.

Workforce by age band



Ethnicity - this is an area of high declaration since only 3.49% did not declare last year and this year 4%. The proportions of staff in the 3 groups of White, Black Minority Ethnics (BME) and White Other remain comparable to last year at 47.82%; 38.9% and 9.77% respectively.

Workforce by ethnicity



Disability, Sexual Orientation and Religion or Belief Declaration – All these workforce areas have low declaration and there is both a need and initiatives planned to encourage more declaration to keep data capture relevant. This is the same position for patient declaration as these are deemed sensitive areas. More confidence is needed to ensure awareness of the purpose and importance off this data capture as well as the privacy given in its controlled and generic use.

Disability - As you can see from the details below there is still a high level of non-declaration of disability status at 35.6%.

	Percentage	Number
Disabled	2.03%	80
Not Declared	35.62%	1407
Not Disabled	62.35%	2463
		3950

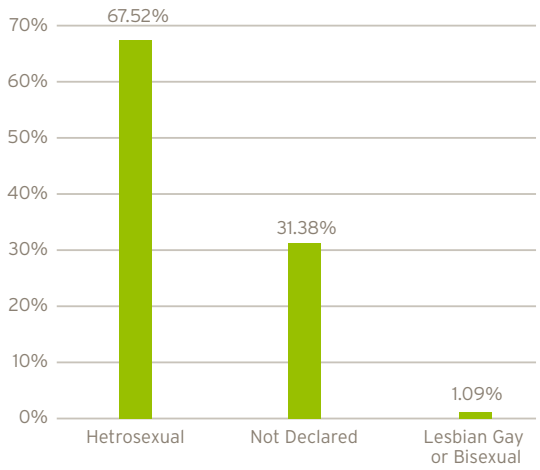
Religion and Belief - as can be seen from the data below the majority for declared religion or belief is Christianity at 42% and the next is Islam at 7%. However, non-declaration is 31.7% which affects the value of the data.

Jainism	8
Judaism	10
Buddhism	17
Sikhism	19
Hinduism	114
Atheism	287

Other	289
Islam	303
Undisclosed	1336
Christianity	1823
Grand Total	**4206**

Sexual Orientation - there has been little variation in the declared data for heterosexual and for Lesbian, Gay or Bisexual staff which is 67.5% and 1.09% respectively. The level of non- declaration is 31.38% which remains high and affects the validity of this data.

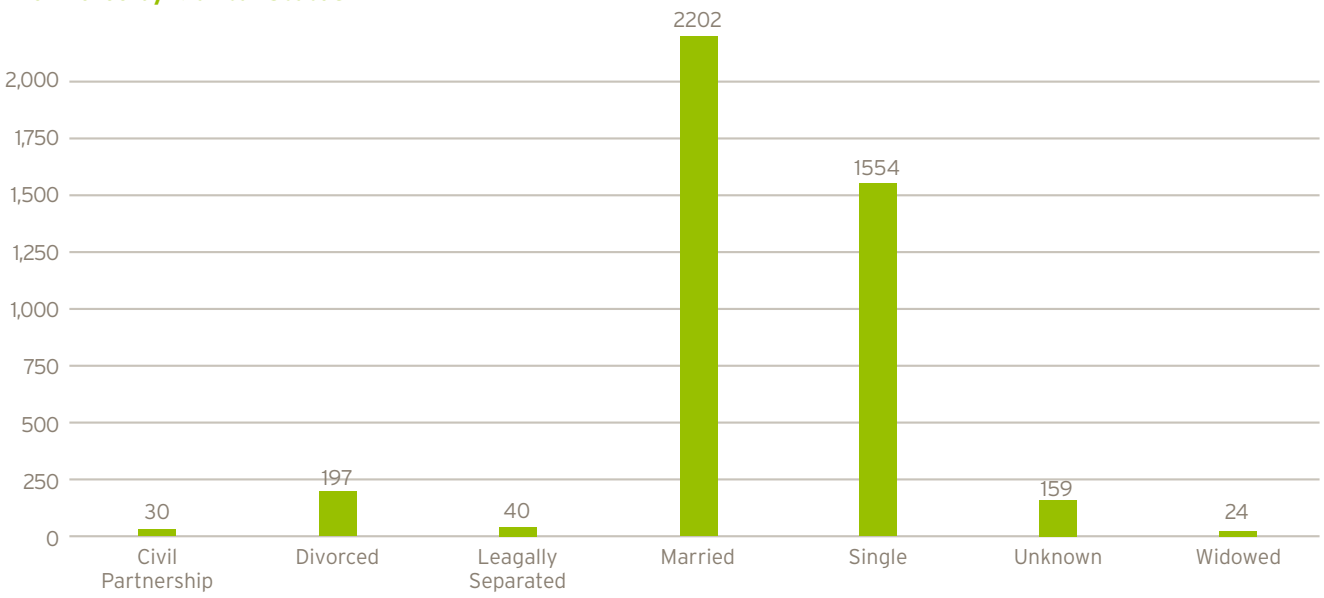
Workforce by Sexual Orientation



Transgender - Transsexual - in terms of "LGBT" considerations, these areas have been linked to sexual orientation initiatives. Both the workforce and patients have had a small number of transsexual and transgender people presenting. As for all areas there is sensitive and confidential handling of this data. Also there is awareness and consideration of the different descriptions that this group may prefer to use to describe their identity.

Partnership status - marriage and civil partnership - As can be seen from the graph below, the majority status for staff is still marriage at 52% followed by single at 37%. By ratios this is similar to last year's data across all categories with a proportional increase. There has been an increase in civil partnerships from 26 to 30 staff.

Workforce by Marital Status



Working with our Partners

The Trust contributes to nationally recognised and statutory partnerships through:

- Ongoing collaboration as part of the Sustainability and Transformation Plans (STP) and the Integrated Care Systems (ICS).
- Part of the Luton Provider Alliance with Luton Borough Council, Cambridge Community Services and East London NHS Foundation Trust.
- Work within the Local Maternity System for BLMK.
- A&E Delivery Board chaired by the L&D Chief Executive.
- Luton Transformation Board (including the Better Care Fund).
- Local strategic partnerships such as System Resilience Groups and Bedfordshire and Luton Local Resilience Forum.
- Local Safeguarding Children's Boards (LSCB) – Luton LSCB and Bedfordshire LSCB.
- Local Safeguarding Vulnerable Adult Boards for Luton and Bedfordshire.
- East of England meetings and events.
- Regular CEO meetings with Clinical Commissioning Groups (CCG) Chief Officers, Directors of Social Care and the Chief Officer of the Local Area Team.
- Better Care Boards with Local Authority and CCGs.
- Ongoing work improving communication across Luton and Bedfordshire with all stakeholders involved in the management of those patients on an end of life care pathway. The collaborative approach of sharing information through SystmOne (Primary Care Information system) will ensure care is timely and patients achieve their preferred place of death by enabling Trust staff access to the advanced care plans.

Governance Report

Board of Directors

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

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

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

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

Independent Professional Advice

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

The Role of the Chairman of the NHS Foundation Trust

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

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

The Role of Non-Executive Directors (NEDs)

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

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

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

Remuneration and Interests

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

Board of Directors 2017/18

Name	Post Held	Year Appointed	Term of Appointment	Status
Mrs Pauline Philip	Chief Executive	2010	Permanent	Seconded from 8th May 2017 Left 17th January 2018
Mr David Carter	Chief Executive	2018*	Permanent	Acting CEO 8th May 2017- 14th February 2018
Mrs Cathy Jones	Deputy Chief Executive	2018**	Permanent	Acting Deputy CEO 8th May 2017-7 March 2018
Mr Andrew Harwood	Director of Finance	2000	Permanent	
Mrs Sheran Oke	Acting Director of Nursing and Midwifery	2017	Interim voting	
Dr Danielle Freedman	Chief Medical Advisor	2015***	Interim voting	
Ms Angela Doak	Director of Human Resources	2010	Permanent	
Ms Marion Collict	Director of Operations and Risk	2017****	Permanent	Left March 2018
Mr Simon Linnett	Chairman	2014	3 Yr Fixed Term	To September 2020
Ms Alison Clarke	Non-Executive Director	2006+	Annual	To July 2017
Mr John Garner	Non-Executive Director	2012	3 Yr Fixed Term	To 1 May 2018
Dr Vimal Tiwari	Non-Executive Director	2012	3 Yr Fixed Term	To 1 May 2018
Mr Mark Versallion	Non-Executive Director	2014	3 Yr Fixed Term	To October 2020
Mr David Hendry	Non-Executive Director	2014	3 Yr Fixed Term	To October 2020
Mrs Jill Robinson	Non-Executive Director	2014	3 Yr Fixed Term	Left October 2017
Mr Cliff Bygrave	Non-Executive Director	2017	Interim voting	To March 2018
Mr Denis Mellon	Non-Executive Director	2017	Interim voting	From October 2017

* Appointed as Managing Director in May 2011 and seconded into Chief Executive in May 2018
** Appointed as Director of Strategic Development in ?? and seconded into Deputy Chief Executive in May 2018
Appointed as Chief Medical Advisor (at the L&D since 1985)
**** Appointed in October 2011 and became a voting Director in February 2017
\+ Reflects appointment to Board of Foundation Trust

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

Compliance with the NHS Foundation Trust Code of Governance

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

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

Independent Evaluation of Board Performance both Collectively and Individually

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

HM Treasury

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

Board Evaluation and Well Led Framework

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

The Trust understands and accepts that a periodic and rigorous board evaluation process represents best-practice and should be considered as part of any governance review. The last review took place in 2013. An evaluation was therefore due in 2016. However, it was agreed to postpone this to 2017/18 due to the CQC report received in June 2016 rating the Trust as outstanding in the Well Led domain. As plans progressed towards a merger with Bedford Hospital, this was further postponed and an evaluation planned 6 months post-merger. Following the agreement to delay the merger, a well-led self-assessment will be undertaken with the Board in early 2018/19.

The Board of Directors continued to hold a number of seminars throughout the year and to assess the strategic direction of the Trust and ensured that PricewaterhouseCoopers (PwC - internal audit) provided independent review of progress within the clinical divisions. The Board also take assurance from the CQC Report from June 2016 that rated the Trust as outstanding in the Well Led domain.

Trust Directors: Expertise and Experience

Executive Directors

Mrs Pauline Philip
Chief Executive – (to May 2017 to go on secondment and left in January 2018)

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

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

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

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

In December 2015, Pauline was appointed to the position of National Director for Urgent and Emergency Care on a part-time secondment from the Trust. David Carter, Managing Director acts up to cover her duties when she is not in the Trust and NHS England have provided financial compensation to provide for other necessary support. In May 2017, Pauline was seconded full time to the National Director role and David Carter became Acting Chief Executive. Pauline resigned from the Trust in January 2018.

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

Mr David Carter
Acting Chief Executive from May 2017-February 2018
Chief Executive from February 2018

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

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

Mrs Cathy Jones
Acting Deputy Chief Executive from May 2017 - February 2018 Deputy Chief Executive from March 2018

Cathy was appointed as Deputy Chief Executive in March 2018 and had been acting Deputy Chief Executive from May 2017. Her previous post was as Director of Service Development. Cathy joined the L&D in 2007 and has held various general management posts in the divisions of Medicine and Surgery. In August 2016 she was seconded to the Bedfordshire, Luton & Milton Keynes STP programme team as Programme Director for Secondary Care.

After completing her BSc in Physiology at the University of Liverpool, Cathy started her NHS career as an Information Analyst working for shared services in Hertfordshire, following which she spent three years at Northampton General Hospital working in Service Development. Cathy's particular interests are in service improvement and transformation, and she is strongly committed to maintaining the L&D's excellent reputation for delivery of high quality clinical services for our patients.

(Membership of Committees – CF, FIP, COSQ)

Mr Andrew Harwood
Director of Finance

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

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

(Membership of Committees – CF, FIP, HRD)

Dr Danielle Freedman
*Chief Medical Advisor**

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

She trained in medicine at the Royal Free Hospital School of Medicine, London University and then went on for further training in Clinical Biochemistry and Endocrinology both at the Royal Free Hospital and the Middlesex Hospital, London University.

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

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

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

*** Medical Directors David Kirby, James Ramsay and Robin White**

(Membership of Committees – CF, COSQ, HRD)

Ms Angela Doak
Director of Human Resources

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

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

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

Mrs Sheran Oke
Acting Director of Nursing and Midwifery

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

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

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

Ms Marion Collict
Director of Operations and Risk – to March 2018

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

(Membership of Committees – CF, COSQ)

Non-Executive Directors

Mr Simon Linnett
Chairman

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

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

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

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

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

Mr John Garner OBE
Non-Executive Director

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

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

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

John was also awarded an OBE for his services to children with special needs.

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

Dr Vimal Tiwari
Non-Executive Director

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

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

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

Mr Mark Versallion
Non-Executive Director

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

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

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

Mr David Hendry
Non-Executive Director

David was born in Luton and qualified as a Chartered Accountant with Whittaker &Co in Castle Street before gaining further professional experience with KPMG.

Following eight years in the profession he moved into the retail sector, firstly with BHS plc, where he went through a series of promotions ultimately heading the Finance Directorate and contributing to the company's significant turnaround. He was then recruited by TK Maxx as the US retailer's European Finance Director, helping them adapt and profitably grow the concept from four UK stores to 212 operating in three countries over the 11 years he was there.

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

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

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

Mrs Jill Robinson
Non-Executive Director To October 2017

Jill has a background in Financial Services and qualified as a certified accountant with Prudential plc. Having gained extensive financial, management and project accounting experience Jill moved into operational roles to use her accountancy skills and progressed to become Operations Director of Prudential Europe and then Operations Transformation Director for Prudential UK. Jill moved to Equitable Life Assurance Society as Operations Director where she was responsible for delivering two regulated projects allowing release of reserves of £540m, restoring stability to the servicing through the elimination of backlogs and resolving complaints within two days. From there she moved to Mercer as Partner, Head of Customer Service Delivery. Jill was responsible for the development of a new operational model, resulting in cost reduction of 30% and improvement of service level standards to 98%. Jill is currently Outsourcing and Finance Director for Marine

& General Mutual, setting strategy and effecting the sale of the company. Jill is passionate about enthusing teams to deliver improved services, at reduced cost, for the benefit of customers and considers it a privilege to be able to use her skills in the NHS for the benefit of patients and staff alike.

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

Mr Clifford Bygrave
Non-Executive Director To March 2018

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

Following his retirement as a partner at Ernst & Young, Clifford is now the National Finance Director of the Boys' Brigade. He has served on the Council of the Institute of Chartered Accountants in England and Wales for 23 years. He also represented the UK Accounting bodies on the International Federation of Accountants Ethics Committee for five years. In addition he represented his Institute in Brussels for a number of years. In view of his seniority on the L&D Board and his extensive governance experience Clifford was appointed as L&D's Senior Independent Director with effect from July 2007 until he retired in July 2015. In February 2017, Cliff was asked to return as an interim Non-Executive Director which he held until the end of March 2018.

Cliff is the Chair of the Charitable Funds Committee.

(Membership of Committees – AC, CF, FIP)

Mr Denis Mellon
Non-Executive Director From October 2017

Denis is a Fellow of Chartered Certified Accountants since 1972 and after qualifying as an accountant with Arthur Young and Co in Glasgow he spent two years with Price Waterhouse in Kingston, Jamaica. Denis gained an MBA at Cranfield Business School in 1986 and since then has worked in a number of senior management roles within a variety of private sector companies. He focussed on business strategy, relationship management, managing large logistics and customer service operations and as Managing Director of a group of fire equipment companies. In addition to the L&D. Denis was previously a Non-Executive Director then a senior General Manager to March 2017. He took up post as a Non-Executive Director again in October 2017.

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

Key to committees:

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

Record of committee membership and attendance

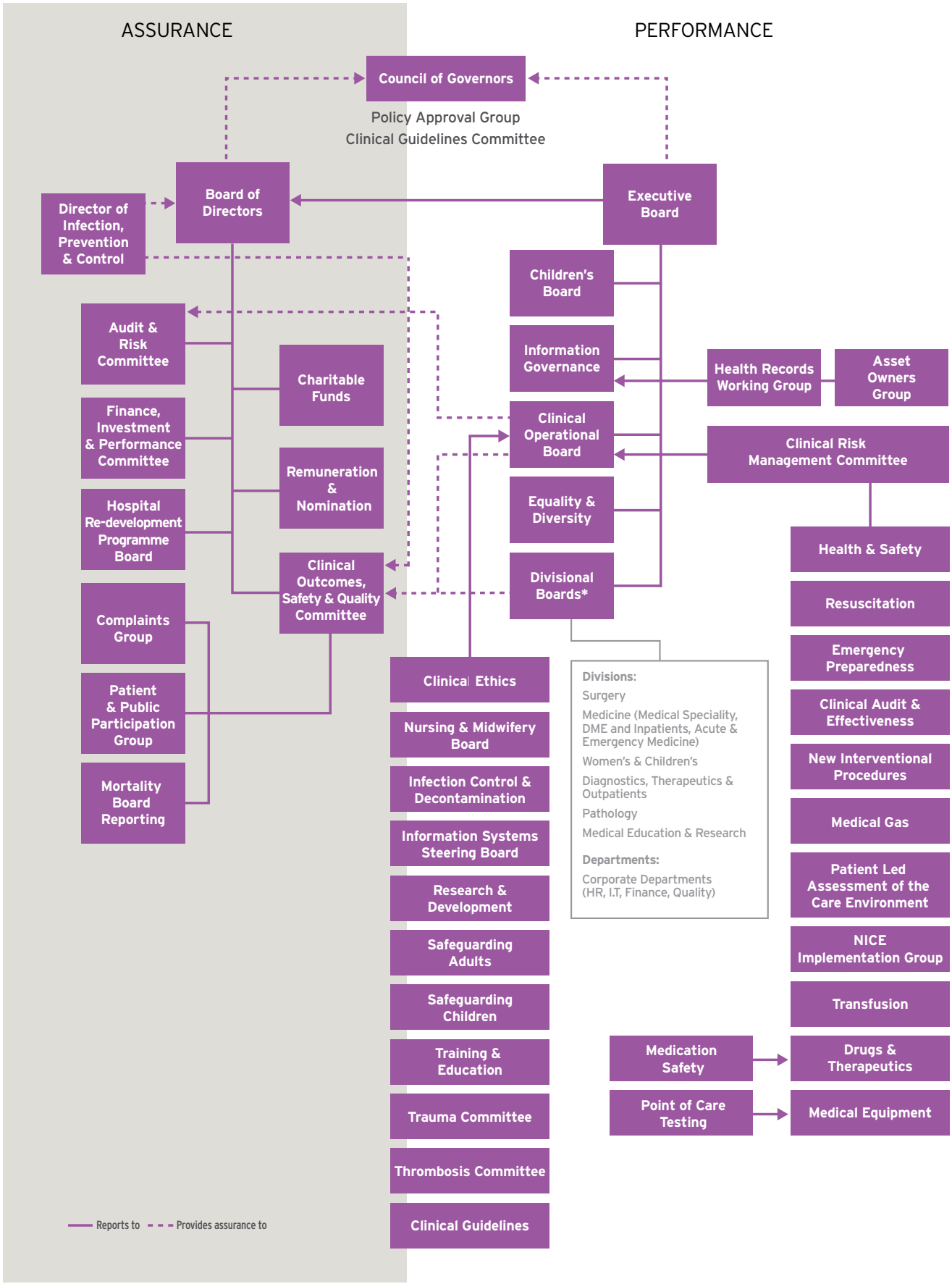
Total Meetings	Public Board Meetings	Private Board Meetings	Audit & Risk	Remuneration and Nomination	Charitable Funds	COSQ	HRD	FIP
Pauline Philip	0/1	1/3			0/1	1/1	1	1/2
David Carter	4/4	8/8			3/5	10/11	8/9	10/11
Simon Linnett	4/4	8/8		7/7	5/5		9/9	9/11
Andrew Harwood	4/4	8/8			5/5		8/9	11/11
Cathy Jones	4/4	8/8			1**	9/11		11/11
Sheran Oke	4/4	8/8			5/5	11/11	1**	5**
Angela Doak	4/4	8/8			4/5	9/11*		8**
Mark England	0/1	0/3					1/1	2/2
Marion Collict	3/4	7/8			0**	10/11		
Medical Directors	4/4	8/8			0**	11/11		1**
Alison Clarke	2/4	7/8	4/4	7/7	4/5	11/11		
John Garner	4/4	8/8	4/4	7/7	5/5		9/9	11/11
Vimal Tiwari	4/4	7/8	3/4	7/7	5/5	9/11		
Mark Versallion	3/4	6/8	3/4	7/7	4/5			9/11
David Hendry	4/4	7/8	4/4	7/7	5/5	8/11	9/9	11/11
Jill Robinson To September 2018	2/2	5/5	2/2	3/5	3/3			6/6
Clifford Bygrave	4/4	7/8	2/4	5/7	4/5			6/11
Denis Mellon from October 2017	2/2	3/3	3/3	2/2	2/2			5/5

* S Gitkin deputised

** Directors asked to attend by invitation should there be an agenda item that needs their attention. They remain a member of the committee should there need to be any formal approvals.

Committees of the Board of Directors

Luton and Dunstable Hospital Governance and Committee Structure



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

Audit and Risk Committee

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

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

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

Membership of the Audit and Risk Committee:

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

Audit and Risk Committee Report

The Audit and Risk Committee reviewed financial and operating performance and compliance against national and regulatory standards. A comprehensive work plan is agreed each year which ensures oversight and monitoring of risks, mitigations and issues relating to the financial statements, internal controls and compliance with regulatory, statutory responsibilities and internal policies and procedures which in turn enables action to be escalated as appropriate, i.e. officer attendance to explain critical risk or failure to implement internal audit recommendations and escalation to the Board where appropriate. An annual report of the Committee's activities and how the Committee has fulfilled its role is reported by the Chair of the Audit & Risk Committee to the Board and the Council of Governors. The Committee has had close oversight throughout the year of the Board Assurance Framework and principal risks on efficiency planning and sustainability. In depth reviews of Financial Governance and Delivery of the Financial Plan, Cyber Security, Delivery of the Financial Savings Scheme, A&E Departmental activity recording, Pharmacy Purchasing and Inventory Management, Serious Incidents and Never Events and Delivery of the Corporate Plan. The final report from 2016/17 Medical Devices review was also presented and a review undertaken of the Discharge Planning process. In relation to CQC compliance with care standards, the Committee reviews regular reports from the Clinical Outcome Safety and Quality Committee and ongoing Quality Improvement initiatives.

Internal Audit

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

External Audit

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

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

The External Audit programme is scheduled to focus on key areas of risk and for 2017/18 the areas of audit risk were:

- The valuation of land and buildings
- The valuation and existence of NHS and non-NHS receivables and completeness, existence and accuracy of NHS and non-NHS income
- The fraud risk from revenue recognition
- The fraud risk from management override of controls

The ISA260 report presented on the 16 May identified that there were no material concerns or control weakness identified during the year.

The appointment of the auditor was made in 2012 as a result of a competitive process under a procurement compliant framework. The appointment was extended in 2014, 2016 and 2017 on the same terms. Each appointment is subject to Council of Governors agreement. Reports from External Audit are received and reviewed at each Audit and Risk Committee to assess the effectiveness of the external audit programme. External Audit confirmed they were able to complete the required testing against the controls in the fee agreed with the Trust.

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

KPMG LLP have also provided tax advice on an ad hoc basis during 2017/18 totalling £18,000 (excluding VAT). Each assignment was subject to an individual engagement letter and undertaken by a separate division within the organisation thereby avoiding any objectivity or independence issues.

Remuneration and Nominations Committee

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

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

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

Membership of the Remuneration and Nominations Committee:

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

Charitable Funds Committee

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

Key responsibilities are to:

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

Membership of the Charitable Funds Committee:

The Charitable Funds Committee membership has been drawn from Board members and is chaired by Mr Clifford Bygrave (NED).

Clinical Outcome, Safety and Quality Committee

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

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

Membership of the Clinical Outcome, Safety and Quality Committee:

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

Finance, Investment and Performance Committee

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

Membership of the Finance, Investment and Performance Committee:

The Finance Investment and Performance Committee membership included Board members, senior managers and clinicians and was chaired by Mrs Jill Robinson (NED) until October 2017 and from November 2017, Mr Denis Mellon (NED).

Hospital Re-Development Programme Board

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

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

Membership of the Hospital Re-Development Programme Board:

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

Council of Governors

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

1. The Membership;

2. The Council of Governors; and

3. The Board of Directors

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

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

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

In addition:

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

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

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

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

The Council of Governors was chaired by Mr Simon Linnett. Council of Governor meetings are held at least three times in each financial year and are open to the public and representatives of the press. Since February 2016, the Council of Governors met formally quarterly and in seminars in the intervening months. This provided opportunity for the Governors to hold meetings with just the Non-Executive Directors to question performance and hold them to account.

In October 2017 the Council of Governors re-elected Mr Roger Turner as Deputy Chair/Lead Governor of the Council of Governors for a term of two years. The Deputy Chairman or Lead Governor of the Council of Governors presides as chair of any meeting of the Council of Governors where the Chairman presiding at that meeting in terms of a conflict of interest (section 12.29 of the Constitution). The Lead Governor is also the nominated person that NHS Improvement would contact in the event that it is not possible to go through the Chair or the Trust's Secretary.

The Council of Governors met seven times during 2017/18 and the attendance is recorded.

Register of Interests of the Council of Governors' Members

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

Elections

Our annual elections to the Council of Governors were held during May – August 2017. Electoral Reform Services (ERS) were our independent scrutiniser to oversee the elections, which were held in accordance with the election rules as stated in our constitution.

The following constituency seats were filled by uncontested candidates

- Staff: Medical and Dental

The following constituency seats were filled by election

- Public: Luton
- Public: Bedfordshire
- Public: Hertfordshire

Analysis of Annual Election Turnout:

Date of election	Constituencies involved	Number of members in Constituency	Number of seats contested	Number of Candidates	Election turnout %
August 2017	Public: Luton	6,890	3	11	16.38%
August 2017	Public: Bedfordshire	3034	3	8	19.15%
August 2017	Public: Hertfordshire	1596	1	2	17.73%

The Trust annual elections to the Council of Governors are held during May – July and the elected candidates initiate their terms from September. The average turnout is around 17%. For each election the Trust requests a voter profiling report to identify whether there are any issues with diversity. During 2017/18, the Trust continued to offer five languages to the letter and envelope and members could request translated packs. However, there were no requests for these packs and voter turnout in the minority groups in Luton remained low.

Governors in post – April 2016 to March 2017

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Appointed Governors					
Luton CCG	Colin Thompson	Appointed from June 2016	Resigned January 2018	3 years	0/3
	Nicky Poulain	Appointed from February 2018	Start of 1st term	3 years	0/0
Bedfordshire CCG	Vacant				
Hertfordshire CCG	Vacant				
Central Bedfordshire Council	Cllr Brian Spurr	Appointed to May 2020	Start of 1st term	3 years	3/4
Luton Borough Council	Cllr Ayub Hussain	Appointed to 2018		3 years	1/4
University College London	Prof Ann Blandford	Appointed to 2020	Resigned February 2018	3 years	1/3
University of Bedfordshire	Bill Rammell	Appointed to 2021	Start of 1st term	3 years	0/0
Public Governors					
Hertfordshire	Mr Donald Atkinson	Elected to 2018		3 years	4/4
	Ms Helen Lucas	Elected to 2018		3 years	3/4
	Mr Malcolm Rainbow	Elected to 2020	Start of 1st term	3 years	2/4

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Bedfordshire	Miss Dorothy Ferguson	Elected to 2018		3 years	4/4
	Ms Jennifer Gallucci	Elected to 2018		3 years	3/4
	Ms Linda Grant	Elected to 2020	Start of 1st term	3 years	2/2
	Mr Ray Gunning	Elected to 2018		3 years	3/4
	Mrs Sue Steffens	Elected to 2019			4/4
	Mr Jim Thakoordin	Elected to 2020	Start of 1st term	3 years	0/2
	Mr Roger Turner	Elected to 2020		3 years	3/4
Luton	Mr Keith Barter	Elected to 2020	Start of 1st term	3 years	1/2
	Mrs Pam Brown	Elected to 2019		3 years	4/4
	Ms Marie-France Capon	Elected to 2018		3 years	2/4
	Mrs Susan Doherty	Elected to Sept 2020		3 years	4/4
	Mr Sean Driscoll	Elected to 2019		3 years	4/4
	Mrs Judi Kingham	Elected to Sept 2020		3 years	3/4
	Mr Henri Laverdure	Elected to Sept 2019		3 years	4/4
	Mr Anthony Scroxton	Elected to 2019		3 years	3/4
	Mr Derek Brian Smith	Elected to 2018		3 years	4/4
	Mr Jack Wright	Elected to 2019		3 years	4/4
	Mr Mohammed Yasin	Elected to 2019		3 years	3/4
	Mr Shaobo Zhou	Elected to 2018		3 years	2/4
Staff Governors					
Admin, Clerical and Management	Mr Jim Machon	Elected to 2018		3 years	2/4
	Mrs Ros Bailey	Elected to 2019		3 years	3/4
Nursing and Midwifery (including Health Care Assistants)	Mrs Belinda Chik	Elected to 2018		3 years	4/4
	Mrs Ann Williams	Elected to 2018		3 years	3/4
	Mrs Marva Desir	Elected to 2019		3 years	2/4
Volunteers	Mrs Janet Graham	Elected to 2018		3 years	3/4
Medical and Dental	Dr Ritwik Banerjee	Elected to 2020	Start of 3rd term	3 years	3/4
Ancillary and Maintenance	Mr Gerald Tomlinson	Elected to 2019		3 years	2/4
Professional and Technical	Ms Cathy O'Mahony	Elected to 2018		3 years	3/4

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

Council of Governors Sub Committees

There are three sub-committees of the Council of Governors

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

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

During 2017/18 the committee met five and has completed the following activities:

- Approved the remuneration and allowances for the Non-Executive Directors.
- Completed the process to be able to recommend to the Council of Governors Non-Executive Directors.
- Initiated a recruitment programme for Non-Executive Directors.

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

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

During 2017/18 the committee met three times and has completed the following activities:

- Issued two *Ambassador* newsletters.
- Reviewed the Membership Strategy.
- Supported the two Medical Lectures on Stoma Care and Dementia.
- Supported the Annual Member's Meeting.
- Visited locations across the catchment to increase membership.
- Put in place an extensive membership drive to support the merger with Bedford Hospital from October 2017 that resulted in 1500 members from Bedford Borough and a considerable increase from those who live in Central Bedfordshire.

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

- To ensure that the Constitution is up to date with new developments.
- To review the Constitution at least annually.
- Recommend amendments to the constitution to the Council of Governors;
- Liaise with Monitor and legal representatives when required.
- Report to the Annual Members Meeting to approve any Constitutional amendments.

During 2017/18 the committee met three times and agreed a number of improvements to the current constitution that were agreed by the Council of Governors and the Board of Directors. None of the amendments affected the powers of the governors.

Foundation Trust Membership

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

i) Luton
ii) Bedfordshire
iii) Hertfordshire

The Trust currently has 18,643 members (13,614 public and 5,029 staff). The FT public membership numbers increase around 3% each year and the Governors set a target of 600 new members annually. The Governors agree a Membership Strategy through the Council of Governors and follows six key objectives:

1. *To increase the membership* - The strategy outlines more focussed work on recruiting members in Bedfordshire with an engagement approach to the Luton and Hertfordshire membership. During 2017/18 this was amended in response to the proposed merger between the L&D and Bedford Hospital NHS Trust. Work was undertaken to sign up members from Bedford Borough and surrounding counties including Central Bedfordshire. This will continue.

2. *To ensure membership diversity* - A review of the diversity of the membership identified that an increase the number of younger members was required. The Trust has made links with the Youth Parliament and Apprenticeship scheme. However increasing the numbers has been challenging.

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

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

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

Strategy for 2018/19

The strategy will be reviewed in May 2018 by the Membership and Communication Sub-Committee to identify the plans for 2018/19. The committee will consider the objectives to include:

- Forecast a small increase in membership due to the focus on increasing the membership of new constituencies in relation to the proposed merger.
- Further increase the membership and hold engagement events in Bedfordshire.
- Target key membership groups to discuss becoming Governors.
- Encourage members to vote for their preferred candidates in the elections.

During 2018/19, there are 13 vacancies; 8 Public Governors (3 Luton, 3 Bedfordshire and 2 for Hertfordshire) and five Staff Governors (2 Nursing and Midwifery, 1 Admin and Clerical, 1 volunteers, 1 professional and technical). The Trust, in conjunction with the Council of Governors and the Board of Directors, is reviewing the Constitution in light of the STP, potential mergers and consideration to the annual election taking place.

Table 1: Membership size and movement:

Public constituency	2017/18 (Plan)	2017/18 (Actual)	2018/19 (Plan)
At year start (April 1)	12,510	12,510	13,614
New members	600	1474	600
Members leaving	200	370	200
At year end (March 31)	12910	13,614	14,014
Staff constituency *			
At year start (April 1)	4519	4519	5029
New members	888	1520	975
Members leaving	736	1010	747
At year end (March 31)	4671	5029	5257
Total Members	17581	**18643**	**19271**
Patient constituency			
Not applicable			

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

Table 2: Analysis of current membership:

Public Constituency	Number of members	Eligible membership+
Age (years):		
0-16	1	370494
17-21	47	91899
22+	9214	1213129
Unknown	4352	
Ethnicity:		
White	6425	1327296
Mixed	87	40567
Asian or Asian British	1706	139935
Black or Black British	527	54924
Other	385	10922
Unknown	4484	
Socio-economic groupings * :		
AB	3461	132796
C1	3947	154585
C2	2941 -	 94527
DE	3229	94885
Unknown	36	
Gender analysis		
Male	5099	834703
Female	8444	858819
Unknown	71	
Patient Constituency		
	Not applicable	

Analysis excludes: 4352 members with no date of birth, 71 with no stated gender, 4484 with no stated ethnicity, and 36 with no stated socio-economic grouping.

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

Notes:

TOTAL - Eligible members:

AGE:	1,675,522
Ethnicity:	1,573,644 **
Socio-economic:	476,793 ***
Gender:	1,693,522

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

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

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

Governor Training, Membership Recruitment and Engagement

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

- Medical Lectures – the Trust held two lectures on key topics identified by the Governors – Critical Care and Stroke. Trust clinical staff presented to 150 or more members at each session.

- Engagement Events – engagement events were held across the Trust to support the Governors and Trust staff to engage with the public.

- Annual Members Meeting – the Trust had over 150 people at the Annual Members Meeting in September and it is considered an excellent event by those that attend.

- Membership recruitment – all Governors are involved with recruiting members. This ranges from visiting GP practices, attending events such as at the Chamber of Commerce and linking with local groups like the Women's Institute. A sub-committee of the Governors oversee this programme to ensure there is diversity of approach and this year we achieved our target of 600 new members. There has been an extensive programme of work to increase membership of a potential new constituency of Bedford Borough and this has involved engaging with the Charity and Patient Council of Bedford Hospital.

- Ambassador Magazine – The Trust issued two 20 page magazines – August 2017 and March 2018 and provides the opportunity for the Governors to report back to the members about Trust progress, Governor involvement and how the Governors are holding the Non-Executive Directors to account.

- Being a Governor awareness sessions – The Trust offers awareness sessions for those interested in becoming a governor. These are held twice a year in April and October and also on a one to one basis as required.

- Governor training – Training is accessible to all Governor through NHS Providers GovernWell programmes. Additionally, joint training sessions with Milton Keynes Governors are taking place. This was an opportunity for the L&D Governors to network and share ideas. The Trust plans to continue this programme for 2017/18 especially in line with the STP activities.

Contact Details

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

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

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

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

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

Financial Performance Report

Review of Financial Performance

A financial surplus for the 19th successive year was achieved with a 2017/18 surplus of £15.4m. Whilst our surplus is in line with our Annual Plan, delivering it relied on non-recurrent items to offset the additional costs of temporary staffing that are very much part of the challenging environment in which the Trust operates. It should be noted that the £15.4m surplus includes a £13.3m performance bonus (known as Sustainability & Transformation Funding) which recognised the achievement of agreed performance and financial targets.

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

Furthermore it should be acknowledged that during latter half of the year the hospital was put under an unprecedented and sustained amount of pressure driven by record emergency attendances, a lack of community bed provision and increased demand for services over the winter period.

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

Fig £m	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Turnover	153.2	169.1	189.3	204.9	211.6	220.8	230.6	244.3	259.2	271.2	308.8	334.1
Surplus	2	2.9	4.3	3.1	2.6	2.5	0.9	0.4	0.1	0.1	12.9	15.4
Cash	18.8	35.4	45.4	43.7	50.9	47.6	37.5	24.8	11.7	9.1	28.2	36.4

All figures £m

Cash balances continued to be monitored closely, with the FT ending the 2017/18 financial year with a balance of £36.4m. This was more than expected and arose as a result of both an increased surplus (arising from bonus Sustainability and Transformation monies received for delivering the Control Total) and some slippage on our capital expenditure programme. The increased cash balance will enable the FT to address a range of site backlog issues (currently totalling £60m) in the future.

The FT has spent nearly £12m on capital in 2017/18 to deliver modern NHS services. Notable developments include a new Maxilliofacial Unit, improvements to the current NICU environment, more than £2m on medical equipment, the installation of a new pathology information system, initial improvements to the Imaging department (including 2 refurbished and 1 new MRI scanner) and the early development phase of a £10m Global Digital Excellence project.

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

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

Going Concern

In 2018/19 the FT will continue to face, along with all other providers, a challenging financial environment. Despite this the FT has submitted a surplus plan for 2018/19 to NHS Improvement, albeit one that contains substantial risk and requires collaboration with NHS leadership organisations to deliver it. After due consideration, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

Key Variances from the Plan in 2017/18

In 2017/18 the Trust was disadvantaged by the twin impact of managing an unparalleled volume of emergency activity during the winter period at a premium cost and the consequential loss of substantial amounts of elective surgical activity.

During 2017/18 the Board became aware that anticipated demand management initiatives identified by commissioners were not materialising as expected. This meant that the Trust was required to increase staffing to accommodate patient need. This led to a substantial unplanned agency pay bill, particularly in relation to medical staff.

This mismatch between CCG anticipated patient numbers and actual growth in patient activity in 2017/18 has given rise to substantial over-performance within the contract, particularly for non-elective workload.

The Board of Directors continued to review the position of the hospital site developments in 2017/18 in order to achieve increased value for money, operational efficiency and effectiveness. It was determined that a more considered approach to major investment was required – particularly in light of the challenges facing the NHS locally and nationally. Accordingly the Board received a full business case that dovetails in with early strategic changes that emerged from the work on the BLMK STP.

Principal Risks and Uncertainties facing the Trust

Looking forward, our main commissioners benefit from both growth per capita and overall growth on their CCG allocations for 2018/19. Nevertheless our commissioners, when compared to their peers, remain behind a 'fair share' funding position. This position is compounded by an expectation that our two main commissioners repay historic debts.

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

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

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

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

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

Remuneration report

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

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

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

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

There were no pay inflation increases for 2017/18.

Assurance on Very Senior Managers (VSM) Pay

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

During 2017/18 the Committee sought assurance by:

- Participating in the annual benchmarking exercise through NHS Providers, the results of which showed are salaries to be in line with other similar Trusts.
- Working with an external consultant to benchmark appropriate salaries.
- Ensured that NHS Improvement were informed of any VSM.

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

David Carter
Chief Executive
23rd May 2018

Fundraising and Charitable Donations

During the 2017/18 financial year the Luton and Dunstable Hospital Charitable Fund received £1,029,294 from 1245 donations from grant-giving trusts, companies, individuals, community groups and legacies.

Of the income, 75% of income was from Charitable Trusts, 11% was from individuals, 6% from events, 4% from legacy and IMO donations and 2% was from companies. The charitable trust figures are higher than usual, as £500k was received from The County Air Ambulance Trust, as part of their £2m pledge towards the new Helipad appeal.

Legacy donations received totalled £18,085 from three separate legacies gifted to benefit the hospital's general fund and also the Diabetes Unit. We also received £32,984 in In Memory donations. Legacies play a key part in shaping the Hospital for future generations. We are planning to host our first legacy event on 21st June 2018. We are currently aware of three legacies going through legal release.

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

This financial year we have appointed a Community Fundraiser to secure community links and promote the charity to schools, community groups, and small local companies. So far they have been engaged with 16 schools, 17 community groups and attended 10 community events with a promotional stand. This role is vital in the growth of the charity and creates lots of positive PR for the hospital.

The Child Oncology room's appeal has been a major success this financial year, with over 80% of the total needed raised. The NICU (Neonatal Intensive Care Unit) still continues to be one of the most supported funds from the local community, current and past patients. It has received 480 donations during 2017 / 2018 totalling £71,605. All of the 2017 Christmas campaigns fundraising income was allocated to the on-going costs of the Parents Facilities. Light up a Life raised £4,000.

We have just launched the new appeal for an onsite helipad. The County Air Ambulance charity has offered to contribute £2m towards this project.

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

- NICU nursery, refurbishment of breast feeding room and overnight room, so that parents with very sick babies can stay on hand or in some circumstances room in with them.
- Wheelchairs, with additional comfort and leg support
- CPAP cardiac device, treating obstructive sleep apnea for cardiac inpatients.
- Renovate the consultation room in breast screening, improving the environment for breast patients.
- Retinal camera, for neonatal and paediatric patients.
- Supporting staff wellbeing by funding the CIC staffs support service, thank you event and Well-being event.
- Patient welcome packs, so that patients who come in as an emergency have access to an overnight kit.
- Ultrasound scanner for breast cancer surgery, enabling surgeons to scan onsite before a procedure.
- Update the Oral Maxillofacial unit, making it a nicer environment for patients.
- New anaesthetic devices.

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

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

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

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

Property Plant and Equipment and Fair Value

As stated in note 1.5 to the accounts, Property Plant and Equipment are stated at Fair Value which is defined as the lower level of replacement cost and recoverable amount. A review is carried out each year for any potential impairment, with a formal revaluation every five years. A full property valuation as at 31 March 2018, was undertaken by Gerald Eve LLP. The Directors' opinion is that there are no fixed assets where the value is significantly different from the value included in the financial statements.

External Auditor

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

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

Private Finance Initiatives (PFI Schemes)

We have two capital schemes arranged under the PFI:

1. 1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 12 years remaining.

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

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

Better Payment Practice Code

We are continuing to maintain cash balances within the needs of our suppliers, settling 87% of non-NHS invoices within 30 days of receipt of a valid invoice

2017/18	Number of invoices	Value £000s
Total Non-NHS trade Invoices paid in the year	81,362	£110,123
Total Non-NHS trade Invoices paid within target	70,909	£92,852
Percentage of Non-NHS trade Invoices paid within target	87%	84%

Off Payroll Engagements

NHS Foundation Trusts are required to disclose the information in the tables below about off-payroll engagements. There is a nil return for 2017/18.

Table 1: For all off-payroll engagements as of 31 March 2018, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2018	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

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

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	0
Number for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

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

Counter Fraud

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

Data Loss

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

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

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

Summary of other personal data related incidents in 2017-18

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

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

Summary of incident requiring investigations involving personal data as reported to the information commissioner' office in 2017/18

Date of Incident (Month)	Nature of Incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
October 2017	Documents found in public car park	Clinical information	12	Reported to the Information Commissioners Office as a level 2 incident
February 2018	Theft of Laptop	Names and Date of Birth	Approx. 950	Reported to the Information Commissioners Office as a level 2 incident

Annual Governance Statement and Accounts

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

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

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- assess the Group and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of its services to another public sector entity.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Signed

David Carter
Chief Executive
Date:23rd May 2018

Annual Governance Statement 2017/18

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Luton and Dunstable University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

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

Risk management training sessions are provided to staff as required.

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

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

The risk and control framework

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

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

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

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

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

L&D Top 5 Risks (Summary)

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Clinical Operational	4. Workforce Pressures 5. Capacity pressures and responding to demand 6. Implementation of integrated care 7. The need for robust and whole system working	High	High	Workforce plans in place Board approved action plans with Trust partners where appropriate Needs Based Care initiative Ongoing collaborative work with BLMK STP and Local Health system, in particular Bedford Hospital, to improve	Weekly Senior Team and Executive meetings Monthly Clinical Outcomes, Safety & Quality Committee Board of Directors strategic oversight

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Finance	Delivering the financial challenge in 2018/19 including Commissioner plans, agency spend and CQUIN	High	High	Monthly review of key income, expenditure, capex, cash, balance sheet and quality performance metrics Monthly performance review meeting with Divisions led by Executive Directors	Monthly reports of cumulative financial performance incorporating clear forecasting and an alert mechanism to identify issues that allow corrective action Monthly Finance, Investment & Performance committee review Introduction of Monthly Service Line Executive Review Framework
Present Hospital Campus	Going forward the Trust site will not be consistent for capacity or clinical requirements for good patient care. Backlog Maintenance	High	High	Robust management and governance arrangements in place to manage ongoing risks and hospital re-development project Finance, Investment and Performance Committee (FIP) oversight of backlog maintenance plans and strategy Progression of Business Case for Acute Services Block via BLMK STP	Board review of Full Business Case and approval of actions arising from STP applications process and through the Merger process with NHSI Finance, Investment & Performance committee review
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legalisation	High	Moderate	Board approved action plans in place	Regular monitoring / Assurance from Board Sub-Committees
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event	High	Low	Ensure that the Emergency and Business Continuity plans are frequently reviewed, communicated and understood by key staff	Ongoing review and testing of Business Continuity plan relevant adaptation of plans Oversight by Board Sub group

Incident reporting is actively promoted and encouraged across all directorates as part of the culture of the organisation. The Trust actively promotes a culture of 'fair blame' or 'just blame', to encourage staff to report incidents. Incidents that have a significant impact on the Trust, its business or an individual are immediately and thoroughly investigated and the lessons learnt are shared across the Divisions. Risks to data security are managed through a security risk register and through incident reporting. Mitigating actions are reviewed through the Information Governance Steering Group and reports to the Executive Board. Duty of Candour is also complied with for all incidents and above that result in moderate or severe harm.

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

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

- Risk management is integrated into core Trust business in relation to equality impact assessments. All policies and procedures when created or reviewed have to include an Equality Analysis Form. If there are any negative impacts on a particular group of people/ equality group following the completion of this form, the Trust will record any changes to the service and/ or policy. Any actions will be integrated into existing service planning and performance management frameworks along with monitoring and review processes.

- Business cases include a risk analysis both financially and clinically.

During the coming year the Trust will continue to embed a culture of external review and engagement of independent expertise to facilitate greater objectivity and learning;

- During the year in addition to using the services of internal and external audit, a number of specific reviews were commissioned.

- The Trust received an external CQC visit and the report received in June 2016 identified the Trust as 'good' with the Well-Led element of the assessment as 'Outstanding'.

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

No enforcement action has been taken against the Trust during the reporting period April 1st 2017 and 31st March 2018 and we have not participated in special reviews or investigations by the CQC during the reporting period.

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

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?

- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?

- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.

- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.

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

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016.

A programme of communication to all staff was undertaken and action plans put in place across the domains. The action plans are monitored by the Clinical Outcome, Safety and Quality Committee on a quarterly basis.

We have in place a CQC self assessment programme for all wards and clinical areas. This involves a three month cycle of self assessment, peer assessment and external peer assessment to support the delivery of performance and the implementation of corrective action in a timely manner. We have reviewed our CQC assessment programme to reflect the revised CQC inspections and these assessments are reported to each Board of Directors meeting.

Non-Executive Assessments (3x3)

The assessment process is further enhanced by Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards. Our Clinical Outcome, Safety and Quality Committee (COSQ) receive these assurance reports.

Transforming Quality Leadership 'Buddy' System

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

The Trust promotes the involvement of patient representatives to ensure the quality of performance data and to triangulate feedback and reviews in many aspects of its activities. Patients and Governors are represented on the following committees:

- Equality and Diversity Committee
- Clinical Audit and Effectiveness Committee
- Patient and Public Participation Group
- PLACE (Patient Led Assessment of the Care Environment)
- Ethics Committee
- Transforming Outpatients
- Hospital Re-Development Board
- Car Parking Working Group
- Re-Engineering Group
- Safeguarding Adults
- Carbon Management

Healthwatch monitor the services provided by the Trust and report directly to the Chief Executive and issues are then referred to appropriate Directorate for consideration and action. Representatives from Luton Healthwatch are members of the Trusts Patient and Public Participation Group. The National Patient Survey action plan is also progressed and monitored through this group. Healthwatch have been involved in the development and assurance of the Quality Accounts.

Since becoming a Foundation Trust the organisation has extended the involvement of staff and the public by creating a Council of Governors. The Council of Governors is responsible for a wide range of duties including, but not exclusively, being consulted on health service changes, meeting with members in their constituency, appointing and holding to account the Chair and Non-Executive Directors and attending Council of Governors' meetings. The Governors include representatives from other key stakeholders such as the CCGs, Local Government Councils and Universities.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments in accordance with emergency preparedness and civil contingency requirements, to ensure that the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Delivery of the Carbon Management Plan is ongoing: the Trust reports on progress with carbon reduction within the Operational Performance section of this report.

Review of economy, efficiency and effectiveness of the use of resources

In addition to the financial review of resources within the quarterly monitoring returns to NHS Improvement and the monthly financial information provided to all budget holders, the processes that have been applied to ensure resources are used economically, efficiently and effectively include Clinical Audit and Effectiveness, Medical Equipment and Medicines Management. The Trust has governance arrangements for the Finance, Investment and Performance Committee with Divisions presenting directly to the committee on a range of financial and operational matters.

A Clinical Audit and Effectiveness Department is also maintained to:

- Oversee the implementation of National Institute of Clinical Effectiveness (NICE) guidance.

- Monitor the introduction of new techniques ensuring clinical and cost effectiveness of new treatments, as well as the appropriate training of clinicians.
- Support clinical audit work within the Trust, ensuring clinicians work in the most effective way, adopting good practice uniformly across the Trust through protocols and guidelines.

The use of management groups charged with monitoring efficiency and effectiveness as part of their terms of reference:

- The Executive Team review the capital bids.
- The Medical Equipment Group advises on the replacement and purchase of new medical equipment.
- The Medicines Management Group oversees the maintenance and development of the drug formulary to ensure clinically appropriate and cost effective use of medicines.

The Trust's efficiency is quantified annually through the national reference costs exercise. The latest published index for the Trust is 89 (based on 2015-17 accounts and activity) compared to a national average index of 100.

The Trust is also engaging in a range of benchmarking exercises to determine best practice and assess the means of implementing it at the L&D for example the Carter Review.

Information Governance

The Trust has had two grade 2 information governance incidents in relation to a confidentiality breach that were both reported to the Information Commission Officer (ICO). One event from October 2017 was closed with no further action and the other event from February 2018 has been received by the ICO and they are considering the next steps.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Account is the responsibility of the Director of Nursing and Midwifery supported by all of the Executive Team and is written following guidance issued by NHS Improvement. Processes put in place via the Information Governance Toolkit, led by the Director of Information Technology, as Senior Information Risk Owner (SIRO), provides assurance that the Trust's Data Quality is reviewed and monitored.

For 2017/18 the Chief Executive, Director of Nursing and Midwifery along with the Associate Director of Nursing for Quality and Patient Experience completed an extensive consultation programme to develop the Quality Strategy and engaged with Trust staff and Trust Governors to review the priorities over the coming years. This was launched at our Staff Engagement Event in December 2017.

Through the Information Governance Toolkit, the Trust has a number of key information policies in place including data quality that sets out the roles and responsibilities.

The Trust has three reports that feed data into the Board of Directors; the Quality and Performance Report, Finance Report and Workforce Report. Each of these contains data that is tracked over months and years to identify variances.

The Trust monitors Dr Foster alerts through the Mortality Board, Clinical Operational Board and Clinical Audit and Effectiveness Committee. Clinical Audit forward plans detail the work undertaken to review the data quality of these alerts. Annually the Trust has an external audit of clinical coding that demonstrated excellent practice and an external peer review of Information Governance that demonstrates assurance against the Information Governance Toolkit that includes Data Quality.

The Trust reviews directorate dashboards e.g. maternity to collect data at source and monitors the effectiveness of central data through the SUS (Secondary Uses Service) reports. The Trust monitors key performance indicators in relation to data quality that demonstrates improving practice across the Trust.

18 week data is generated by the Information Department on a weekly and monthly basis and then actively used by key departments to manage the patients' pathways so that patients receive treatment within 18 weeks of referral. Although initial checks are made by the Information Department, this data is further validated by our separate 18 week team who interrogate the files and physically track the patients pathway on our current IT systems and record comments regarding the progress of the pathway. Inputting of the 18 week data is restricted to a core team to reduce the risk of inaccurate data entry and the further weekly validation allows for

any errors to be rectified immediately. Weekly graphs are produced which are cascaded to a wider senior team both specifically around waiting list demand and 18 week performance, both which are able to highlight data discrepancies should they arise. A fortnightly meeting also interrogates the Flash report which details the 18 week patients at specialty level.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Clinical Outcome, Safety and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control during 2017/18 was monitored by the following:

- The Board of Directors – The Board places reliance upon the Audit and Risk Committee for assurances that the system of internal control is sound. They require the quality and financial sub-committees to oversee the actions and outcomes from the Internal Audits.

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

- The structure of the Board of Directors meetings allows the appropriate time to ensure matters regarding Performance and Quality would be managed through the whole Board

- The Clinical Outcome, Safety and Quality Committee focus on assurance issues relating to clinical and corporate governance, risk management and assurance framework and report monthly to the Board. This committee is supported by the Clinical Operational Board that ensures divisional clinical leadership. The COSQ committee also receive assurance against the Care Quality Commission Quality Outcomes on a monthly basis.

- The Clinical Audit and Effectiveness Committee reports to the Clinical Operational Board. The committee ensures clinical leadership through the divisions, monitors the implementation of NICE guidance and reviews the Dr Foster benchmarking data sets to review trends. This process is reported to the Executive Board and assurance provided to the Clinical Outcome, Safety and Quality Committee.

- The Finance, Investment and Performance Committee takes an overview of operational activity and performance against national and local targets.

- Internal Audit – Internal Audit review the system of internal control during the course of the financial year and report accordingly to the Audit and Risk Committee.

- A Provider Licence Assurance Framework was reviewed by the Audit and Risk Committee. The Trust has reviewed Governance arrangements through the assessment of the Healthy Board 2013 and the Monitor Code of Governance. These assessments have been cross referenced against the Licence requirements laid out in condition 4 of the FT Governance.

Compliance with the NHS Foundation Trust Code of Governance

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

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

My review is also informed by:

Internal Audit which has completed reviews of Financial Governance and Delivery of the Financial Plan, Cyber Security, Delivery of the Financial Savings Scheme, A&E Departmental activity recording, Pharmacy Purchasing and Inventory Management, Serious Incidents and Never Events and Delivery of the Corporate Plan. The final report from 2016/17 Medical Devices review was also presented and a review undertaken of the Discharge Planning process. This work has supported the Audit and Risk Committee's understanding and review of the key issues facing the Trust. Internal Audit reviews are conducted using a risk-based approach covering areas agreed as being the priority for review based on a risk assessment agreed between the Audit and Risk Committee, Management and the auditors.

The Head of Internal Audit reports that they have completed the programme of internal audit work for the year ended 31 March 2018. Their work identified low, moderate and high rated findings there was one critical risk rated report in 2017/18 that included one critical recommendation. This has resulted in a split opinion for 2017/18.

Based on the work that internal audit have completed, the Head of Internal Audit has concluded governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

The key factors that contributed to this opinion included the following matters:

- Further work required on medical device replacement reviews and training records.
- Delivery of savings schemes and detailed plans
- Improvements suggested to the Cost Improvement Plan review including the management of the Quality Impact Assessments.
- Further work on the Scheme of Delegation to improve the performance management process for Divisions.
- consider the implementation of systems to enhance the process of activity recording in the Emergency Department

In the case of Cyber Security, their healthcheck revealed significant weaknesses in the framework of governance, risk management and control which put the achievement of the organisational objectives for security and resilience of systems and data at risk. In this area, major improvement was required to improve the adequacy and effectiveness of governance, risk management and control. At the time of their review of Cyber Security, management had identified a number of actions that needed to be taken to improve system security and resilience. Their review confirmed the importance of completing these actions and also identified some additional actions to strengthen the framework of control. Actions to address the weaknesses have since been taken, with good progress having been made and the Audit and Risk Committee monitoring progress closely.

All recommendations arising from Internal Audit's work are considered by managers and an action plan agreed. The report, action plan and subsequent progress in implementing those actions are reviewed and monitored by the Audit and Risk Committee, and where relevant also by the Clinical Outcome, Safety and Quality Committee and the Finance Investment and Performance Committee.

The Trust has taken action throughout the year to address the issues raised through the Internal Audit process. This included:

- Completed the priority actions to increase cyber security controls.
- Completed an Executive review of the medical device replacement schemes.
- Implemented a new Quality Impact Assessment process that will provide assurance to the Clinical Outcome, Safety and Quality Committee.
- Completed a significant review to the Scheme of Delegation that will be implemented in 2018/19.
- Further developed the plans for cost improvement programmes to support monitoring and achievement.

Conclusion

The generally sound system of internal control is supported by a robust governance structure that reviewed any identified weaknesses regularly. Some areas for action were identified during the year and immediate action taken to mitigate and resolve the concerns.

David Carter
Chief Executive
Date: 23rd May 2018

KPMG

Independent auditor's report

to the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the group financial statements of Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2018 which comprise the Group and the Trust's statement of comprehensive income, statement of financial position, statement of cash flows, statement of changes in equity and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure for the year then ended; and

— the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: Group financial statements as a whole	£5.9m (2016/17: £5.5m) 2% (2016/17: 2%) of total income from activities	
Coverage	100% (2016/17:100%) of total income income	
Risks of material misstatement		**vs 2016/17**
Recurring risks	Valuation of land and buildings	◄►
	NHS and non-NHS income	◄►

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters [(unchanged from 2017)], in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Plant, Property and equipment (£ 91 million; 2016/17: £ 86.2 million) *Refer to page 108 (Audit & Risk Committee Report), pages C20 to C23 (accounting policy) and page C39 to C41 (financial disclosures)*	**Subjective Valuation-land and buildings (excluding dwellings):** Land and buildings are required to be held at fair value. Initially, land and buildings are recognised at cost, but subsequently are recognised at current value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. A review is carried out each year for any potential impairment, with a full valuation every five years. Further, DRC is decreased if VAT on replacement costs is deemed to be recoverable. Both of these assumptions can have potentially significant effects on the valuation . The Group operates from one site of which it holds land assets with a value of £12.27 million and buildings (excluding dwellings) with a value of £79.11 million as at 31 March 2018. A full property valuation took place at 31 March 2018 by an external valuer, Gerald Eve LLP. As a result of the proposed acquisition of Bedford Hospital Trust. This review has resulted in an increase in land and buildings of £3.1m since the prior year. Estimates are inherently risky due to their subjectivity and reliance on the valuer's credentials, assumptions used and choice of methodology.	Our procedures included: **Assessing transparency**: We considered the adequacy of the disclosures in relation to the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities with reference to the Department of Health' s Group Accounting Manual 2017/18; **Methodology choice:** We considered how management had assessed the need for any impairments across its asset base either due to loss of value or reduction in future benefits that would be achieved; **Assessing valuer's credentials:** We assessed the scope, qualifications, objectivity and independence of the Trusts valuer from Gerald Eve LLP; **Our valuation expertise:** We utilised our own valuation specialist to aid us in our assessment. We inspected the instructions provided to the Trusts' valuer to assess whether they were appropriate for the requirements; **Tests of details:** For a sample of assets added during the year we tested that an appropriate valuation basis had been adopted and it was appropriate to capitalise them; **Tests of details:** for a sample of assets that were reclassified in year we reviewed the transfer from assets under construction and confirmed that the value transferred was appropriate; and **Tests of details:** For a sample of the assets recorded in the accounts as under construction we tested the status to assess the appropriateness of the impairment and write off applied to its value. **Our results** We found the resulting valuation of land and buildings to be balanced.

	The risk	Our response
NHS and non- NHS Income *NHS and non-NHS receivables - £ 34.59 million, PY £25.6 million and completeness, existence and accuracy of NHS and non-NHS income - £ 334 million, PY £ 309 million* *Refer to page 108 (Audit & Risk Committee Report), page C19 and pages C25 to C27 (accounting policy) and pages C30 to C31 and pages C43 to C44 (financial disclosures).*	**2017/18 Income** The main source of income for the Group is the provision of health care services to the public under contracts with NHS commissioners, which make up 94.75% of income from activities (2017/18: 92.7%). Income from NHS England and CCGs is captured through the Agreement of Balances (AOB) exercises performed at months 6, 9 and 12 to confirm amounts received and owed. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes In 2017/18 the Department of Health introduced the Sustainability and Transformation Fund (STF) enabling Trusts to secure additional funding upon achievement of specified financial and operational targets. In 2017/18, the Trust secured £13.3m of STF funding, representing achievement of all four quarterly targets and a bonus element. In addition to this patient care income the Group reported total income of £31 million (2016/17: £26 million) from non-NHS bodies. Much of this income is generated by contracts with Local Authorities and from overseas or private patients. Consequently there is a risk that income will be recognised on a cash rather than an accruals basis. We do not consider NHS and non-NHS income to be at high risk of significant misstatement, or to be subject to a significant judgement. However, due to its materiality in the context of the financial statements as a whole, NHS and non-NHS income is considered to be one of the areas that had the greatest effect on our overall audit strategy and allocations of resources in planning and completing our audit.	Our procedures included: **Tests of details:** We undertook the following tests of details: — We agreed a sample of the NHS income recorded in the financial statements to the signed contracts in place with key commissioners; — We agreed a sample of invoices to confirm they had been issued in line with the contracts signed with four of the Trust's key commissioners, comprising 84% of the total income billed; — We obtained third party confirmations from commissioners . through the AoB exercise and compared the values they are disclosing within their financial statements to the value of income and receivables captured in these financial statements; — We sample tested non-NHS income by agreeing to invoices and subsequent receipt of funds; — We agreed receivables to post year-end cash receipts, supporting invoices and other documentation. This included testing the assumptions made by the Group in respect of income due that was based on meeting agreed performance targets with commissioners known as CQUIN targets and ensuring that any fines or deductions have been taken into account; — We confirmed that the approach to impairing receivables was in line with the Trust's accounting policies, and that the Group's judgement for the level of provision is appropriate; and — We reviewed the Trust's calculation of performance against the financial and operational targets used in determining receipt of transformation funding to determine the amount the Trust qualified to receive. **Our results** We found the resulting estimates made by the Trust in relation to NHS income and receivables to be balanced.

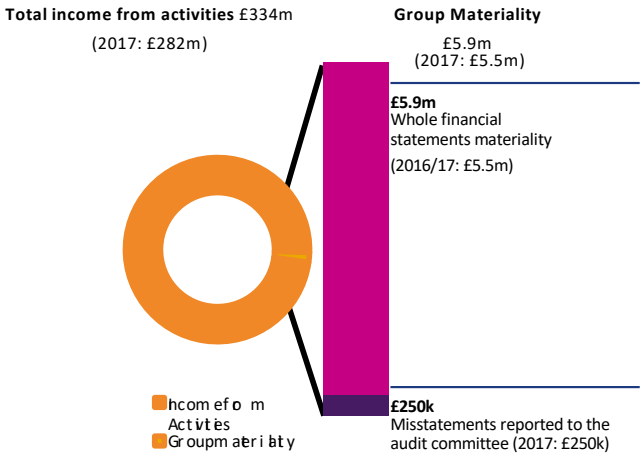
3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £5.9m (2016/17: £5.5m,determined with reference to a benchmark of total income from activities (of which it represents approximately 2%). We consider total income form activities to be more stable than a surplus- or deficit-related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £5.9 million (2016/17: £5.5 million), determined with reference to a benchmark of total income from activities (of which it represents approximately 2%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £250k (2016/17:(£250k), in addition to other identified misstatements that warranted reporting on qualitative grounds.

For the Charitable subsidiary the Group audit team have completed specified risk-focused audit procedures. As it is not individually financially significant enough to require a full scope audit for group purposes.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 130 the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

KPMG

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources..

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

We did not identify any significant risks during our risk assessment.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Luton and Dunstable University Hospital NHS Foundation Trust NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Fleur Nieboer

for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

15 Canada Square, Canary Wharf, London, E14 5GL

25 May 2018

KPMG

Foreword to the Accounts

These accounts for the year ended 31 March 2018 have been prepared by the Luton and Dunstable University Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

David Carter
Chief Executive
Date: 23rd May 2018

Statement of comprehensive income

		Parent (L&D NHSFT)		Group (L&D NHSFT & NHS Charitable Funds)	
		2017/18	Restated 2016/17	2017/18	Restated 2016/17
	note	£000	£000	£000	£000
Operating Income from continuing operations	2.5	**334,074**	308,790	**334,497**	309,588
Operating Expenses of continuing operations	3	**(314,437)**	(291,656)	**(315,565)**	(292,246)
OPERATING SURPLUS		**19,637**	**17,134**	**18,932**	**17,342**
Finance Costs					
Finance income	6.1	**63**	25	**137**	116
Finance expense - financial liabilities	6.2	**(1,115)**	(967)	**(1,115)**	(967)
Finance expense - unwinding of discount on provisions		**(2)**	(2)	**(2)**	(2)
PDC Dividends payable		**(3,214)**	(3,264)	**(3,214)**	(3,264)
NET FINANCE COSTS		**(4,268)**	**(4,208)**	**(4,194)**	**(4,117)**
Gains/(losses) of disposal of assets		**(1)**	(7)	**32**	400
Surplus / (deficit) from continuing operations		**15,368**	12,919	**14,770**	13,625
SURPLUS / (DEFICIT) FOR THE YEAR		**15,368**	**12,919**	**14,770**	**13,625**
SURPLUS/ (DEFICIT) FOR THE YEAR		**15,368**	12,919	**14,770**	13,625
Other comprehensive income					
Revaluation Impact	23	**3,597**	(3,205)	**3,597**	(3,205)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**18,965**	**9,714**	**18,367**	**10,420**

Note: Allocation of profits for the period: This surplus is wholly attributable to the owner of the parent.

[1] Restatement relates to presentational change for movement in fair value of investment property and other investments

Statement of financial position

	note	Parent 31 March 2018 £000	Parent 31 March 2017 £000	Group 31 March 2018 £000	Group 31 March 2017 £000
Non-current assets					
Intangible assets	7	**124**	194	**124**	194
Property, plant and equipment	8	**120,722**	113,538	**120,722**	113,538
Other investments	11	**0**	0	**2,216**	3,075
Trade and other receivables	14	**1,886**	1,917	**1,886**	1,917
Other assets	15	**2,432**	2,574	**2,432**	2,574
Total non-current assets		**125,164**	**118,223**	**127,380**	**121,298**
Current assets					
Inventories	13	**3,421**	3,291	**3,421**	3,291
Trade and other receivables	14	**32,701**	23,665	**32,656**	23,614
Cash and cash equivalents	25	**36,400**	28,176	**37,716**	28,986
Total current assets		**72,522**	**55,132**	**73,793**	**55,891**
Current liabilities					
Trade and other payables	16	**(26,673)**	(24,134)	**(26,810)**	(24,253)
Borrowings	18	**(1,485)**	(1,423)	**(1,485)**	(1,423)
Provisions	22	**(267)**	(521)	**(685)**	(830)
Other liabilities	17	**(1,608)**	(1,650)	**(1,608)**	(1,650)
Total current liabilities		**(30,033)**	**(27,728)**	**(30,588)**	**(28,156)**
Total assets less current liabilities		**167,653**	**145,627**	**170,585**	**149,033**
Non-current liabilities					
Borrowings	18	**(28,126)**	(29,611)	**(28,126)**	(29,611)
Provisions	22	**(630)**	(619)	**(776)**	(641)
Total non-current liabilities		**(28,756)**	**(30,230)**	**(28,902)**	**(30,252)**
Total assets employed		**138,897**	**115,397**	**141,683**	**118,781**
Financed by					
Taxpayers Equity					
Public Dividend Capital		**66,047**	61,512	**66,047**	61,512
Revaluation reserve	23	**11,914**	8,317	**11,914**	8,317
Income and expenditure reserve		**60,936**	45,568	**60,936**	45,568
Others' Equity					
Charitable Fund Reserves	24	**0**	0	**2,786**	3,384
Total taxpayers & others' equity		**138,897**	**115,397**	**141,683**	**118,781**

Signed:
D Carter
Date: 23 May 2018

The notes on pages C18 to C55 form part of the financial statements.

Statement of changes in equity

	Parent - Pre Consolidated				Group Consolidated				
	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Charitable Funds Reserves £000	Total £000
Taxpayers' and Others' Equity at 1 April 2017 - as previously stated	61,512	8,317	45,568	**115,397**	61,512	8,317	45,568	3,384	**118,781**
Surplus/(deficit) for the year	0	0	15,368	**15,368**	0	0	14,760	10	**14,770**
Revaluation Impact	0	3,597	0	**3,597**	0	3,597	0	0	**3,597**
Public Dividend Capital received	4,535	0	0	**4,535**	4,535	0	0	0	**4,535**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	608	(608)	**0**
Taxpayers' and Others' Equity at 31 March 2018	**66,047**	**11,914**	**60,936**	**138,897**	**66,047**	**11,914**	**60,936**	**2,786**	**141,683**
Taxpayers' and Others' Equity at 1 April 2016 - as previously stated	**61,512**	**11,522**	**32,649**	**105,683**	**61,512**	**11,522**	**32,649**	**2,678**	**108,361**
Surplus/(deficit) for the year	0	0	12,919	**12,919**	0	0	12,602	1,023	**13,625**
Revaluation Impact	0	(3,205)	0	**(3,205)**	0	(3,205)	0	0	**(3,205)**
Public Dividend Capital received	0	0	0	**0**	0	0	0	0	**0**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	317	(317)	**0**
Taxpayers' and Others' Equity at 31 March 2017	**61,512**	**8,317**	**45,568**	**115,397**	**61,512**	**8,317**	**45,568**	**3,384**	**118,781**

Statement of cash flows

	Group	
		Restated1
	2017/18 £000	2016/17 £000
Cash flows from operating activities		
Operating surplus from continuing operations	18,932	17,342
Operating surplus	**18,932**	**17,342**
Non-cash income and expense:		
Depreciation and amortisation	8,719	8,685
Non-cash donations/grants credited to income	0	0
(Increase)/Decrease in Trade and Other Receivables	(9,002)	(3,564)
(Increase)/Decrease in Inventories	(130)	(81)
Increase/(Decrease) in Trade and Other Payables	3,322	1,779
Increase/(Decrease) in Other Liabilities	(42)	(173)
Increase/(Decrease) in Provisions	(244)	80
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	240	(179)
Other movements in operating cash flows	10	(31)
NET CASH GENERATED FROM OPERATIONS	**21,805**	**23,858**
Cash flows from investing activities		
Interest received	63	25
Purchase of Property, Plant and Equipment	(12,954)	(10,451)
Sale of Property, Plant and Equipment	0	10
NHS Charitable funds - net cash flows from investing activities	967	494
Net cash generated used in investing activities	**(11,924)**	**(9,922)**
Cash flows from financing activities		
Public Dividend Capital received	4,535	0
Movement in loans from the Department of Health and Social Care	(835)	10,140
Other loans repaid	(8)	(7)
Capital element of Private Finance Initiative obligations	(580)	(397)
Interest paid	(408)	(216)
Interest element of Private Finance Initiative obligations	(707)	(729)
PDC Dividend paid	(3,148)	(3,144)
Net cash used in financing activities	**(1,151)**	**5,647**
Increase/(decrease) in cash and cash equivalents	8,730	19,583
Cash and Cash equivalents at 1 April 2017	28,986	9,403
Cash and Cash equivalents at 31 March 2018	**37,716**	**28,986**

1 Restatement relates to presentational heading change only.

1. Accounting policies and other information

1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow IFRS to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Body. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern

These accounts have been prepared on a going concern basis.

The FT is facing, along with all other providers, a challenging financial environment. The FT has, however, submitted a surplus plan for 2018/19 to NHS Improvement, albeit one that contains risk and requires collaboration with NHS leadership organisations to deliver the plan. After due consideration, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- review of operating leases to determine whether the significant risks and rewards of ownership of the leased assets have transferred. To mitigate the risk of incorrect conclusions an external advisor's opinion was obtained.

Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- allocation of lifes to acquired plant and equipment (excluding buildings for which a valuer's opinion is obtained) to calculate the depreciation charge. This is estimated based on the lives of similar assets and knowledge of the procurer.
- income generated from partially completed spells and non contract income. These are estimated assuming that patterns of provision of service are consistent from year to year.
- accrued expenditure for annual leave is estimated by applying NHS employment contracts' terms and conditions and Trust policy to the average annual leave balance for a sample of departments.

1.3 Consolidation

The trust is the corporate trustee to Luton & Dunstable Hospital NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Trust does not have any other subsidiaries, associates, joint ventures or joint operations as defined under International Financial Reporting Standards.

Unless otherwise stated the notes to the accounts disclose the group position.

1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is

contracts with commissioners in respect of healthcare services. At the year end, the trust accrued income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 Expenditure on Employee Benefits

Short-term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

1.5 Expenditure on Employee Benefits (cont)

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The trust also has employees who are members of the NEST pension scheme. This is a defined contribution scheme and employers pension cost contributions are charged to operating expenses as and when they become due.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant and Equipment

Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has an individual cost of at least £5,000; or
- the item forms a group of assets which individually have a cost of more than £1,000, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates and are under single managerial control.
- the item forms a group of assets which are the initial equipping costs of a new or reconfigured asset with a collective value of over £20,000 and the group of assets are under common managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. All property (land and buildings, excluding infrastructure assets) are restated to current value using professional valuations in accordance with IAS16 every five years. An interim valuation is also carried out.

1.7 Property, Plant and Equipment (cont)

The Trusts properties were valued on 31 March 2018 by an external valuer, William Arkell MRICS of Gerald Eve LLP. The total proportion of fees payable by the client during the preceding year relative to the total fee income of the firm during the preceding year are minimal. The valuations were in accordance with the requirements of theValuation – Global Standards 2017 of the Royal Institution of Chartered Surveyors (RICS). The valuation of each property was on the basis of market value, subject to the following assumptions:

- for owner-occupied property: the property would be sold as part of the continuing business;
- for investment property: the property would be sold subject to any existing leases; or
- for surplus property and property held for development: the property would be sold with vacant possession in its existing condition.

The valuer's opinion of market value was primarily derived using:

- comparable recent market transactions on arm's length terms and;
- the depreciated replacement cost approach, because the specialised nature of the asset means that there are no market transactions of this type of asset except as part of the business or entity.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The land value for existing use purpose is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use where the capital cost is greater than £5m.

PFI scheme assets have been valued in accordance with the policy above.

Operational equipment is valued at depreciated historic cost. Equipment surplus to requirements is valued at net recoverable amount.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- • the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- • the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

1.8 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

-
- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciatetd replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Revenue government and other grants

Government grants are grants from Government bodies other than income from clinical commissioning groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation. Allowances acquired under the scheme are recognised as intangible assets.

1.13 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade/Settlement date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are categorised as 'fair value through income and expenditure', loans and receivables or 'available-for-sale financial assets'.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account.

Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial Liabilities - Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

The bad debt provision comprises of specific bad debts for known disputed items, debtors greater than one year, and debtors where there is a history of non-payment.

1.14 Leases

The trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating lesases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.15 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. For charitable funds decisions made by the Charitable Fund Committee for which there is a constructive obligation to undertake activities are recognised at the point the decision is made.

The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.18 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation Tax

The majority of the Trust's activities are related to core healthcare and are therefore not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the corporation tax threshold, as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

1.20 Foreign exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM, see Note 25.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and special payments register which reports on a cash basis with the exception of provisions for future losses, see Note 32.

1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

The GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers -- Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods
- beginning on or after 1 January 2019.

2.1 OPERATING INCOME (by classification)

	2017/18 Total £000	2016/17 Total £000
Income from Activities		
Elective income	**41,067**	40,291
Non elective income	**101,920**	83,384
Outpatient income	**43,979**	45,085
A & E income	**15,346**	13,343
Other NHS clinical income	**91,578**	87,831
Additional income for delivery of healthcare services	**4,500**	8,700
Private patient income	**2,071**	2,156
Other clinical income	**706**	792
Total income from activities	**301,167**	**281,582**

2.2 Commissioner Requested Services

The Trust's provider licence specifies the Commissioner Requested Services, for details see www.improvement.nhs.uk. This note analyses income from activities between Commissioner Requested Services and Non Commissioner Requested Services.

	2017/18 £000	2016/17 £000
Commissioner Requested Services	**293,891**	269,934
Non Commissioner Requested Services	**7,276**	11,648
	301,167	**281,582**

2.3 Operating lease income

		2017/18 Total £000	2016/17 Total £000
Operating Lease Income			
Rents recognised as income in the period		**755**	745
TOTAL	**755**	**745**	
Future minimum lease payments due on leases of Buildings expiring			
- not later than one year;		**345**	169
- later than one year and not later than five years;		**1,292**	676
- later than five years.		**1,271**	578
TOTAL		**2,908**	**1,423**

2.4 Overseas visitors (relating to patients charged directly by the NHS foundation

	2017/18 £000	2016/17 £000
Income recognised this year	**172**	123
Cash payments received in-year	**109**	137
Amounts added to provision for impairment of receivables	**-**	22
Amounts written off in-year	**83**	3

2.5 OPERATING INCOME (by type)

	Parent		Group	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Income from activities				
NHS Foundation Trusts	**438**	573	**438**	573
NHS Trusts	**1,245**	1,391	**1,245**	1,391
CCGs and NHS England	**285,371**	261,036	**285,371**	261,036
Local Authorities	**2,573**	2,864	**2,573**	2,864
NHS Other	**469**	469	**469**	469
Non NHS: Private patients	**2,071**	2,156	**2,071**	2,156
Non-NHS: Overseas patients (non-reciprocal)	**172**	123	**172**	123
NHS injury scheme (was RTA)	**705**	792	**705**	792
Non NHS: Other*	**3,623**	3,478	**3,623**	3,478
Additional income for delivery of healthcare services	**4,500**	8,700	**4,500**	8,700
Total income from activities	**301,167**	**281,582**	**301,167**	**281,582**

*Non NHS: Other relates to a contract with private sector provider, previously commissioned by NHS Bedfordshire

	Parent		Group	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Other operating income				
Research and development	**972**	826	**972**	826
Education and training	**9,298**	8,492	**9,298**	8,492
Education and training - notional income from apprenticeship fund	**74**	0	**74**	0
Charitable and other contributions to expenditure	**566**	275	**0**	0
Received from NHS charities: Other charitable and other contributions to expenditure	**42**	42		00
Rental revenue from operating leases	**755**	745	**755**	745
Income in respect of staff costs where accounted on gross basis	**1,421**	1,517	**1,421**	1,517
NHS Charitable Funds: Incoming Resources excluding investment income	**0**	0	**1,031**	1,113
Sustainability and Transformation Fund income[1]	**13,313**	10,078	**13,313**	10,078
Other[2]	**6,466**	5,233	**6,466**	5,235
Total other operating income	**32,907**	**27,208**	**33,330**	**28,006**
TOTAL OPERATING INCOME	**334,074**	**308,790**	**334,497**	**309,588**

[1] NHS Performance bonus received for achieving financial and performance targets

[2] This includes car parking income of £1,738k (2016/17 £1,703k). This is strictly an income generation activity whereby income exceeds cost and the surplus is invested in the provision of patient care. There are other Trust objectives delivered through this activity including a contribution to the patient and staff safety and experience agenda (additional security and maximising the availability of car parking spaces).

3.1 OPERATING EXPENSES (by type)

	Parent		Group	
	2017/18 £000	Restated 2016/17 £000	2017/18 £000	Restated 2016/17 £000
Employee Expenses - Non-executive directors	**127**	138	**127**	138
Employee Expenses - Staff & Executive directors	**203,555**	187,659	**203,555**	187,659
Supplies and services - clinical (excluding drug costs)	**28,205**	28,371	**28,205**	28,371
Supplies and services - general	**5,626**	4,581	**5,626**	4,581
Establishment	**7,066**	6,113	**7,066**	6,113
Transport (including staff and patient travel)	**582**	336	**582**	336
Premises	**16,651**	15,358	**16,651**	15,358
Increase / (decrease) in provision for receivable impairments	**195**	(10)	**195**	(10)
Change in provisions discount rate	**0**	44	**0**	44
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**27,476**	27,558	**27,476**	27,558
Rentals under operating leases - minimum lease receipts	**996**	1,022	**996**	1,022
Depreciation on property, plant and equipment	**8,649**	8,615	**8,649**	8,615
Amortisation on intangible assets	**70**	70	**70**	70
Audit fees payable to the External Auditor				
audit services- statutory audit1	**49**	49	**49**	49
other services: audit-related assurance services'	**7**	7	**7**	7
other auditor remuneration (external auditor only)	**18**	23	**18**	23
Audit fees payable re charitable fund accounts	**0**	0	**3**	3
Clinical negligence (Insurance Premiums)	**10,277**	7,443	**10,277**	7,443
Legal fees	**165**	123	**165**	123
Consultancy costs	**2,285**	1,724	**2,285**	1,724
Internal Audit Costs - not included in employee expenses	**61**	96	**61**	96
Training, courses and conferences	**959**	797	**959**	797
Education and training - notional expenditure funded from apprenticeship fund	74	0	**74**	0
Car parking & Security	**754**	722	**754**	722
Redundancy - (not included in employee expenses)	**14**	166	**14**	166
Hospitality	**6**	6	**6**	6
Insurance	**90**	114	**90**	114
Other services, eg external payroll	**244**	230	**244**	230
Grossing up consortium arrangements	**61**	30	**61**	30
Losses, ex gratia & special payments	**96**	15	**96**	15
NHS Charitable funds: Other resources expended	**0**	0	**1,125**	587
Other	**79**	257	**79**	257
TOTAL	**314,437**	**291,656**	**315,565**	**292,246**

*1 Excluding non-recoverable VAT.

4.1 Employee Expenses (excluding non-executive directors)

	2017/18 Permanent £000	2017/18 Other £000	2017/18 Total £000	2016/17 Permanent £000	2016/17 Other £000	2016/17 Total £000
Salaries and wages	134,871	22,563	**157,434**	126,285	17,279	**143,564**
Social security costs	14,319	1,933	**16,252**	13,507	1,385	**14,892**
Apprenticeship Levy	626	92	**718**	0	0	**0**
Pension costs - defined contribution plans Employers contributions to NHS Pensions	15,912	1,209	**17,121**	14,778	870	**15,648**
Agency/contract staff	0	14,838	**14,838**	0	14,707	**14,707**
Costs capitalised as part of assets	(2,203)	(591)	**(2,794)**	(669)	(317)	**(986)**
TOTAL	**163,525**	**40,044**	**203,569**	**153,901**	**33,924**	**187,825**

4.2 Average number of employees (WTE basis)

	2017/18 Permanent Number	2017/18 Other Number	2017/18 Total Number	2016/17 Permanent Number	2016/17 Other Number	2016/17 Total Number
Medical and dental	563	157	**720**	534	117	**651**
Administration and estates	761	94	**855**	651	96	**747**
Healthcare assistants and other support staff	558	254	**812**	574	210	**784**
Nursing, midwifery and health visiting staff	1,331	185	**1,516**	1,262	161	**1,423**
Nursing, midwifery and health visiting learners	7	0	**7**	5	0	**5**
Scientific, therapeutic and technical staff	368	14	**382**	345	11	**356**
Healthcare science staff	156	47	**203**	145	53	**198**
Other	3	0	**3**	3	0	**3**
Number of Employees (WTE) engaged on capital projects	(55)	(10)	**(65)**	(17)	(5)	**(22)**
TOTAL	**3,692**	**741**	**4,433**	**3,502**	**643**	**4,145**

4.3 Employee benefits

There were no employee benefits during either 2017/18 nor 2016/17.

4.4 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There were 2 (2016/17: 1) retirements, at an additional cost of £82k (2016/17: £21k). This information has been supplied by NHS Pensions.

4.5.1 Senior Managers Remuneration

2017/18

Name and Title		Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman				
Simon Linnett	Chairman	40 to 45	n/a	40 to 45
Non Executive Directors				
Alison Clarke	Non-Executive Director	15 to 20	n/a	15 to 20
Ninawatie Tiwari	Non-Executive Director	10 to 15	n/a	10 to 15
John Garner	Non-Executive Director	10 to 15	n/a	10 to 15
Mark Versallion	Non-Executive Director	10 to 15	n/a	10 to 15
David Hendry	Non-Executive Director	15 to 20	n/a	15 to 20
Jill Robinson	Non- Executive Director (to 10/11/17)	5 to 10	n/a	5 to 10
Clifford Bygrave	Non-Executive Director (to 31/03/18)	10 to 15	n/a	10 to 15
Denis Mellon	Non-Executive Director (from 11/11/17)	5 to 10	n/a	5 to 10
Executive Directors				
Pauline Philip	Chief Executive (Seconded from 8/5/17)[1]	205 to 210	n/a	205 to 210
David Carter	Chief Executive (Acting from 8/5/17 appointed 14/2/18)			
Managing Director (to 07/05/17)		175 to 180	105 to 107.5	280 to 285
Andrew Harwood	Director of Finance	130 to 135	85 to 87.5	220 to 225
Danielle Freedman	Chief Medical Advisor	160 to 165	n/a	160 to 165
Cathy Jones	Deputy Chief Executive (Acting from 8/5/17 appointed 7/3/18)[1]	105 to 110	117.5 to 120	220 to 225
Sheran Oke	Director of Nursing (Acting)	90 to 95	120 to 122.5	215 to 220
Marion Collict	Director of Transformation (to 31/03/18)	110 to 115	95 to 97.5	210 to 215
Angela Doak	Director of Organisational Development	120 to 125	27.5 to 30	150 to 155

[1] Salary is for full year for all staff (including period when not voting Director)

		2016/17		
Name and Title		Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000
Chairman				
Simon Linnett	Chairman	40 to 45	n/a1	50 to 55
Non Executive Directors				
Alison Clarke	Non-Executive Director	15 to 20	n/a	15 to 20
Ninawatie Tiwari	Non-Executive Director	10 to 15	n/a	10 to 15
John Garner	Non-Executive Director	10 to 15	n/a	10 to 15
Mark Versallion	Non-Executive Director	10 to 15	n/a	10 to 15
David Hendry	Non-Executive Director	15 to 20	n/a	15 to 20
Jill Robinson	Non- Executive Director	10 to 15	n/a	10 to 15
Clifford Bygrave	Non-Executive Director (from 11/1/17)	0 to 5	n/a	0 to 5
Executive Directors				
Pauline Philip	Chief Executive	205 to 210	n/a	205 to 210
David Carter	Managing Director	150 to 155	135 to 137.5	285 to 290
Andrew Harwood	Director of Finance	125 to 130	17.5 to 20	145 to 150
Danielle Freedman	Chief Medical Advisor	160 to 165	n/a	160 to 165
Patricia Reid	Director of Nursing (to 30/1/17)	95 to 100	25 to 27.5	125 to 130
Sheran Oke	Director of Nursing (from 30/1/17)[2]	80 to 85	17.5 to 20	100 to 105
Marion Collict	Director of Transformation (from 11/1/17)[2]	100 to 105	27.5 to 30	135 to 140
Angela Doak	Director of Organisational Development	120 to 125	17.5 to 20	135 to 140
Mark England	Director of Reengineering and Informatics	120 to 125	27.5 to 30	145 to 150

[1] Pension related benefits 2016/17 were in the band £7.5k to £10k, however the individual has since retrospectively opted out of the pension scheme with a full refund of the contributions.

[2] Salary is for full 2016/17 year (including period prior to appointment as voting Director)

For the purpose of this note Senior Managers are defined as being the Chief Executive, Non Executive Directors and Executive Directors. I.e. Those individuals with voting rights.
Senior Managers have not received any taxable benefits, annual performance-related bonuses or long-term performance related bonuses in either 2017/18 or 2016/17.

4.5.2 Pension benefits

			2017/18		
	Real increase in pension and related lump sum at age 60	Total accrued pension and related lump sum at age 60 at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value
Name and title	(bands of £2,500)	(bands of £2,500)	£000	£000	£000
Pauline Philip[1] Chief Executive (Seconded from 8/5/17, left 17/1/18)					
David Carter Chief Executive (Acting from 8/5/17 appointed 14/2/18) Managing Director (to 07/05/17)	17.5 to 20	152.5 to 155	741	640	101
Andrew Harwood Director of Finance	17.5 to 20	210 to 212.5	1,079	930	149
Danielle Freedman[1] Chief Medical Advisor					
Cathy Jones Deputy Chief Executive (Acting from 8/5/17 appointed 7/3/18)	20 to 22.5	67.5 to 70	239	171	68
Sheran Oke Director of Nursing (Acting)	22.5 to 25	152.5 to 155	779	643	136
Marion Collict Director of Transformation (to 31/03/18)	17.5 to 20	152.5 to 155	838	711	127
Angela Doak Director of Organisational Development	0 to 2.5	182.5 to 185	895	848	47

[1] No longer contributing to pension scheme

			2016/17		
	Real increase in pension and related lump sum at age 60	Total accrued pension and related lump sum at age 60 at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2015	Real Increase in Cash Equivalent Transfer Value
Name and title	(bands of £2,500)	(bands of £2,500)	£000	£000	£000
Pauline Philip[1] Chief Executive					
David Carter Managing Director	5 to 7.5	140 to 142.5	640	500	140
Andrew Harwood Director of Finance	0 to 2.5	192.5 to 195	930	875	55
Danielle Freedman[1] Chief Medical Advisor					
Patricia Reid Director of Nursing (to 30/1/17)	0 to 2.5	110 to 112.5	n/a	n/a	n/a
Sheran Oke Director of Nursing (from 30/1/17)	0 to 2.5	130 to 132.5	643	600	42
Marion Collict Director of Transformation (from 11/1/17)	0 to 2.5	132.5 to 135	711	646	65
Angela Doak Director of Organisational Development	0 to 2.5	182.5 to 185	848	798	50
Mark England Director of Reengineering and Informatics	0 to 2.5	17.5 to 20	210	181	29

[1] No longer contributing to pension scheme

4.5.3 Median Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

	2017/18	2016/17
Band of Highest Paid Director's Total Remuneration	205 to 210	205 to 210
Median Total	**26,565**	**27,361**
Ratio	7.7	7.6

The highest paid director's remuneration did not change during 2017/18. There was a decrease in median pay.

4.5.4 Staff Exit Packages

	2017/18		2016/17	
Exit package cost band (including any special payment element)	Total number of exit packages	Total cost of exit packages £'000	Total number of exit packages	Total cost of exit packages £'000
<£10,000	11	35	16	47
£10,001 - £25,000	2	24	4	45
£25,001 - 50,000	0	0	2	57
£50,001 - £100,000	0	0	1	83
£100,001 - £150,000	0	0	0	0
>£150,000	0	0	0	0
Total	**13**	**59**	**23**	**232**

	2017/18	2017/18	2016/17	2016/17
	Payments agreed	Total value	Payments agreed	Total Value
	Number	£'000	Number	£'000
Compulsory redundancies	1	14	6	166
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Contractual payments in lieu of notice	12	45	17	66
	13	**59**	**23**	**232**

Note 4.5.5 Expenses of Governors and Directors

The Foundation Trust had a total of 35 (34 in 2016/17) governors in office in 2017/18. 7 (8 in 2016/17) of these governors received expenses in 2017/18, with aggregate expenses paid to governors of £1,100 (£1,200 in 2016/17).

The Foundation Trust had a total of 17 (17 in 2016/17) directors in office in 2017/18. 11 (9 in 2016/17) of these directors received expenses in 2017/18, with aggregate expenses paid to directors of £9,400 (£8,000 in 2016/17)

5.1 Operating leases

	2017/18	2016/17
	£000	£000
Minimum lease payments	996	1,022
TOTAL	**996**	**1,022**

Note 5.2 Arrangements containing an operating lease

Future minimum lease payments due:	2017/18 £000 Land	2017/18 £000 Buildings	2017/18 £000 Other	2017/18 £000 Total	2016/17 £000 Total
- not later than one year;	76	125	0	**201**	463
- later than one year and not later than five years;	382	400	0	**782**	888
- later than five years.	605	1,380	0	**1,985**	2,186
TOTAL	**1,063**	**1,905**	**0**	**2,968**	**3,537**

The Trust does not have any significant leasing arrangements.

5.3 Limitation on auditor's liability

There is £1m limitation on the auditors liability.

5.4 The late payment of commercial debts (interest) Act 1998

£0k was paid in respect of the late payment of commercial debts (interest) Act 1998 (£1k in 2016/17)

5.5 Other Audit Remuneration

£18k expenditure was incurred with the external audit provider in respect of tax advice in 2017/18. (£23k 2016/17)

5.6 Impairment of assets (PPE & intangibles)

No impairments have been charged to expenditure in either 2016/17 nor 2017/18.

6.1 Finance income

	Parent		Group	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Interest on instant access bank accounts	**63**	25	**63**	25
Interest on held-to-maturity financial assets	**0**	0	**0**	0
NHS Charitable funds: investment income	**0**	0	**74**	91
TOTAL	**63**	**25**	**137**	**116**

6.2 Finance costs - interest expense

	Parent		Group	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Capital loans from the Department of Health	**408**	237	**408**	237
Interest on late payment of commercial debt	**0**	1	**0**	1
Finance Costs in PFI obligations				
Main Finance Costs	**707**	729	**707**	729
TOTAL	**1,115**	**967**	**1,115**	**967**

7.1 Intangible Assets 2017/18

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2017 as previously stated	536	**536**
Additions - purchased	0	**0**
Cost or valuation at 31 March 2018	536	**536**
Amortisation at 1 April 2017 as previously stated	342	**342**
Provided during the year	70	**70**
Amortisation at 31 March 2018	412	**412**
Net book value		
NBV - Owned at 31 March 2018	124	**124**
NBV total at 31 March 2018	**124**	**124**

7.2 Intangible Assets 2016/17

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2016 as previously stated	536	**536**
Additions - purchased	0	**0**
Cost or valuation at 31 March 2017	536	**536**
Amortisation at 1 April 2016 as previously stated	272	**272**
Provided during the year	70	**70**
Amortisation at 31 March 2017	342	**342**
Net book value		
NBV - Owned at 31 March 2017	194	**194**
NBV total at 31 March 2017	**194**	**194**

8.1 Property, plant and equipment 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017 as previously stated	10,650	82,027	438	8,104	28,979	3,900	14,621	210	**148,929**
Additions - purchased (including donated)	0	1,912	0	6,798	2,907	0	598	22	**12,237**
Reclassifications	0	2,580	0	(3,694)	0	0	1,114	0	**0**
Revaluations	1,620	(7,782)	(63)	0	0	0	0	0	**(6,225)**
Disposals[1]	0	0	0	0	(852)	0	0	0	**(852)**
Cost or valuation at 31 March 2018	**12,270**	**78,737**	**375**	**11,208**	**31,034**	**3,900**	**16,333**	**232**	**154,089**
Accumulated depreciation at 1 April 2017 as previously stated	0	6,436	26	0	20,109	2,029	6,587	204	**35,391**
Provided during the year	0	3,347	13	0	2,477	454	2,355	3	**8,649**
Revaluations	0	(9,783)	(39)	0	0	0	0	0	**(9,822)**
Disposals[1]	0	0	0	0	(851)	0	0	0	**(851)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**0**	**21,735**	**2,483**	**8,942**	**207**	**33,367**
Net book value									
NBV - Owned at 31 March 2018	12,270	64,977	355	11,208	8,423	1,417	7,391	17	**106,058**
NBV - PFI at 31 March 2018	0	11,962	0	0	0	0	0	0	**11,962**
NBV - Donated at 31 March 2018	0	1,798	20	0	876	0	0	8	**2,702**
NBV total at 31 March 2018	**12,270**	**78,737**	**375**	**11,208**	**9,299**	**1,417**	**7,391**	**25**	**120,722**

[1] No assets used in the provision of commissioner requested services have been disposed of during the year.

8.2 Property, plant and equipment 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016 as previously stated	10,650	80,026	438	7,302	27,464	3,900	15,105	210	**145,095**
Additions - purchased (including donated)	0	956	0	5,806	2,437	0	722	0	**9,921**
Reclassifications	0	4,250	0	(5,004)	0	0	754	0	**0**
Revaluations	0	(3,205)	0	0	0	0	0	0	**(3,205)**
Disposals[1]	0	0	0	0	(922)	0	(1,960)	0	(2,882)
Cost or valuation at 31 March 2017	**10,650**	**82,027**	**438**	**8,104**	**28,979**	**3,900**	**14,621**	**210**	**148,929**
Accumulated depreciation at 1 April 2016 as previously stated	0	3,124	13	0	18,472	1,538	6,302	202	**29,651**
Provided during the year	0	3,312	13	0	2,552	491	2,245	2	**8,615**
Disposals[1]	0	0	0	0	(915)	0	(1,960)	0	(2,875)
Accumulated depreciation at 31 March 2017	**0**	**6,436**	**26**	**0**	**20,109**	**2,029**	**6,587**	**204**	**35,391**
Net book value									
NBV - Purchased at 31 March 2017	10,650	61,374	380	8,104	8,294	1,871	8,025	6	**98,704**
NBV - PFI at 31 March 2017	0	12,514	0	0	0	0	0	0	**12,514**
NBV - Donated at 31 March 2017	0	1,703	32	0	576	0	9	0	**2,320**
NBV total at 31 March 2017	**10,650**	**75,591**	**412**	**8,104**	**8,870**	**1,871**	**8,034**	**6**	**113,538**

[1] No assets used in the provision of commissioner requested services have been disposed of during the year.

Note 8.3 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	n/a	n/a
Buildings excluding dwellings	0	124
Dwellings	0	112
Assets under Construction & POA	n/a	n/a
Plant & Machinery	0	15
Transport Equipment	0	7
Information Technology	0	8
Furniture & Fittings	0	10
Intangible Software Licenses	0	8

9 Other Property Plant & Equipment Disclosures

The Trust received £566k of donated property, plant and equipment from the charitable funds associated with the hospital.

The Trust entered into a 10 year contract for the provision of medical records in February 2013. Due to the length of the contract, the expected life of the equipment in question and, on the basis that the equipment is solely used by this Trust, the Trust has recognised this equipment as property plant and equipment. The value of this equipment as at 31 March 18 was £1,310k.

The Trust's estate, encompassing land and buildings was revalued as at 31 March 2018. This valuation was completed by Gerald Eve LLP, professional valuers in accordance with the RICS Valuation - Professional Standards published by the Royal Institution of Chartered Surveyors. The Directors' opinion is that there are no property plant or equipment where the value is significantly different from the value included in the financial statements.

Land was valued using existing use value methodology at £12,270k using the concept of economic substitution of the service utility of the asset.

Given the specialised nature of the buildings the majority of the estate has been valued using depreciated replacement cost based on modern equivalent assets at a value of £78,739k.

There are various small assets which are temporarily idle, although not for sale, where the period for which the asset is idle is uncertain these have had their depreciation accelerated and are held on the Statement of Financial Position at values reflecting their short remaining economic lives.

10.1 Non-current assets for sale and assets in disposal groups

The Trust held no non-current assets for sale nor assets in disposal groups in 2016/17 or 2017/18.

10.2 Liabilities in disposal groups

The Trust held no liabilities in disposal groups in 2016/17 nor 2017/18.

11 Investments

	Parent		Group	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
NHS Charitable funds: Other investments				
Carrying value at 1 April 2017	0	0	3,075	3,072
Acquisitions in year - other	0	0	258	455
Fair value gains (taken to I&E)	0	0	34	408
Fair value losses (impairment) [taken to I&E]	0	0	0	(1)
Disposals	0	0	(1,151)	(859)
Carrying value at 31 March 2018	**0**	**0**	**2,216**	**3,075**

Note 12 Associates & Jointly Controlled Operations

The NHS foundation trust is the corporate trustee to Luton & Dunstable Hospital Charitable Funds. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The main financial statements disclose the NHS organisation's financial position alongside that of the group (which is the NHS organisation and the NHS charity). The NHS charity's accounts, which have been prepared in accordance with UK Financial Reporting Standard (FRS) 102, can be found on the Charity Commission website and are summarised in note 24 to these accounts.

As the accounting policies applicable to both the Trust and the Charitable Funds are consistent no adjustment other than intra-group transactions has been required.

The Trust had no other associates nor jointly controlled operations in 2016/17 nor 2017/18.

Note 13.1 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	955	1,023
Consumables	2,466	2,268
TOTAL INVENTORIES	**3,421**	**3,291**

Note 13.2 Inventories recognised in expenses

	2017/18 £000	2016/17 £000
Additions	47,828	47,347
Inventories recognised in expenses	(47,698)	(47,266)
MOVEMENT IN INVENTORIES	**130**	**81**

14.1 Trade receivables and other receivables

	Parent		Group	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
NHS Receivables	**10,506**	7,503	**10,506**	7,503
Other receivables with related charitable funds	**54**	51	**0**	0
Other receivable with related parties	**1,007**	614	**1,007**	614
Provision for impaired receivables	**(852)**	(943)	**(852)**	(943)
Prepayments	**4,192**	3,893	**4,192**	3,893
Prepayments - Lifecycle replacements	**44**	44	**44**	44
Accrued income	**13,214**	8,470	**13,214**	8,470
VAT receivable	**1,341**	1,298	**1,341**	1,298
Other receivables	**3,195**	2,735	**3,195**	2,735
NHS Charitable funds: Trade and other receivables	**0**	0	**9**	0
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**32,701**	**23,665**	**32,656**	**23,614**
Non-Current				
Prepayments	**568**	487	**568**	487
Prepayments - PFI related	**306**	350	**306**	350
Accrued income	**1,012**	1,080	**1,012**	1,080
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**1,886**	**1,917**	**1,886**	**1,917**

Note 14.2 Provision for impairment of receivables

	31 March 2018 £000	31 March 2017 £000
At 1 April 2017	**943**	993
Increase/(Decrease) in provision	**195**	(10)
Amounts utilised	**(286)**	(40)
At 31 March 2018	**852**	**943**

14.3 Analysis of impaired receivables

	31 March 2018 £000	31 March 2017 £000
Ageing of impaired receivables		
0 - 30 days	**35**	35
30-60 Days	**35**	35
60-90 days	**35**	42
90- 180 days	**104**	110
over 180 days	**643**	721
Total	**852**	**943**
Ageing of non-impaired receivables past their due date		
0 - 30 days	**6,290**	326
30-60 Days	**906**	638
60-90 days	**1,081**	462
90- 180 days	**591**	1,564
over 180 days	**2,963**	5,227
Total	**11,831**	**8,217**

The Trust has reviewed the not due and non impaired receivables and has satisfied itself that there is no evidence of impairment which have an impact on the estimated future cash flows of the assets.

14.4 Finance lease receivables

During 2017/18 the Trust did not have any finance lease receivables.

15 Other assets (Non Current)

	31 March 2018 £000	31 March 2017 £000
PFI Scheme - lifecycle costs	**2,432**	2,574
Total	**2,432**	**2,574**

16.1 Trade and other payables

	Parent		Group	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Receipts in advance	**57**	0	**57**	0
NHS payables	**3,969**	3,829	**3,969**	3,829
Amounts due to other related parties - revenue	**2,642**	2,225	**2,642**	2,225
Trade payables - capital	**1,370**	2,229	**1,370**	2,229
Other trade payables	**4,742**	5,071	**4,742**	5,071
Social Security costs	**4,668**	3,884	**4,668**	3,884
Other payables	**719**	598	**719**	598
Accruals	**8,342**	6,201	**8,342**	6,201
PDC Dividend Payable	**164**	97	**164**	97
NHS Charitable funds: Trade and other payables	**0**	0	**137**	119
TOTAL CURRENT TRADE & OTHER PAYABLES	**26,673**	**24,134**	**26,810**	**24,253**

There were no non current trade or other payables at either 31 March 2017 or 31 March 2018.

NHS payables do not include any outstanding pension contributions due to NHS Pensions Agency as at 31 March 2018.

Note 17 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred Income	**1,608**	1,650
TOTAL OTHER CURRENT LIABILITIES	**1,608**	**1,650**

There are no non current other liabilities in 2016/17 nor 2017/18.

Note 18 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Capital loans from Department of Health	**835**	835
Other loans	**11**	8
Obligations under Private Finance Initiative contracts	**639**	580
TOTAL CURRENT BORROWINGS	**1,485**	**1,423**
Non-current		
Capital loans from Department of Health	**17,970**	18,805
Other loans	**0**	11
Obligations under Private Finance Initiative contracts	**10,156**	10,795
TOTAL OTHER NON CURRENT LIABILITIES	**28,126**	**29,611**

Note 19. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2016 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

Note 20. Finance lease obligations

The Trust had no finance lease obligations during 2017/18 other than the PFI scheme arrangement.

Note 21.1 PFI obligations (on SoFP)

	31 March 2018 £000	31 March 2017 £000
Gross PFI liabilities	**15,744**	17,032
of which liabilities are due		
- not later than one year;	**1,318**	1,287
- later than one year and not later than five years;	**5,587**	5,459
- later than five years.	**8,839**	10,285
Finance charges allocated to future periods	**(4,949)**	(5,656)
Net PFI liabilities	**10,795**	**11,375**
- not later than one year;	**639**	580
- later than one year and not later than five years;	**3,311**	3,007
- later than five years.	**6,845**	7,788

Note 21.2 The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 March 2018 Total £000	31 March 2017 Total £000 (Restated)
Within one year	**1,829**	1,769
2nd to 5th years (inclusive)	**7,688**	7,537
Later than 5 years	**13,696**	15,675
Total	**23,213**	**24,981**

The Trust incurred £512k expenditure in respect of the service charge under the PFI contract (£584k in 2016/17). This is shown within the Premises category in Note 3.1.

22 Provisions for liabilities and charges

Parent	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Pensions relating to other staff	**65**	64	**630**	619
Other legal claims	**177**	295	**0**	0
Redundancy	**0**	152	**0**	0
Other	**25**	10	**0**	0
Total	**267**	**521**	**630**	**619**

Group	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Pensions relating to other staff	**65**	64	**630**	619
Other legal claims	**177**	295	**0**	0
Redundancy	**0**	152	**0**	0
Other	**25**	10	**0**	0
NHS charitable fund provisions	**418**	309	**146**	22
Total	**685**	**830**	**776**	**641**

	Pensions - other staff £000	Other legal claims £000	Redundancy £000	Other £000	NHS charitable fund provisions £000	Total £000
At 1 April 2017	**683**	**295**	**152**	**10**	**330**	**1,470**
Arising during the year	75	35	0	15	0	125
Utilised during the year	(65)	(141)	(152)	0	0	(358)
Reversed unused	0	(11)	0	0	0	(11)
Unwinding of discount	2	0	0	0	0	2
NHS charitable funds: movement in provisions	0	0	0	0	233	233
At 31 March 2018	695	178	0	25	563	1,461
Expected timing of cashflows:						
- not later than one year;	65	178	0	25	417	685
- later than one year and not later than five years;	266	0	0	0	146	412
- later than five years.	364	0	0	0	0	364
TOTAL	695	178	0	25	563	1,461

Provisions for legal claims represents the gross estimated liability from employer and public liability cases. These cases are managed by NHS Litigation Authority through the LTPS scheme, the amount of the provision recoverable from NHS Litigation Authority is included within debtors.

£163,330k is included in the provisions of the NHS Litigation Authority at 31/03/2018 in respect of clinical negligence liabilities of the Trust (31/03/2017 £101,859k).

Other provisions relate to various provisions for trading and employment contractual issues (all less than £1m).

Note 23 Revaluation reserve

	Revaluation Reserve -property, plant and equipment	Total Revaluation Reserve*
	£000	£000
Revaluation reserve at 1 April 2017	8,317	**8,317**
Revaluation Impact	3,597	**3,597**
Other Movements	0	**0**
Revaluation reserve at 31 March 2018	**11,914**	**11,914**
Revaluation reserve at 1 April 2016	11,522	**11,522**
Revaluation Impact	(3,205)	**(3,205)**
Other Movements	0	**0**
Revaluation reserve at 31 March 2017	**8,317**	**8,317**

* The Trust held no revaluation reserve in respect of intangible assets.

24 Charitable Funds Summary Statements

As per Note 12, below summarises the NHS Charity's accounts which have been consolidated within the Group's accounts in accordance with IAS 27.

	Subsidary	
	2017/18 £000	2016/17 £000
Statement of Financial Activities/ Comprehensive Income		
Incoming resources	**1,031**	1,113
Resources expended	**(1,736)**	(905)
Net resources expended	**(705)**	208
Incoming Resources: investment income	**74**	91
Fair value movements on investments	**34**	407
Net movement in funds	**(597)**	706

	31 March 2018 £000	31 March 2017 £000
Statement of Financial Position		
Non-current assets	**2,216**	3,075
Current assets	**1,324**	810
Current liabilities	**(609)**	(479)
Non-current liabilities	**(145)**	(22)
Net assets	**2,786**	**3,384**
Funds of the charity		
Endowment funds	**1**	1
Other Restricted income funds	**871**	1,320
Unrestricted income funds	**1,914**	2,063
Total Charitable Funds	**2,786**	**3,384**

25 Cash and cash equivalents

	Parent		Group	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
At 1 April (as previously stated)	**28,176**	9,146	**28,986**	9,403
Net change in year	**8,224**	19,030	**8,730**	19,583
At 31 March	**36,400**	28,176	**37,716**	28,986
Broken down into:				
Cash at commercial banks and in hand	**83**	39	**83**	39
NHS charitable funds: cash held at commercial bank	**0**	0	**1,315**	810
Cash with the Government Banking Service	**36,318**	28,137	**36,318**	28,137
Cash and cash equivalents as in SoFP	**36,400**	28,176	**37,716**	28,986
Cash and cash equivalents as in SoCF	**36,400**	28,176	**37,716**	28,986

The Trust held £0.2k cash at bank and in hand at 31/03/18 which relates to monies held by the Trust on behalf of patients.

Note 26.1 Contractual Capital Commitments

The Trust had contractual capital commitments totalling £3.1m at 31 March 2018.

26.2 Events after the reporting period

There have been no events after the reporting period end requiring disclosure.

The Director of Finance authorised the financial statements for issue on 23 May 2018.

27. Contingent (Liabilities) / Assets

	31 March 2018 £000	31 March 2017 £000
Gross value of contingent liabilities	29	59
Net value of contingent liabilities	29	59
Net value of contingent assets	0	0

Contingent liabilities relate to claims that the NHS Litigation Authority is aware of and has requested that we disclose.

Note 28 Related Party Transactions

The Luton & Dunstable Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the NHS Foundation Trust.

All bodies deemed to be within the remit of the United Kingdom 'Whole of Government' are regarded as related parties. During the year the Trust has had significant transactions with the bodies disclosed in this note.

The Trust is the Corporate Trustee for the Charitable Funds, the transactions for which have been consolidated within these financial statements in accordance with IAS 27.

	Income 2017/18 £000	Expenditure 2017/18 £000	Income 2016/17 £000	Expenditure 2016/17 £000
NHS and DH				
Aylesbury Vale CCG	**3,118**	**0**	2,795	0
Bedfordshire CCG	**72,979**	**0**	65,708	0
Department of Health	**4,532**	**3,597**	8,702	3,167
Health Education England	**9,242**	**0**	8,427	0
Herts Valleys CCG	**24,427**	**0**	21,640	0
Luton CCG	**130,225**	**0**	125,962	0
NHS England: East Commissioning Hub	**34,565**	**0**	30,355	0
NHS England: Central Midlands Local Office	**9,627**	**0**	9,701	0
NHS England: Core	**14,997**	**0**	10,261	0
NHS Resolution (Previously NHS Litigation Authority)	**0**	**10,304**	0	7,447
Central Government				
HM Revenue and Customs	**0**	**17,738**	0	14,893
National Health Service Pension Scheme	**0**	**17,595**	0	15,647

28 Related Party Transactions continued

	Receivables 31 March 2018 £000	Payables 31 March 2018 £000	Receivables 31 March 2017 £000	Payables 31 March 2017 £000
Related Party Balances NHS and DH				
Aylesbury Vale CCG	**819**	**0**	165	0
Bedfordshire CCG	**3,551**	**0**	2,182	33
Department of Health	**1**	**0**	1	139
Health Education England	**793**	**0**	134	2
Herts Valleys CCG	**47**	**0**	1,755	0
Luton CCG	**2,240**	**0**	831	0
NHS England: East Commissioning Hub	**1,006**	**0**	1,928	0
NHS England: Central Midlands Local Office	**45**	**0**	748	0
NHS England: Core	**8,445**	**0**	3,435	0
NHS Resolution (Previously NHS Litigation Authority)	**0**	**0**	0	0
Central Government				
HM Revenue and Customs	**1,341**	**4,668**	1,341	3,884
National Health Service Pension Scheme	**0**	**2,574**	0	2,193

29.1 For PFI schemes deemed to be off-SoFP

The Trust ended the off SoFP PFI scheme relating to the provision of the electronic patient record system in 2011/12. There are no transactions within either 2016/17 or 2017/18 relating to an off-SoFP PFI scheme.

29.2 Further narrative on PFI schemes

The Trust had two capital schemes arranged under PFI arrangements, one of these ended in 2011/12.

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 12 years remaining. The operator is responsible for maintaining the building during this period and ownership reverts to the Trust at the end of the contract. There are no break clauses nor re-pricing dates (On-SoFP)

2. The contract for the electronic patient record scheme ***has now finished. This contract was for 10 years.***

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

30.1 Financial assets by category

	Parent		Group	
	Loans and receivables £000	Total £000	Loans and receivables £000	Total £000
Assets as per SoFP				
Trade and other receivables excluding non financial assets (at 31 March 2018)	23,126	**23,126**	23,126	**23,126**
Cash and cash equivalents (at bank and in hand (at 31 March 2018))	36,400	**36,400**	36,400	**36,400**
NHS Charitable funds: financial assets (at 31 March 2018)	0	**0**	3,539	**3,539**
Total at 31 March 2018	**59,526**	**59,526**	**63,065**	**63,066**
Trade and other receivables excluding non financial assets (at 31 March 2017)	13,852	**13,852**	13,801	**13,801**
Cash and cash equivalents (at bank and in hand (at 31 March 2017))	28,176	**28,176**	28,175	**28,175**
NHS Charitable funds: financial assets (at 31 March 2017)	0	**0**	3,886	**3,886**
Total at 31 March 2017	**42,028**	**42,028**	**45,862**	**45,862**

Financial Assets risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS receivables	Low	Low	Low
Accrued income	Low	Low	Medium
Other debtors	Low	Low	Medium
Cash at bank and in hand	Low	Medium	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

The Trust has a robust, audited, debt management policy that mitigates against the debtor liquidity risk. The Trust mitigates the cash credit risk by investing only in line with the NHS Improvement compliant Treasury Management Policy.

30.2 Financial liabilities by category

	Parent		Group	
	Other financial liabilities £000	Total £000	Other financial liabilities £000	Total £000
Liabilities as per SoFP				
Borrowings excluding finance lease and PFI liabilities (at 31 March 2018)	18,816	**18,816**	18,816	**18,816**
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2018)	10,795	**10,795**	10,795	**10,795**
Trade and other payables excluding non financial liabilities (at 31 March 2018)	26,674	**26,674**	26,674	**26,674**
NHS Charitable funds: financial liabilities (at 31 March 2018)	0	**0**	191	**191**
Total at 31 March 2018	**56,285**	**56,286**	**56,476**	**56,477**
Borrowings excluding finance lease and PFI liabilities (at 31 March 2017)	19,659	**19,659**	19,659	**19,659**
Obligations under Private Finance Initiative contracts (31 March 2017)	11,376	**11,376**	11,376	**11,376**
Trade and other payables excluding non financial liabilities (31 March 2017)	20,152	**20,152**	20,152	**20,152**
NHS Charitable funds: financial liabilities (31 March 2017)	0	**0**	172	**172**
Total at 31 March 2017	**51,187**	**51,187**	**51,359**	**51,359**

Financial Liabilities risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS creditors	Low	Low	Low
Other creditors	Low	Low	Low
Accruals	Low	Low	Low
Capital creditors	Low	Low	Low
Provisions under contract	Low	Low	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

All major contractors are credit checked prior to the awarding of the contract, thus limiting credit risk.

The Trust mitigates the liquidity risk via 12 month forward cash planning.

30.3 Maturity of Financial Liabilities

			31 March 2018 £000	31 March 2017 £000
In one year or less			28,345	**22,843**
In more than one year but not more than two years			1,548	**1,480**
In more than two years but not more than five years			5,103	**4,868**
In more than five years			21,480	**21,996**
Total	**56,476**	**51,187**		

30.4 Fair values of financial assets at 31 March 2018

The fair value of the Trust's financial assets were the same as the book value as at 31 March 2018 (and 31 March 2017).

30.5 Fair values of financial liabilities at 31 March 2018

The fair value of the Trust's financial liabilities were the same as the book value as at 31 March 2018 (and 31 March 2017).

Note 31.1 On-Statement of Financial Position pension schemes.

The Trust has no on Statement of Financial Position Pension Scheme transactions.

Note 31.2 Off-Statement of Financial Position pension schemes.

NHS Pension Scheme
See Note 1.3 for details of the accounting treatment of the NHS Pension Scheme.

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period. In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

31.2 Off-Statement of Financial Position pension schemes (cont.)

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

National Employment Savings Trust (NEST
The Trust offers employees an alternative pension scheme, NEST. This is a defined contribution, off statement of financial position scheme and the number of employees opting in and the value of contributions have been negligible (£5k employers contribution costs in year.)

32 Losses and Special Payments

	2017/18 Total number of cases Number	2017/18 Total value of cases £000's	2016/17 Total number of cases Number	2016/17 Total value of cases £000's
LOSSES:				
1. c. other causes	0	0	2	0
2. Fruitless payments and constructive losses	0	0	1	7
3.a. Bad debts and claims abandoned in relation to private patients	25	4	0	0
3.b. Bad debts and claims abandoned in relation to overseas visitors	28	83	7	3
3.c. Bad debts and claims abandoned in relation to other	21	117	35	2
4.b Damage to buildings, property etc. due to stores losses	1	65	0	0
4.c Damage to buildings, property etc. due to other	1	17	0	0
TOTAL LOSSES	**76**	**286**	**45**	**12**
SPECIAL PAYMENTS:				
7.a. Ex gratia payments in respect of loss of personal effects	22	14	21	6
7.d. Ex gratia payments in respect of other negligence and injury	0	0	9	2
7.g. other	7	0	0	0
TOTAL SPECIAL PAYMENTS	**29**	**14**	**30**	**8**
TOTAL LOSSES AND SPECIAL PAYMENTS	**105**	**300**	**75**	**20**

There were no compensation payments received.

33 Discontinued operations

There were no discontinued operations in 2017/18.

34 Corporation Tax

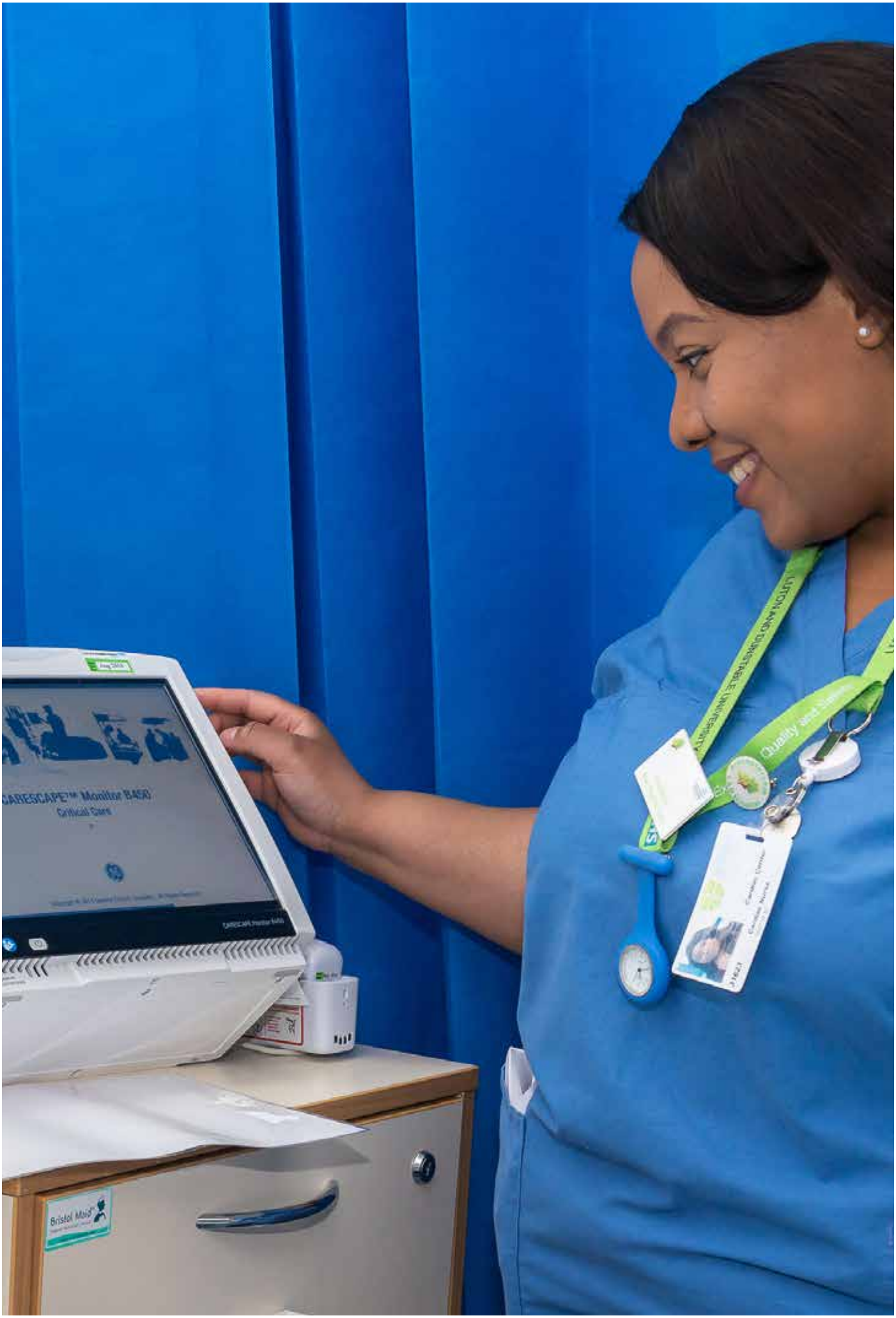
Corporation Tax is not due as the Trust is below the de minimis threshold as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

35 Segmented Operations

The Trust operates in one segment, that of the provision of healthcare, as reported to the Chief Operating Decision Maker, the Board.

36 Foundation Trust Income Statement and Statement of Comprehensive Income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's surplus for the period was £15,368k (2016/17: £12,919k). The trust's total comprehensive income for the period was £18,965k (2016/17 comprehensive income: £9,714k).


CARESCAPE™ Monitor B450
Critical Care
Bristol Maid

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 is the 'quality' of the services provided defined?

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

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

About our Quality Account

This report is divided into sections.

- A statement on quality from the Chief Executive and sets out our corporate objectives for 2018/19.
- Our performance in 2017/18 against the priorities that we set for patient safety, clinical effectiveness and patient experience.
- Our quality priorities and goals for 2018/19 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.

Some of the information in the Quality Account is mandatory; however most is decided by our staff and Foundation Trust Governors.

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

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

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

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

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 2017/18 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

1. A Statement on Quality from the Chief Executive

Part 1

Improving clinical outcome, patient safety and patient experience remain the core values of the L&D. This can be seen by reading our corporate objectives and understanding the progress that we are making year on year delivering sustained improvement.

During the year, we have continued our focus on quality improvement initiatives. As reported last year we launched our Advancing Quality and Patient Safety Framework at our Staff Engagement Event in December 2016 where over 2000 staff were engaged in delivering our plans. We continued this work reporting back progress against the Quality Improvement programmes in July 2017 at our Engagement Events and again in December 2018.

As in previous years we delivered against most of the national and local quality and performance targets. We continued to be one of the best performing hospitals in the country for the waiting time targets in A&E and we achieved cancer performance targets. We also maintained a low number of C Diff with 9 cases. However, we had some challenges with waiting times for diagnostics in endoscopy that was resolved by March 2018 and in delivering the 18 week target due to the unprecedented winter pressures. Action plans are in place to recover this position and whilst not achieving the 92% we have continued to maintain a high percentage seen within 18 weeks.

Our quality priorities set out for 2017/18 have been embedded into our systems and processes and we made considerable progress. We:

- Maintained over 90% compliance with the 3 day anti-biotic reviews in all clinical areas.
- Maintained a high focus on mortality and implemented a new more intensive mortality review processes and we have seen a reduction in HSMR during 2017/18.
- Worked closely with our mental health provider, East London NHS Foundation Trust, we have seen a 47% reduction in A&E attendances of mental health patients who frequently attend.
- Maintained a falls rate of below the national average and a reduction in the number of falls that resulted in harm.
- Worked on a new model of care called Needs Based Care that will see patients directed to a ward based on their need rather than their age.
- Maintained a cardiac arrest rate below the national average and continued to learn from each incident to further strengthen our processes.
- Improved our provision of support for dementia patients that has received positive feedback from patients.
- Further improved our engagement with patients to include more feedback into our governance and strategies.

This Quality Account also focuses on how we will deliver and maintain our progress against our key quality practices in the coming year. These priorities have been developed from our own intelligence of where we need to improve, engaging with all stakeholders to develop a comprehensive Quality Strategy, commissioning quality goals (CQUIN) and our CQC report.

David Carter
Chief Executive
23rd May 2018

Corporate Objectives 2017/18

The Trust's Strategic and Operational Plans are underpinned by seven Corporate Objectives. A report against these objectives is included in the Trust Annual Report 2017/18.

1. Deliver Excellent Clinical Outcomes

- Year on year reduction in Hospital Standardised Mortality Ratio in all diagnostic categories

2. Improve Patient Safety

- Year on year reduction in clinical error resulting in harm
- Year on year reduction in Hospital Acquired Infection

3. Improve Patient Experience

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

4. Deliver National Quality and Performance Targets

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

5. Implement our Strategic Plan

- Deliver new service models:
  - Emergency Hospital
  - Women's and Children's Hospital
  - Elective Centre
  - Academic Unit
- Implement preferred option for the re-development of the site.

6. Secure and Develop a Workforce to meet the needs of our Patients

- Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.
- Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes.
- Deliver excellent in teaching and research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

7. Optimise our Financial Plan

- Deliver our financial plan

2. Report on Priorities for Improvement in 2017/18

Part 2

Last year we identified three quality priorities. This section describes what we did and what we achieved as a consequence. All of these priorities continue to be relevant and will be further developed during this current year.

We had key priorities each for patient safety, patient experience and clinical outcome.

Priority 1: Clinical Outcome

Key Clinical Outcome Priority 1

- **Improve our approach to mortality surveillance, identifying and reducing avoidable deaths**

Why was this a priority?

The Trust maintained an extensive focus on hospital mortality during 2017/18 which was reflected in a comprehensive programme of work. It built on the report commissioned in 2016 for an independent review into the Trusts HSMR performance by Dr Bill Kirkup CBE. The report was supportive of the work undertaken to date and made further recommendation which was added to the programme.

Overall the program included, the review of all deaths using a standardised Mortality tool; improving the access to specialist palliative care; establishing Mortality and Morbidity meetings in all of the Divisions and changes to coding. The Mortality Board monitors the progress of the programme and ensures learning is shared across the Trust.

What did we do?

- The Trust Mortality Board has overseen the development and publication of the Trust Mortality Review Policy. The first draft was published on the Trust website before the September deadline set out in the Learning From Deaths agenda.

- We have changed the methodology of our mortality reviews, from one adapted from the East of England Mortality Review Tool, to the Structured Judgement Review introduced by the Royal College of Physicians. This entailed training all consultants in the new methodology, and supporting their first few notes reviews. The process is now embedded, and teams are familiar with the Potential Avoidability score being used as the end-point of the review.

- We now have an established two-stage process for reviewing notes of deceased patients. The data being collated is now much more robust, and learning themes are being presented to governance meetings to improve system performance.

- We have referred all Learning Disability deaths to the LeDeR co-ordinators since the scheme was launched in October 2017, and Child, Maternal and Neonatal deaths continue to be reported and investigated through the appropriate national review programmes.

- The number of patients dying in hospital within 72 hours of admission from a nursing home has increased, from 49 last year to 56 this year. We have established a process for individual cases identified through mortality reviews as a potentially inappropriate in-hospital death to be escalated to Primary Care for review. The next step is a focussed piece of work trying to support a single care home to look after dying patients without the need for them to be admitted to hospital.

How did we perform?

- We have seen our HSMR improve from a statistically significant high of 110 in Feb 2017 to its current level of 101.9, moving us out of lower quartile performance.

- HSMR continues on a downward trend, and the last five months have been within the expected range after two consecutive years of being "significantly above expected." A considerable amount of work has gone into looking for systemic causes of our higher than expected mortality. Significant progress on the key issues of palliative care coding, Charlson score capture, VTE risk assessment and prophylaxis pathways, and DNACPR/Treatment Escalation Plans appear to be linked to this improvement, which has occurred on a background of significant activity increases over the same timeframe.

- In the first two months of the final quarter of 2017-18, we have achieved a primary review in 97% of all deaths (275/284). From these, we requested 74 full mortality reviews, of which to date, 51 (69%) have been completed. This is significant progress from the previous quarter, where only 35% of requests were completed.

- Key learning themes were identified around appropriate discussion of "Do Not Resuscitate" orders, recognition of the end of life phase, and the need for improvements in the completion rates of requested full mortality reviews.

This priority will continue as an L&D quality priority for 2018/19.

Key Clinical Outcome Priority 2

- **Reduce the impact of serious infections (Antimicrobial Resistance and Sepsis)**

Why was this a priority?

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these, it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. This quality improvement initiative (which is also a National CQUIN scheme), is aimed at embedding NICE guidance to improve sepsis management. Furthermore, the approach taken to combine a responsive approach to the detection and treatment of sepsis needs to be balanced with a rigorous approach to the stewardship of antibiotics. Antimicrobial resistance has increased in recent years and the Chief Medical Officer believes that it is a major risk for healthcare. Without a reversal of the trend, we may find we have no drugs to treat serious infections in the future. The approach to these two key areas for improvement is taken from the viewpoint that the issues of sepsis and antimicrobial resistance are complementary and that developing and implementing a joint improvement scheme (CQUIN) will support a coherent approach towards reducing the impact of serious infections.

What did we do?

The Trust has appointed a Medical Director as the Trust-wide Lead for Sepsis. Clinical Champions have been appointed to support the improvement work in all Divisions in conjunction with an additional Sepsis Improvement Lead.

We have revised and implemented Sepsis Screening tools which provide clear management strategies for patients who trigger for sepsis. These have been re-designed to align with the updated requirements for NICE and the CQUIN for 2017-19.

We have provided training and education to the multi-disciplinary team in the recognition and management of sepsis.

The CQUIN audit has highlighted some clear areas for improvement especially in the patients who develop sepsis whilst in patients. A newly appointed Sepsis Improvement Collaborative will be set up to lead this work in the year 2018-19.

To support improved antibiotic stewardship the antibiotic pharmacist in conjunction with the microbiologist has been conducting antibiotic ward rounds for targeted patients. In addition the antibiotic pharmacist has been providing on-going support and guidance to junior doctors to review antibiotic prescribing practice in line with best practice recommendations.

How did we perform?

The Trust has demonstrated excellent compliance with sepsis screening as monthly audit has shown that on average over the last year 98% of patients have been screened appropriately for sepsis, both in the Emergency Department and for patients developing sepsis whilst in patients.

Monthly audit has shown that on average over the last year in the Emergency Department 90% of patients presenting with sepsis have been provided with antibiotics within 1 hour of diagnosis of sepsis. ***

Audit has shown an average of 90% of patients with sepsis have been having clinical antibiotic reviews within 72 hours of antibiotic administration.

Key Clinical Outcome Priority 3

- **To improve services for people with mental health needs who present to Accident and Emergency**

Why was this a priority?

People with mental health problems are three times more likely to present to A&E than the general population. Nationally, more than 1 million presentations are currently recorded as being directly related to mental health. Furthermore, evidence has shown that people with mental health issues have 3.6 times more potentially preventable emergency admissions than those without and that the high levels of emergency care used by people with mental health problems indicate that there are opportunities for planned care to do more. A large majority of the people with the most complex needs who attend A&E most frequently are likely to have significant physical and mental health needs and may benefit from assessment and review of care plans with specialist mental health staff and further interventions from a range of health and social services. This is a National priority and a CQUIN has been developed to support cross-provider working to deliver improvements in care to this group of patients by providing enhanced packages of care from the most appropriate services.

What did we do?

- Regular monthly meetings were set up and are running successfully between the Trust and East London Foundation Trust. Further wider partnership sessions were also held in September 2017, January and March 2018 which included representatives from Bedfordshire Police, Luton Borough Council, Central Bedfordshire Council, Luton CCG, Bedfordshire CCG, MIND, CGL, East of England Ambulance Service, Herts Urgent Care as well as representatives from East London Foundation Trust and the Trust where both system working was discussed as well as the individual management of the patients within the frequent attenders programme. These are continuing throughout 2018/19.

- Clinicians from the Trust and East London Foundation Trust identified a group of 20 patients who had attended A&E most frequently during 2016/17 and it was felt would benefit most from further interventions. A Frequent Attender Project Lead was appointed by East London Foundation Trust and 16 of those contacted agreed to engage in the Frequent Attenders Programme.

- Individual care plans were jointly drawn up with the patients and the Frequent Attender Project Lead, and links developed and strengthened with existing services that could support the patient with their mental health issues and offer an alternative to attendance at A&E. These are regularly reviewed and amendments made to suit the needs of the patient at that point in their life including patient experience and satisfaction.

- A number of audits were carried out on data samples from the two patient systems used by the East London Foundation Trust and the Trust to review current data quality and make sure processes are in place to improve the collection and accuracy of data in relation to mental health signs and symptoms.

How did we perform?

- A reduction in attendances of 47% has been seen in the group of frequently attending patients.

This priority will continue as an L&D quality priority for 2018/19.

Key Clinical Outcome Priority 4

- **To provide services to patients experiencing frailty in line with best practice**

Why was this priority?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this quality improvement initiative is to implement best practice guidance to enable us to take action to prevent these adverse outcomes and help people live as well as possible with frailty. Appropriate services, delivered effectively to this group of patients will support a reduction in length of stay, reduced morbidity and mortality and a better experience for patients and their carers. Furthermore, the initiative will support the delivery of the Trust priority to deliver Continuity of Care and improve the flow of patients admitted as emergencies to the hospital.

What did we do?

Frailty is not an inevitable part of ageing and can be improved or can prevented with early identification and long term co-ordinated care planning. The Directorate for Medicine of the Elderly (DME) Team and Luton CCG and other stakeholders have worked together to develop a Framework for Frailty which is divided into prevention (P1) and treatment (P2) whereby patients aged over 65 years of age are assessed. The DME team have regularly attended the Frailty and Falls Group Meeting and MDTs. New pathways have been completed and are being rolled out across the Trust for delivery of the Frailty Unit. Initially this will be led by ward 19a at the L&D but as the new Needs Based Care (see key patient safety priority 1) rolls out it is planned to have the beds for Frailty within the Acute Assessment unit.

How did we perform?

The work completed throughout 2017/18 enabled the frailty unit to become operational in February 2018, therefore have not been able measure the appropriateness of referrals as yet, or gained sufficient feedback from service users. However, we will be monitoring the following performance indicators over the next year to identify whether there has been:

- A reduction in the number of frail patients being admitted to hospital via A&E or EAU
- A reduction in the length of stay for patients with frailty
- A decrease in the proportion of patients with frailty who are admitted to hospital for an overnight stay

This priority will continue as an L&D quality priority for 2018/19.

Priority 2: Patient Safety

Key Patient Safety Priority 1

- **Improving Continuity of Care and delivering Needs Based Care model**

Why was this a priority?

The delivery of 7 day consultant led services and early senior review and decision making for patients admitted to hospital as an emergency has been a significant area of quality improvement for the Trust, with significant increases in consultant presence out of hours and at the 'front-door' of the hospital over the last few years. However, as our model for emergency care has gradually evolved, an unintended consequence has been an increase to the number of consultants that have sequential input into a patient's care. It is not unusual for a patient admitted to a medical specialty as an emergency to receive care from a number of different consultants during their hospital stay. This can lead to confusion for the patient and their family as to what is happening, difficulties in co-ordinating the plan where the owning consultant is not following it through, and does not make it easy for senior medical staff to closely monitor a patient's progress and assess the effectiveness of treatment. By improving the continuity of consultant care for an individual patient, we will improve patient experience, reduce length of stay and minimise the clinical risk of patient management plans being handed over between senior clinical staff multiple times.

Within the range of emergency admissions to hospital, there will be some patients who will benefit from being cared for by physicians with a particular specialist interest, such as stroke, cardiology or respiratory. There are other patients who may be admitted with a straightforward medical issue, such as an infection or after a fall, but have very complex needs perhaps because of underlying long term conditions, poly-pharmacy, or extensive social or support needs.

These patients require care from a senior general medical physician, with support from a wide range of professionals, and carefully managed transitions between hospital and usual place of residence. Getting the patient to the right specialty team as early in their admission as possible is really important to avoid unnecessary investigations, support the patient to be managed at home wherever possible and to enable rapid and targeted treatment and intervention without having to wait for advice from another specialist.

What did we do?

The Medical Division have been working on developing a model of Needs Based Care since late 2015. The team had already embedded ambulatory care pathways running 7 days a week and opened a cardiac ward for patients to be admitted under cardiologists where appropriate, rather than being admitted under a general physician who would then seek advice from a cardiologist. This has shown a reduction in length of stay for patients with cardiac diagnosis, and the initial data review suggested that this change was saving up to 15 medical beds. The next steps for implementation of Needs Based Care are to;

- Deliver admission for patients directly to respiratory specialists 7 days a week, we have currently been delivering an in reach service to the EAU's Monday to Friday until 5.00pm, this will be expanding once we have substantive recruitment.
- Works to the lifts in the medical block to facilitate specialty ward moves and create a larger flexible EAU bed base at the front of the hospital has not yet started therefore we are unable to deliver a larger EAU environment, the plan for this will now be in 2018/19.
- The design of the complex and general medical senior medical model to enable movement to full needs based care for all specialties has been completed with a full business case going to the Board in November of last year for approval.
- The implementation phase is now in progress with recruitment to all Consultants, Pharmacy and Therapy posts.

How did we perform?

The detailed work to support Needs Based Care resulted in extended time to develop the business case which was approved in November 2017. As this current time we have been taking the appropriate action to support the initiative and a programme of measures will be

monitored through the Programme Board for Needs Based Care including a:

- Reduction in the number of consultant handovers within an inpatient episode
- Increase the % of patients discharged by the same consultant for a related re-admission
- Increase the % of patients discharged by their named outpatient consultant where applicable
- Reduction in length of stay for emergency medical patients
- Improved patient satisfaction regarding communication and involvement in decision making around their care
- Fewer non-value adding days to patient hospital stays due to improved co-ordination of the treatment plan

This priority will continue as an L&D quality priority for 2018/19.

Key Patient Safety Priority 2

- **To reduce the incidence of falls amongst patients staying in hospital**

Why was this a priority?

Over the past five years, the Trust has shown a year on year improvement in the prevalence of falls with harm but the incidence of falls (rate per 1000 bed days) has remained relatively static. Whilst the Trust has a lower incidence of falls than the national average, we are committed to refocusing our multidisciplinary team efforts in order to reduce our rate of falls. When a patient has a fall in hospital, the effect can be both physically and psychologically detrimental and in many cases may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the efficiency of delivery of services to patients by less effective use of beds. Research has shown that when staff such as doctors, nurses and therapists work more closely together, they can reduce falls by 20-30% (RCP 2016). The Trust plans to build upon the work already undertaken to strengthen our approach to the prevention of falls thereby improving patient safety and experience.

What did we do?

- In October the Trust held an inpatient "Falls Summit" which was attended by all relevant stakeholders. A thematic analysis of inpatient falls with harm was presented by the Clinical Advisor to the Board. As a result of this report recommendations in line with NICE and Royal College of Physicians (RCP) were considered and supported.
- A "Falls Summit Action Plan" has subsequently been developed and is being managed through the Trust Falls Steering Group with the Director of Nursing as executive lead.
- The Trust took part in the 2nd RCP Inpatient Falls audit in May. Audit results show an improvement in 5 of the 6 key indicators with 1 remaining unchanged from previous audit in 2015. L&D results noted to be above national average.
- Following bedrail audit in April which revealed variable results across the Trust. The Wards now audit bedrail assessment and use on a monthly basis. These results are brought to Quality performance meetings led by Director of Nursing.
- The "Baywatch" enhanced observation initiative commenced in October. The scheme enables the wards to focus on their high risk patients and to co-hort vulnerable patients in bays with staff member present at all times.
- Patient information leaflet on Falls prevention in Hospital is available across the Trust.
- Posters highlighting falls risks in bathrooms and toilets are in place on all wards. This information is also included in the patient information leaflet.
- The nursing documentation which includes the falls multi factorial assessment has been reviewed and updated led by the Corporate Nursing team. The document is due to be piloted within the next 2 months.
- The bed contract is currently under negotiation with plan to agree new contract within the next 6 months. As part of the contract there will be an increased supply of low rise beds.

How did we perform?

- In line with RCP Inpatient falls audit the Trust now collects two sets of falls rate per 1000 bed days data. One set for the all trust patients and one for patients aged 16 and over and excluding maternity patients.
- For patients over 16 excluding maternity figures show

that apart from one month the Trust has remained below the RCP mean.

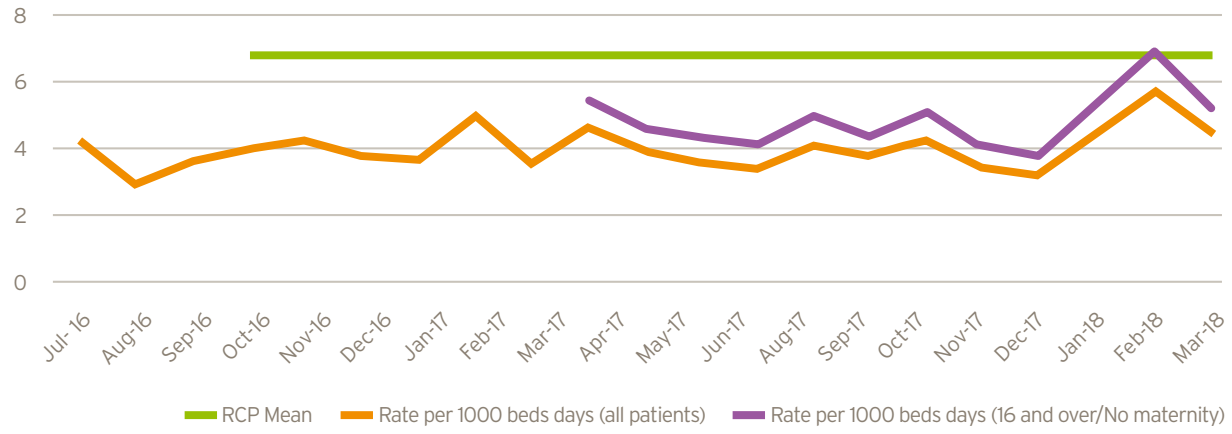
- The Whole Trust falls rate of below 4 per 1000 bed days has proved more challenging to achieve with just 7 months showing rate below 4. The increased activity and the opening of contingency areas for most of January , February and March has meant that staffing has been a challenge with senior staff moved to contingency areas and skill mix reduced on base wards.

- Reporting of falls associated with use of toilets and bathrooms continues. On review of datix reports it was found that the reports had not always been fully completed as "Where did the patient fall" question was not mandatory. This has now been updated and accurate data is now being collected. Results over the year have been variable and have not shown a significant reduction. The falls in toilet /bathroom rate per 1000 bed days for 2017/8 was 0.63. This will continued to be monitored and reported to the board.

- The patient information leaflet on Preventing Falls in Hospital is now included in the Welcome Pack that is being given to patients on the acute admission wards and Ward 17. The leaflets are also available on all the adult wards.

- Action from the Falls Summit meeting has resulted in 3 consultants joining the Trust Falls Steering group.

Falls Rate per 1000 Bed Days



This priority will continue as an L&D quality priority for 2018/19.

Key Patient Safety Priority 3

- **Improve the management of deteriorating patients**

Why was this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2016-17 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, there is a need to continue in our improvements to deliver more sensitive, appropriate care at the end of a person's life. It is vital that for those patients, nearing the end of their life, that appropriate, timely decisions are made and care plans put in place to provide compassionate dignified care when aggressive treatment or resuscitation are not appropriate.

What did we do?

We continued to conduct reviews into all cardiac arrests to identify any learning points. As a result of the reviews a number of cases have required serious incident case reviews or directorate level investigations, and action plans put in place to minimise re-occurrence of any issues identified. Where it has been deemed following review of the case that there is local learning only, then clinical areas have been requested to devise a local action plan to address any issues.

As part of the cardiac arrest review process we have

monitored: 1. Compliance with observations protocols for deteriorating patient, 2. Compliance with the correct process for escalating concerns, 3. Compliance with timely medical response. The review team in conjunction with the responsible clinicians critically analyse decisions made and action taken by medical and nursing staff prior to the arrest to identify whether management was optimal to prevent further deterioration. An improvement approach is then taken to in conjunction with the clinical teams to lessons learned, and action plans implemented to optimise future patient management. In addition as part of the reviews the team have monitored the setting of appropriate ceilings of care, and the use of Personal Resuscitation Plans and where appropriate and DNAPR orders. To support the setting of appropriate ceilings of care a Treatment Escalation Plan has been designed and implemented in Spring 2017 by the Resuscitation team. In clinical practice the outreach team promote the use of appropriate ceilings of care, in conjunction with the responsible clinicians and the patient.

In the Emergency Department best practice interventions are used to optimise recovery for patients presenting with Acute Kidney Injury (AKI).
For in-patients a workstream has begun to support better practice in fluid monitoring in order to prevent 'avoidable' AKI in in-patients. This has included the design and pilot of an innovative fluid chart to provide guidance to clinical staff caring for patients 'at risk' of AKI.

How did we perform?

- On average the annual cardiac arrest rate has been maintained below the National cardiac arrest rate. Cardiac arrest reviews have highlighted a 50% reduction over the year in the numbers of concerns related to both timely and appropriate observations and escalation of concerns and timely end of life decision making. Thus reducing the incidence of 'Avoidable' arrests, and ensuring patients nearing the end of their life are appropriately assessed and provided with a careplan to ensure the most appropriate care delivery.

This priority will continue as an L&D quality priority for 2018/19.

Key Patient Safety Priority 4

- **To reduce the incidence of medication errors for inpatients**

Why was this a priority?

Every step in the processes associated with the use of medicines has the potential for failure to a varying degree. Medication safety is therefore, the responsibility of all staff and most effective when underpinned by a culture of openness and honesty when things go wrong. It is vital that we learn and use our developing understanding of medication safety incidents to most effectively deal with the causes of failure. The reporting, analysis of and learning from medication safety incidents is vital even where no harm has occurred to a patient. This allows the best quality learning to take place as the 'what', 'how' and 'why' things went wrong, so that effective and sustainable solutions can be put in place to reduce the risk of similar incidents occurring.

Research evidence (NHS England 2014) indicates the following medication error rates in the medicine use process nationally:

- Prescribing error rate in hospital, 7% of prescription items;
- Medicine administration errors in hospital, 3 - 8%;
- Dispensing error rate in hospitals, 0.02 - 2.7% of dispensed items;

Drug incidents accounted for 7% of all incidents reported on the Trust's patient safety incident reporting system during 2016/17, 95% of which caused no harm or low harm. However, there is opportunity to increase reporting rates of medication incidents following an apparent reduction in reporting during some parts of the year.

Since being chosen as one of the pilot sites for the 'Safer Patient Initiative' over a decade ago, significant progress has been made through an organisation-wide approach to patient safety and medication safety. The findings of the Francis Report also resulted in measures being put in place to address areas of concern relating to medicines use. The Trust Medication Safety Review Group (MSRG) reviews medication error reports each month, identifying themes and ensuring multidisciplinary, trust-wide learning is shared. This priority, aims to refocus attention across all professions to maximise the opportunities afforded by learning for quality improvements to further drive up our safety in medicines management.

What did we do?

- Medication error sub-category on Datix was reviewed and streamlined as part of the incident categorisation project.
- Missed doses audit was completed – results and recommendations are yet to be shared with senior nurses. A robust high risk medicines monitoring system is being proposed.
- The Medication Safety Review Group (MSRG) continues to monitor trends and themes from the medication error analysis and this has formed the basis for various improvement work streams.
- Multi- professional insulin quality improvement (QI) work stream was undertaken to reduce insulin related errors.
- EPMA insulin drug-lines were reviewed to reduce selection errors by prescribers.
- High risk medicines alerts on EPMA - in response to a number of Datix incidents involving non-vitamin K oral anticoagulants (NOACs), the MSRG approved the introduction of high risk medication alert functionality on EPMA as a safety prompt for prescribers.
- Learning from recurring medication errors continue to be highlighted and disseminated through the MIST newsletter, a quarterly publication by the Pharmacy department.
- Junior doctors prescribing errors feedback sessions have continued with excellent feedback – an abstract was recently submitted to Health Education England (HEE).

How did we perform?

- Medication error reporting declined in 2017(n=852) compared to the preceding year (n= 944). No errors resulted in a patient death or severe harm, 10 resulted in moderate harm, 90 resulted in low harm and the remaining 749 resulted in no harm.
- Administration errors continue to account for the highest number of medication errors reported and constitute about 32% of medication errors reported.
- Combined missed and omitted doses accounted for 17.5% and prescribing errors accounted for 15% of reported medication incidents, both of which were similar to the previous year.
- The results from the missed doses audit in August 2017 showed that 13% of doses due for administration were omitted however only 2% of these omissions were high risk medicines.
- Some reduction in the number of insulin related incident reports has been identified from the monthly medication error analysis in Q4 (2017/18) but more work is still ongoing to improve insulin use.

This priority will continue as an L&D quality priority for 2018/19.

Priority 3: Patient Experience

Key Patient Experience Priority 1

- **Improve the experience and care of patients at the end of life and the experience for their families**

Why was this a priority?

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. The last two years have seen improvements in communication with patients and families, improved symptom management and spiritual care, investment in training and education and reduction in inappropriate cardiac arrests through more timely decisions regarding DNACPR. This year, the focus will be on working with our community colleagues and our commissioners to ensure patients achieve their choice of 'place to die' and that this is achieved in a timely manner.

What did we do?

- The Specialist Palliative Care Team have formed excellent working relationships with Wards and Clinical teams. The team has expanded to include a full time Palliative Care Consultant. Dr Herodotou is now available in the hospital Monday to Friday.
- Referrals are received from all areas. EOLC Nurse post is embedded across the Trust.
- The individual Care Plan for the Dying is now used across the Trust for all expected deaths when a patient is identified as imminently dying.
- "Small Things Make a Difference" – This continues to be promoted, with the patient linen property bags now in place.
- A working group has developed the concept of an End of Life Care Trolley with staff on Ward 15. The aim is to enhance the comfort and experience for family members and carers. The trolley is currently being trialled on Ward 15, if successful; the hope is to roll this out across the Trust. This will be evaluated and feedback obtained.
- In order to improve communication several initiatives have been successful
  - Review of all available information including information packs for families and carers in the EOLC trolley
  - A leaflet "information for families after a loved one is dying" has been developed
  - Bereavement Booklet has been redesigned
- Patients are regularly referred for Chaplaincy Service for spiritual support. Chaplains also attend the weekly Palliative Care MDT.
- Review of data collection has taken place to ensure monitoring of referrals and outcome of patient choice of place of death.
- Successful business plan for the implementation of System 1 – This is due to go live on 9th April. This will have a huge impact on patient care, enabling Health Care Professionals to communicate across all care settings.
- Care of the Dying – Guidelines have been reviewed and updated to include a last offices checklist – aim is to improve privacy and dignity.

How did we perform?

The number of patients put on end of life care plan has improved and the Trust meets the national guidance.

This priority will continue as an L&D quality priority for 2018/19

Key Patient Experience Priority 2

- **To improve the experiences of people living with dementia and their carers when using our outpatient services.**

Why was this a priority?

Patients with Dementia can have complex care needs. This care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their care pathway, provide good quality patient care and experience whilst they are attending hospital and communicate effectively with primary care in order to more effectively address their specific needs and provide a better quality experience. Service user feedback provided by the Alzheimer's Society has shown that there is an opportunity to improve the experiences of the person with dementia and their carer who attend our out-patient departments. The Trust is committed to focusing on this element of patient experience for the coming year.

What did we do?

- We used patient experience feedback to focus our improvements on specific Dementia related issues. A meeting was held with key department leaders

to agree the improvement objectives, training was offered to clinic clerks and receptionists, opportunities to share new ideas and awareness training offered.

- We agreed to pre alert the outpatient department to those patients already known to be living with a dementia with future appointments.
- We invited attenders to alert reception staff if they have a memory loss or Dementia on arrival to the department and a poster is on display in these areas.
- We met with the eye clinic staff to raise awareness and gathered their thoughts and ideas for improvements.
- We developed a simple visual aid and prompt (a butterfly) to alert staff to consider the additional needs for the person with Dementia during their consultation period.
- We surveyed our clinic staff to establish their training needs and improvement ideas
- We identified a quiet area for those patients needing a calmer environment.

How did we perform?

- We now have eight Dementia champions working in the department. They are trained at an enhanced level to promote awareness and offer appropriate signposting and referrals. These staff act as role models and advocate for the person with dementia and their carers whilst in the department.
- All clinic clerks and receptionists have received awareness training.
- We have introduced four distraction boxes across the department. These are available for the person with dementia and the carer to utilise while waiting for appointments.
- Environmental improvements were carried out and we introduced calendar clocks and provided appropriate signage in outpatients which meets the national recommendations for dementia friendly design.
- Patients with dementia are offered the earliest consultation, where possible, to avoid delays and unnecessary distress.
- Staff are referring to/signposting to the hospital Dementia Clinical Nurse Specialist for advice and follow up.
- We have received positive feedback regarding staff in the department, praising their approach and management of the person with Dementia.
- A carer/patient feedback survey is planned for April –June 2018 to measure success.

This priority will not continue as an L&D quality priority for 2018/19 as it now forms part of the ongoing monitoring and development through the NHS Improvement Single Oversight Framework reported to the Board.

Key Patient Experience Priority 3

- **Ensure proactive and safe discharge in order to reduce length of stay**

Why was this a priority?

There is considerable national evidence for the harm caused by poor patient flow. Delays lead to poor outcomes and experiences for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has a serious impact across health and care systems, reducing the ability of emergency departments to most efficiently and effectively respond to people's needs, and increasing costs to local health economies.

Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend – between 2013 and 2015, recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million beds days. For older people in particular, long stays in hospital can lead to worse health outcomes and can increase their long term care needs.

This is a national issue and, as such, local A&E Delivery Boards are being asked to implement key initiatives to address some of the major underlying issues causing delayed discharges. The National CQUIN scheme builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways.

What did we do?

- The Integrated Discharge Team have regular multi- disciplinary patient tracking sessions to look at complex patients and their length of stay. This incorporates and compliments the red to green work that has been implemented on the majority of wards across the Trust.
- The process for tracking patients is constantly reviewed and up-dated by the discharge team. There

have been a number of changes made to pathways and processes for both the Trust and the community providers. This is an on- going piece of work. Patient tracking is now embedded into the discharge officer's daily routine and provides the Discharge Managers with the information required to problem solve and address complex issues that cannot be addressed by ward staff.

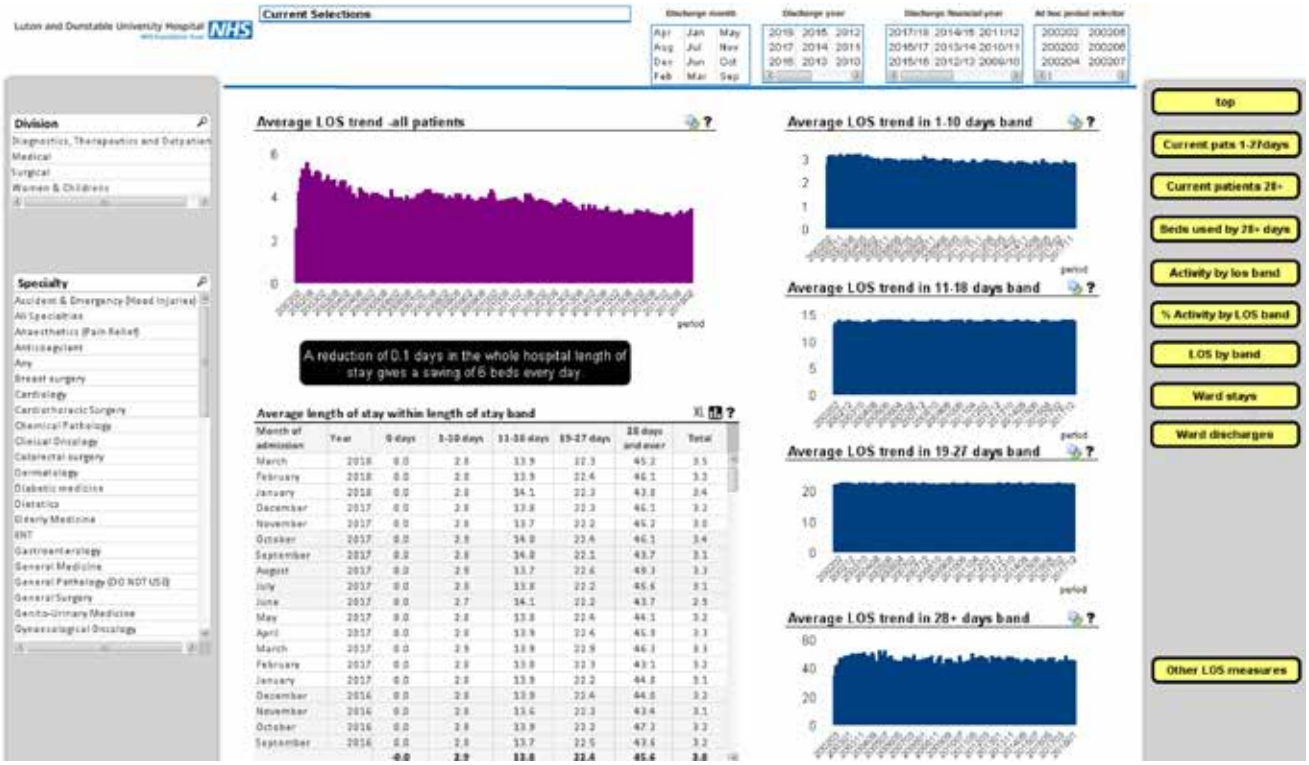
- The Integrated Discharge team have escalation processes in place supported by the Trust Executives and those from partner organisations and are regularly discussed in the A&E Delivery Board. There are a number of discharge pathways created by the local authorities and CCG's whose patients are admitted into the Trust. These pathways have been created to provide whole system working to reduce length of stay and provide better outcomes for patients leaving the L&D. The 'Delayed Transfers of Care' have reduced for both Luton and Central Bedfordshire and now both organisations are National Leaders in their performance. We are currently working collaboratively to support Hertfordshire to achieve better outcomes for their patient group. All the work that has been achieved relating to discharge has supported the flow of patients out of the Emergency Department.

How did we perform?

- The L&D are recognised for the performance they achieve for the Emergency Department and Integrated Discharge; however this is only achieved with constant high performance of staff with all parties concentrating on achieving the flow required to keep patients safe.

- Although at a national level we appear to manage the situation well the intensity this places on all staff involved is not sustainable longer term. We are constantly looking at improving ways of working that are more sustainable for staff and have better outcomes for patients.

- There is an investment now across the Trust that discharging patients is the responsibility of all staff. The team are currently producing a new spread sheet that will be rolled out across all wards with all disciplines pro- actively being involved. We regularly monitor activity. The information below shows some reduction in bed days. Although this may appear small changes a reduction of 0.1 days in the whole hospital length of stay gives a saving of 6 days every day.



This priority will not continue as an L&D quality priority for 2017/18 as it now forms part of the Needs Based Care Quality Priority for 2017/18.

Key Patient Experience Priority 4

- **Improving experience of care through feedback from, and engagement with, people who use our services**

Why was this a priority?

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. Patients and their carers are at the heart of what we do and seeking a better understanding of, and responding more effectively to, their experiences is a core element of how we deliver our services.

Furthermore, the NHS Five Year Forward View says that 'we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services'1 (2014). The concept of patient leadership is emerging as one important new way of working collaboratively with patients and carers. 'One new concept – patients as leaders – is beginning to gain popularity' (Kings Fund 2013). Nationally, initiatives are emerging which place high priority on involving patient leaders in the endeavours of NHS organisations to secure better information from service users and to support

In addition to this priority for our patients' experience, it is also a priority to improve the experiences of staff. The 2016 national staff survey results showed our Trust to be in the lower 20% of Trusts in England for effective use of patient/service user feedback. Our key priority therefore needs to be to ensure that we increase the opportunities to gain feedback from our patients and carers, that we seek to increase the usefulness and quality of the information we gather and that we increase the scale and pace of quality improvement initiatives which are directly responding to our patient experience feedback.

What did we do?

- Increased the use of iPads on wards and in departments to collect feedback from more patients, using both the FFT and patient surveys.

- •Supplemented the FFT question routinely asked on discharge, with a range of questions to provide a better understanding of patient experience and also changed the supplementary questions in light of feedback from the national inpatient survey.

- Ward managers and departmental managers receive weekly FFT reports and electronic notification of negative responses immediately they are posted by patients. This allows them to receive feedback in real time and enables them to put in changes immediately rather than waiting for a month end report.

- Patient experience findings and related quality improvements have been included on Divisional Boards and actions plans from the national patient surveys have been tabled and reviewed.

- Key findings of the national surveys have been presented and publicised at various meetings. Briefing papers have been provided to Boards and the Patient Experience Team has attended Divisional Meetings to monitor the actions in place following the results of their national surveys.

- Maximise the opportunities to make direct links between staff experience and patient experience by the Patient Experience Manager attending the Staff Involvement Group and to work alongside staff who are responsible for organising the staff survey.

- Continued to build on a culture where patient and carer experience is everybody's business by including presentations at learning and sharing events, as well as presenting to all new staff during their induction programme,

- We have re – introduced patient stories to inform the Board and Services Managers about patient's experiences and what lessons can be learned and shared.

- Assisted services to set up engagement events with patients and families to gather qualitative feedback and share their experiences.

- Assisted services to set up and facilitate service user groups in gather patient input and feedback to influence quality improvement and service development.

How did we perform?

- We have an increased number of IPads available for use in services areas, and more teams are now requesting additional equipment to help them record other service specific feedback which they collect from patients.

- The FFT scores have been consistent, if not better throughout to the year, compared to national benchmarks, particularly in relation to Outpatients

and ED 'recommend' scores. Also when weekly reporting was introduced we saw an improvement in scores in a number of areas and staff have found the early feedback useful enabling them to take action immediately rather than waiting for a monthly report.

- The additional questions introduced along with the FFT questions, which we asked patients on discharge, allowed us to monitor improvements throughout the year against last year's national inpatient survey. This resulted in improved results relating to those questions in the national inpatient survey for this year.

- NICU, the Integrated Pain Management Service and the Breast Care Support Group have undertaken engagement events and focus groups. Also the Patient and Public Participation Group has met regularly throughout the year to oversee and input into Trust wide improvement projects. This has included participating in a focus group to discuss the design of the new Trust website.

- Patient Stories have been very successful this year, highlighting issues to the Clinical Outcome and Safety Board, where we can improve services. By involving relevant service managers they have been able to hear first hand from patients about their experiences and can share this with their teams. It also shows to patients that their feedback is listened to and gets directly back to the frontline teams.

This priority will continue as an L&D quality priority for 2018/19 through the development of 'Always Events'.

Key Patient Experience Priority 5

- **To support the continued delivery of care within residential and nursing homes to patients nearing the end of their life**

Why was this a priority?

People nearing the end of their life who are living in nursing or residential homes are sometimes brought into hospital because of a failure in provision in the community. 30% of patients stay in hospital for less than one day and a significant number die within 48 hours of admission because they are patients who are at the end of their life. These two groups of patients particularly have the potential to receive more appropriate care if it were able to be delivered within their place of residence. Evidence suggests that staff within nursing homes and residential homes are often reluctant to call an ambulance because they are aware that the patients' needs could be adequately provided for within the community had the appropriate services been consistently available. The effect is that people may be dying in hospital unnecessarily and that some beds are being used for less appropriate admissions. Through this service we aim to provide an alternative to calling for an emergency ambulance when intervention in the home would effectively prevent the patient transfer.

What did we do?

We have had a number of recruitment challenges which has delayed the original implementation of this project. Therefore, the project scope was reviewed to be able to support the project within the current establishment. This resulted in one care home trailing the virtual equipment and concept of virtual support within hours of 8am – 8pm Monday to Friday. We:

- Engaged Alicia care home

- Ensured concept equipment was loaned to the care home

- Set up the care home with training for the Circuit virtual concept

- Put in place a secure email account for the care home

- Engaged IT project lead to support the IT side of the project

- Had positive engagement from the care home

- Agreed a contact process

- Agreed a daily call to the care home

- Engaged medical support from the L&D

How did we perform?

Due to the delays and the scoping of the revised project, during 2017/18 we succeeded in putting the processes in place to initiate the project in April 2018. Audit tools have been drawn up to measure performance and this will be measured over the next year.

Although the Trust will continue to participate in this project this priority will not continue as an L&D quality priority for 2018/19 as it is a whole system project forming part of the STP.

3. Priorities for Improvement in 2018/19

The Trust's overarching quality strategy was updated and launched for 2018-2021. There are now four key priority areas:

1. Improving Patient Experience

2. Improving Patient Safety

3. Delivering Excellent Clinical Outcomes

4. Prevention of Ill Health

These are based on local, STP and national priorities and are set within a broader three year strategy for quality and improvement. Within each of the key priority areas listed above, there are a range of ambitious programmes of 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.

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 is this a priority?

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

What will we do?

The values will be launched by the Board which will then enable a range of developments:

- Revision of Corporate Induction for all new starters that encompasses the values and what they mean to the Trust linked to comprehensive guidance for managers on local induction.

- Development and delivery of a communication campaign that launches the values to all our stakeholders, both internal and external.

- Review and development of a refreshed set of appraisal documentation that will ensure that all staff covered by Agenda for Change reflect on how they contribute to ensuring that we work to our values for the benefit of both staff and patients.

- Introduction of recruitment practices that enable us to judge how candidates match up to our values.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Staff will be recruited into the Trust having been judged to hold shared values.

- New starters will understand what the values mean and how they will be used to support effective team behaviours and a conducive working environment.

- Appraisals will include discussion and review of the up to date values with each member of staff.

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

Why is this a priority?

Always Events® is a tried and tested improvement methodology using co-production and really ensures that patients and families are true partners in designing improvements to services. We want to use co-production with patients and families to ensure that patients have the best possible experience of care. Always Events® improvement methodology will help us to make sure that care is focused on what matters most to patients.

What will we do?

- We will sign up to the NHS England campaign and select one area to join the programme in May 2018.

- Through the national programme, benefit from the coaching and support to implement the toolkit within the Trust.

- After using the methodology in one area, rollout and spread to other areas.

- Work with patients, families and carers to develop the Always Events® using findings from national and local surveys to help provide direction.

- Assess impact through the evaluation of local patient experience surveys.

- Roll out a high profile communication campaign to share the developments and create interest from other areas to join in.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- At least one ward has developed an Always Events® which has been evaluated.
- Patients have been involved in supporting the quality improvement.
- Patient experience has been shown to improve in respect of the issue being addressed.
- At least 3 other areas are implementing Always Events by the end of the year.

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

Why is this a priority?

Improving End of Life (EOL) care continues to be a priority if we are 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. Further, it is difficult to get meaningful feedback from the families and carers of those patients who are dying because of the sensitive nature of the situation. However, we understand from the analysis of complaints and anecdotal evidence, that there is more we can do to improve the end of life care experience for both patients and their families and carers.

What will we do?

- Employ a second End of life Care Nurse and continue to raise the profile of the team
- Continue to present at clinical multidisciplinary meetings to promote the end of life individualised care plan and embed national guidelines for EOL care.
- Improve communication with partner provider organisations by implementing SystmOne in the Trust.
- Focus on the quality of discharge for patients nearing the end of their life
- Introduce special trollies for use by patients and their families to help provide a more conducive environment and helps to address the small things which make a big difference (music/toiletries/ accessories/information).
- Relaunch the referral process for Meaning Centred Counselling and Therapy (MCCT) and Partnership in Excellence in Palliative Support (PEPs.)
- Seek feedback through the newly updated bereavement booklet which includes a feedback section for families and carers.
- Embed the updated care of the dying guidelines to promote and improve dignity after death.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- That issues identified in complaints are used to make a positive difference.
- Positive changes to feedback received from relatives and carers of EOL patients.
- Reduction in the incidents and complaints relating to end of life care.
- New initiatives implemented are in use by wards across the Trust.
- Improved performance shown through local feedback – bereavement booklet includes a family/carer feedback section.
- Improved results from the national 'Care of the Dying' audit (due in June 2018).

Priority 2: Improve Patient Safety

2.1 Improve continuity through the delivery of Needs Based Care

Why is this a priority?

The delivery of 7 day consultant led services and early senior review and decision making for patients admitted to hospital as an emergency has been a significant area of quality improvement for the Trust, with significant increases in consultant presence out of hours and

at the 'front-door' of the hospital over the last few years. However, as our model for emergency care has gradually evolved, an unintended consequence has been an increase to the number of consultants that have sequential input into a patient's care. It is not unusual for a patient admitted to a medical specialty as an emergency to receive care from a number of different consultants during their hospital stay. This can lead to confusion for the patient and their family as to what is happening, difficulties in co-ordinating the plan where the owning consultant is not following it through, and does not make it easy for senior medical staff to closely monitor a patient's progress and assess the effectiveness of treatment. By improving the continuity of consultant care for an individual patient, we will improve patient experience, reduce length of stay and minimise the clinical risk of patient management plans being handed over between senior clinical staff multiple times.

Within the range of emergency admissions to hospital, there will be some patients who will benefit from being cared for by physicians with a particular specialist interest, such as stroke, cardiology or respiratory. There are other patients who may be admitted with a straightforward medical issue, such as an infection or after a fall, but have very complex needs perhaps because of underlying long term conditions, poly-pharmacy, or extensive social or support needs. These patients require care from a senior general medical physician, with support from a wide range of professionals, and carefully managed transitions between hospital and usual place of residence. Getting the patient to the right specialty team as early in their admission as possible is really important to avoid unnecessary investigations, support the patient to be managed at home wherever possible and to enable rapid and targeted treatment and intervention without having to wait for advice from another specialist.

What will we do?

The Medical Division have been working on developing a model of Needs Based Care since late 2015, and has already embedded ambulatory care pathways, which are now running 7 days, and opened a cardiac ward for patients to be admitted under cardiologists where appropriate, rather than being admitted under a general physician who would then seek advice from a cardiologist. This has shown a dramatic reduction in length of stay for patients with cardiac diagnosis, and the initial data review suggested that this change was saving up to 15 medical beds. The next steps for implementation of Needs Based Care are to;

- Deliver admission for patients directly to respiratory specialists 7 days a week
- Complete works to the lifts in the medical block to facilitate specialty ward moves and create a larger flexible EAU bed base at the front of the hospital
- Complete the design of the complex and general medical senior medical model to enable movement to full needs based care for all specialties.

In terms of facilitation of increased continuity, there are three transitions of care to be considered:

- When a patient with a long term medical condition comes into hospital, they should be cared for by a consultant who has been managing their outpatient care with their GP
- When a patient is admitted to hospital, they should have the same consultant for as much of their stay as possible, with no avoidable handovers.
- When a patient comes into hospital for a second time, they should return to the care of the consultant who discharged them, so that the treatment and plan can be reviewed in the context of the patient's prior admission.

It is our intention to remodel the way the consultant care of inpatients is delivered to maximise consultant continuity for patients against each of these three elements of the pathway. This will require changes to consultant timetables, to enable ongoing care of patients rather than the traditional 'on-ward, off-ward' patterns of work.

Furthermore, by continuing to deliver reductions in length of stay through delivery of the Red to Green initiative* and focussed management of patients with length of stay in hospital of over 7 days, we will reduce the number of patients that are not admitted to the right bed first time, and so will reduce avoidable handovers that result from patient movement between wards.

* a visual management system to assist in the identification of wasted time in a patients journey. If it is red, the patient has not progressed, green they have.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Reduction in the number of consultant handovers within an inpatient episode
- Increase the % of patients discharged by the same consultant for a related readmission
- increase the % of patients discharged by their names outpatient consultant where applicable
- Reduction in length of stay for emergency medical patients
- improved patient satisfaction regarding communication and involvement in decision making around their care
- Fewer non-value adding days to patient hospital stays due to improved coordination of the treatment plan

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

Why is this a priority?

Over the past five years, the Trust has shown a year on year improvement in the prevalence of falls with harm but the incidence of falls (rate per 1000 bed days) has remained relatively static. Whilst the Trust 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. When a patient has a fall in hospital, the effect can be both physically and psychologically detrimental and in many cases may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the 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 RCP audit results (RCP 2017), the Trust will continue to build upon the work already undertaken to strengthen our approach to the prevention of falls thereby improving patient safety and experience.

What will we do?

- Roll-out and embed the updated multifactorial risk assessment for all patients aged 65 and over and for those aged 18-64 who are have a clinical risk factor for falling.
- Educate staff, audit practice and undertake targeted improvement work to ensure that the best practice guidelines of NICE and the Royal College of Physicians is consistently implemented for all our patients.
- Ensure that all patients receive the Falls Prevention Leaflet which has been published for patients in hospital and their families and carers
- Undertake focused quality improvement initiatives to reduce the number of falls associated with use of bathrooms and toilets
- Evaluate the impact of Baywatch on the incidence of falls
- Continue to investigate and analyse themes and trends from falls to inform the implementation of appropriately targeted actions for improvement
- Following the outcome of the RCP 2017 audit, to focus on the improvement of three key indicators:
  - Delirium – embed use of standardised tools and link assessments to related clinical issues (such as falls).
  - Medication review – ensuring that medication is reviewed for all patients 65 and over specifically around falls risk, working with pharmacists.
  - Lying and Standing blood pressure – to be checked on all patients aged 65 and over as appropriate.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- A reduction in the rate of falls to a consistent rate of less than 6.0 per 1000 bed days (RCP methodology).
- A reduction in the rate of falls specifically associated with patient use of toilets and bathrooms.
- Learning from root cause analysis investigations is disseminated across all areas of the Trust.

2.3 Improve the management of deteriorating patients

Why is this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to

further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2017-18 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, there is a need to continue in our improvements to deliver more sensitive, appropriate care at the end of a person's life. It is vital that for those patients, nearing the end of their life, that appropriate, timely decisions are made and care plans put in place to provide compassionate dignified care when aggressive treatment or resuscitation are not appropriate.

What will we do?

- Continue to embed the implementation of the Treatment Escalation Plans
- Continue to deliver training and support to clinical teams in the assessment of patients nearing the end of their life and in having effective, sensitive conversations with the patient and their family or carers.
- Continue to audit the observation and treatment of patients who deteriorate and implement learning from the findings.
- Embed the implementation of 'Best practice Interventions' for patients presenting to the Emergency Department with Acute Kidney Injury (AKI).
- Reduce the incidence of in-patient deterioration as a result of AKI, by implementing a systematic approach to fluid intake and output monitoring.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline.
- To continue to sustain improvements all along the deteriorating patient pathway ensuring:
  1. Timely and appropriate observations
  2. Timely escalation of concerns to medical staff
  3. Timely medical response times,
  4. Improvement in timely and appropriate decision making by medical staff.
- Patients nearing the end of their life are appropriately assessed and provided with a careplan to ensure the most appropriate care delivery.
- 90% of patients presenting to the Emergency department with AKI are provided with 'best practice interventions' to optimise their renal recovery. The implementation of a systematic approach to fluid intake and output monitoring.

2.4 To improve our reliability in ensuring that patients receive timely VTE assessment and thromboprophylaxis where appropriate

Why is this a priority?

"Venous Thrombo-Embolism (VTE) is a significant cause of mortality, chronic ill health and disability in England". An estimated 25,000 people in the UK die from preventable hospital-acquired thrombosis 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) In the past year the Trust has had a number of Serious Incidents related to Hospital Acquired Thrombosis and the non-adherence with 'Best Practice' recommendations. As a consequence an improvement programme has been set up to address these.

House of Commons Health Committee (2005) The prevention of venous thromboembolism in hospitalised patients. London: The Stationery Office

NICE (2015) Venous thromboembolism in adults: reducing the risk in hospital NICE CG 92 (2010, updated 2015).

What will we do?

Optimise the use of technology to ensure prompt and reliable risk assessments are carried out on admission and that patients are reassessed as appropriate throughout their stay.

Ensure that all high risk patients are reliably provided with appropriate prophylaxis and use technology to support the timely review of patients whose conditions are changing in order to ensure appropriate prophylaxis is always provided for those patients most at risk.
Ensure that patients are reliably informed of the risks of

VTE and preventative measures, by provision of verbal and written patient information on admission and at discharge so that they can be more involved in helping to prevent clots.
Raise awareness of the risks of VTE through a Trust-wide "Stop the Clot" campaign, providing education and training to the multidisciplinary team.
Continue to undertake the HAT audits and root cause analysis in order to highlight any themes which need to be addressed.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

No avoidable hospital acquired thrombosis experienced by any of our patients
VTE risk assessment compliance remains consistently above 95% on admission
Patients routinely receive patient information leaflets and advice
Prophylaxis is provided to all patients who require it

2.5 To reduce the incidence of medication errors for inpatients

Why is this a priority?

Every step in the processes associated with the use of medicines has the potential for failure to a varying degree. Medication safety is therefore, the responsibility of all staff and most effective when underpinned by a culture of openness and honesty when things go wrong. It is vital that we learn and use our developing understanding of medication safety incidents to most effectively deal with the causes of failure.

Drug incidents (n=866)accounted for 9% of all incidents reported on the Trust's patient safety incident reporting system during 2017/18, 98% of which caused no harm or low harm. The reporting, analysis of and learning from medication safety incidents are vital even where no harm has occurred to a patient. This allows the best quality learning to take place as the 'what', 'how' and 'why' things went wrong, so that effective and sustainable solutions can be put in place to reduce the risk of similar incidents occurring.

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 inevitable and avoidable, they occur when weak medication systems and/or human factors (e.g. fatigue, poor environmental conditions or staff shortages) affects all/or part of the medicine use process (prescribing, transcribing, dispensing, administration, monitoring and use) and can result in severe harm. The Trust Medication Safety Review Group (MSRG) will continue to review medication error reports each month, identifying themes and ensuring multidisciplinary, trust-wide learning is shared. Our strategy therefore will focus on:

- Reducing the incidence of avoidable medication errors with the potential to cause harm to patients
- Strengthening measurements and safety monitoring systems

What will we do?

The Trust Medication Safety Review Group (MSRG) will oversee and monitor the following actions:

- Promote a good safety culture by encouraging more reporting, learning and sharing of medication errors and near misses.
- Develop and launch the L & D Medication Without Harm strategy.
- Promote MDT collaboration in identifying and addressing system design weaknesses within the medicine use process.
- Promote safer medicine use through engagement with frontline staff .
- Effective dissemination of lessons learned from medication errors using various mechanisms e.g. newsletter, safety briefings, clinical governance meetings, error sessions. The Pharmacy Department quarterly publication MIST will continue to be used to highlight risks identified from Datix.
- Leverage on EPMA and new technologies to reduce medication errors especially for high risk medicines.
- Implement the best practice recommendations from the Royal College of Physicians (RCP) on supporting junior doctors in safe prescribing e.g. error feedback and learning sessions and a trial introduction of pharmacy buddies with the next cohort of junior doctors.
- Encourage active patient/carer involvement in their medicines through the provision of appropriately tailored medicine information.

- Support the effective implementation of self-administration of insulin process for adult inpatients.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- An increase in the rate of reporting of no harm medication safety incidents
- A reduction in the rate of avoidable medication errors due to errors in prescribing
- A reduction in the rate of avoidable medication errors due to administration errors
- A reduction in the incidence of missed or delayed doses involving high risk medicines

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 is this a priority?

In March 2017, the NHS Quality Board published a paper entitled "National Guidance on Learning from Deaths. " The paper outlines the principles behind Mortality Reviews, their methodology, and how their conduct and the learning from them needs to be reported. The guidance made a number of recommendations which have since been incorporated into the Trust Mortality Review Policy (LDH 2017). There is national focus on improvement that can come from mortality reviews and therefore, the recommendations of the national paper, included amongst other things that:

- Structured Judgement Reviews have been introduced as a new methodology for mortality reviews
- There should be a Board-level Executive lead for the Mortality Review Process, and a non-Executive lead charged with oversight and challenge.
- There is a requirement for the outcomes of the Mortality Reviews to be shared quarterly through the Board Quality report (which took effect from September 2017). This has been contractually enforced through changes at a national level to the Quality Accounts regulations.

The Trust's Mortality Board continues to focus on HSMR and SHMI and provide direction and monitoring of the Trust's mortality review policy.

National Guidance on Learning from Deaths, First Edition, March 2017 National Quality Board. Available at https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

What will we do?

- Review the Learning from Deaths policy by September 2018
- Agree improved processes for mortality reviews in the surgical division and implement these by September 2018
- Configure Datix Cloud IQ to deliver an electronic mortality review process
- Feedback to the CCG, any deaths that require a review of the community care

How will improvement be measured and reported?

- Quarterly report of "Avoidable Deaths" to the Trust Board
- Quarterly update of figures published on the Trust website
- Annual summary report of key themes from mortality reports to the Mortality Board every July (based on deaths April – March)
- Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Improvement in HSMR
- Fewer deaths within 24 hours of admission

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

Why is this a priority?

The purpose of this initiative, which is also a national CQUIN, it to embed a systematic approach towards the prompt identification and appropriate treatment of life threatening infections, while at the same time, reducing the chance of the development of strains of bacteria that are resistant to antibiotics.

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these, it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. This quality improvement initiative, is aimed at embedding NICE guidance to improve sepsis management. Furthermore, the approach taken to combine a responsive approach to the detection and treatment of sepsis needs to be balanced with a rigorous approach to the stewardship of antibiotics. Antimicrobial resistance has increased in recent years and the Chief Medical Officer believes that it is a major risk for healthcare. Without a reversal of the trend, we may find we have no drugs to treat serious infections in the future. The approach to these two key areas for improvement is taken from the viewpoint that the issues of sepsis and antimicrobial resistance are complementary and that developing and implementing a joint improvement scheme (CQUIN) will support a coherent approach towards reducing the impact of serious infections.

What will we do?

The Trust will build on the work undertaken since 2015/16 with a particular focus on:

- Continuing to deliver and improve upon the timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Continuing to deliver and improve upon the timely treatment of sepsis in emergency departments and acute inpatient settings
- To continue to deliver upon the 24-72 hour review of antibiotics for patients with sepsis who are still inpatients at 72 hours and to continue to improve upon the quality of those reviews
- Ensure that Trust guidelines and protocols continue to meet best practice standards and are in line with CQUIN requirements.
- To reduce total antibiotic consumption per 1,000 admissions in two domains:
  - Total antibiotics
  - Carbapenems
- Increase the proportion of antibiotic consumption within the specified group in accordance with best practice

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- To consistently screen 90% or more of the relevant patients for sepsis.
- To deliver antibiotics within one hour of identification of sepsis to at least 90% of those patients.
- •To undertake clinical antibiotic reviews between 24-72 hours in at least 90% of patients with sepsis.
- To reduce antibiotic consumption per 1000 admissions within two specific categories: [1] total antibiotic usage [2] carbapenems and increase the usage for the antibiotics within the Access group the AWaRe category to either 55% or by 3%.

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

Why is this a priority?

People with mental health problems are three times more likely to present to AA&E than the general population. Nationally, more than 1 million presentations are currently recorded as being directly related to mental ill health. Furthermore, evidence has shown that people with mental ill health have 3.6 times more potentially preventable emergency admissions than those without mental ill health and that the high levels of emergency care use by people with mental ill health indicate that there are opportunities for planned care to do more. A large majority of the people with most complex needs who attend AUE the most frequently are likely to have significant health needs including physical and mental comorbidities and may benefit from assessment and review of care plans with specialist mental health staff and further interventions from a range of health and social services. This is a National priority and the CQUIN has been developed to support cross-provider working to deliver improvements in care to this group of patients by providing enhanced packages of care from the most appropriate services.

What will we do?

- The Trust will continue to work in partnership with East London Foundation Trust, the provider of our mental health services and a range of other partners including ambulance service, primary care, police, substance misuse services, 111
- A group of patients who attend A&E most frequently will be reviewed in order to identify those who would benefit from assessment, review and care planning with specialist mental health staff
- Appropriate models of service delivery will be considered and adopted in order to provide specialist input for people who frequently attend A&E with primary mental health problems
- To co-produce, with the patients, a care plan and ensure that these are shared, with the patient's permission, with partner care providers across the system
- Continue to best use our IT systems to ensure that information about the conditions of our patients is accurately collected in order to help target improvements to the most appropriate patients

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- To maintain the reduction in A&E attendances for a group of patients with whom we worked during 17/18 by providing appropriate mental health services outside of the A&E setting (maintaining at least 20% reduction when compared to their 16/17 attendances)
- To reduce the number of attendances for a second group of frequently attending patients by 20% over the next year, amongst the patients who would benefit from mental health and psychosocial interventions
- To have collected patient experience feedback in order to further develop the service

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

Why is this a priority?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this quality improvement initiative is to implement best practice guidance to enable us to take action to prevent these adverse outcomes and help people live as well as possible with frailty. Appropriate services, delivered effectively to this group of patients will support a reduction in length of stay, reduced morbidity and mortality and a better experience for patients and their carers. Furthermore, the initiative will support the delivery of the Trust priority to deliver Continuity of Care and improve the flow of patients admitted as emergencies to the hospital.

What will we do?

- To establish models of care and service delivery in line with standards set by the British Geriatric Society "Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings"
- Identify and develop/provide the resources required to deliver a high quality service
- Establish referral criteria and care pathways
- Ensure that there is rapid access to appropriately trained and skilled staff to undertake a comprehensive, early assessment and care planning in order to deliver early intervention by the multidisciplinary team
- Ensure that clinical navigation is embedded within the service delivery plan

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- That a frailty service is operational and receiving appropriate referrals

- That patients and their carers are satisfied with the service and that feedback is used to help further improve and develop the service
- A reduction in the number of frail patients being admitted to hospital via A&E or EAU
- A reduction in the length of stay for patients with frailty
- An increase in the proportion of patients with frailty who, following comprehensive assessment and care planning, are able to be discharged to their usual place of residence
- A decrease in the proportion of patients with frailty who are admitted to hospital for an overnight stay

Priority 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 is this a priority?

- This is a national CQUIN scheme which seeks to deliver on the objectives of the NHS Five Year Forward View, particularly around the need for a radical upgrade in prevention and to be supporting healthier behaviour.
- Smoking is estimated to cost £13.8bn to society – of which £2bn cost to the NHS through hospital admissions. Smoking is England's biggest killer, causing nearly 80,000 premature deaths a year and is also the single largest cause of health inequalities. Evidence shows that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis, and contributes to reduced wound infection rates and improved healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. The quit rates amongst those with a referral to stop smoking services are between15-20% compared to those without a referral at 3-4%.
- Nationally, the coverage of advice and referral interventions for smokers are patchy. In secondary care, not all patients are asked if they smoke and fewer are given brief advice to stop as an inpatient.
- For alcohol, evidence shows that in England, 25% of the adult population consume alcohol at levels above the uK low-risk guideline and increase 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. This is the group for whom Identification and Brief Advice (IBA) is most effective.
- Currently IBA delivery in secondary care is patchy and needs to be improved to optimum levels so that large scale delivery will impact most significantly on the population.

What will we do?

- Identify and provide training to staff in how to assess tobacco and alcohol use and inhow to give brief advice.
- Conduct baseline and ongoing audits in line with the national CQUIN requirements.
- Screen at least 90% of patients, aged 18 and over, who are admitted for at least one night) for tobacco and alcohol use.
- Provide brief advice to appropriate patients in respect of tobacco or alcohol use.
- Provide an offer of medication and referral to smoking cessation services and make those referrals.
- Ensure that screening, advice and referrals for both tobacco and alcohol are recorded in a clear and consistent way in patients' records.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- At least 90% of patients are screened for tobacco use and 50% are screened for alcohol intake (age 18 and over, admitted for one night or more, excluding maternity).
- AT least 90% of smokers are given very brief advice to help them quit.
- At least 30% of smokers are offered stop smoking medication and 30% are referred to smoking cessation services.

- At least 80% of patients are given brief advice or offered a specialist referral if the patient is potentially alcohol dependant.

- Records are kept clearly and consistently in the patients records.

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 is this a priority?

PHE's report "sugar reduction – the evidence for action" published in October 2015 outlined the clear evidence behind focusing on improving the quality of food on offer. It is important for this Trust, as part of a campaign across the NHS in England, to lead the way in ensuring that all food and drink outlets on NHS premises provide healthier options for staff, patients and visitors.

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. By supporting staff, patients and visitors to make healthier choices when on NHS sites, the aim of lowering sugar consumption will support staff, patients and visitors in managing their own health and wellbeing.

What will we do?

- Ensure that our food and drink outlets refrain from advertising and offering price promotions on food and drinks high in fat, sugar and salt

- Work with all of the Trust outlets to ensure that they deliver the balanced requirements of healthy food and drink in line with the national CQUIN

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- At least 90% of drinks sold on site are free from added sugar

- At least 80% of confectionary and sweet lines available are no more than 250kcal

- AT least 75% of pre-packed sandwiches and other savoury pre-packed meals are 400kcal or less and contain no more than 5% saturated fat

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

Why is 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. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected.

The green book recommends that healthcare workers directly involved in patient care are vaccinated annually. It is also encouraged by the General Medical Council and by the British Medical Association.

What will we do?

- Vaccine will be administered by the Occupational Health team, with additional assistance.

- All staff will be actively encouraged to have the vaccine during visits to wards, talks, attendance at stat training, induction, grand round, various meetings, emails, posters.

- Drop in clinics will be held in Occupational Health every week day.

- Banner posters will be displayed within various areas of the Trust.

- During our Annual Christmas staff engagement event, part of the programme will include flu vaccination promotion.

- Publicity and role modelling by senior members of staff who had already received their vaccine.

- Display the jab 'o 'meter, giving regular updates on how many staff have received their vaccine.

- Staff who indicate that they do not wish to receive the vaccine will be asked to complete a declination form stating their reasons via a selection of tick box options.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- By 28th February 2019, at least 75% of frontline clinical staff will have received their flu vaccination or will have signed a declination form indicating informed withholding of consent.

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

Why is this a priority?

Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. 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 and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients. The Five Year Forward View made a commitment '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 the Health & Wellbeing CQUIN introduced in 2016 encourages providers to improve their role as an employer in looking after employees' health and wellbeing. The 2018-19 CQUIN rewards organisations who make a sufficient impact on staff perceptions about the changes organisations make to improve health and wellbeing– via improvements to the health and wellbeing questions within the NHS staff survey.

To help organisations meet the CQUIN target NHS England has developed a new 'Staff Health and Wellbeing Framework' which will be launched in Spring 2018. The Framework 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. The 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 will we do?

- The Trust will review the NHS England "Staff Health and Wellbeing Framework" following its launch in Spring 2018
- Identify and implement appropriate actions to address the health and wellbeing areas that showed scope for improvement in the 2017 staff survey

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

A 5% improvement (in the 2018 survey as compared with the 2016 survey) in two of three questions within the national staff survey which relate to:

1. Does your organisation take positive action on health and wellbeing?
2. In the last 12 months have you experienced musculoskeletal problems as a result of work activities?
3. During the last 12 months have you felt unwell as a result of work related stress?

4. Statements related to the quality of services provided

4.1 Review of Services

During 2017/18 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes. The Board of Directors considers performance reports quarterly including progress against national quality and performance targets. The Board also receives reports from the Clinical Outcome, Safety and Quality sub committee. Quality is managed by the Divisional Boards and the Clinical Operational Board providing assurance to the Clinical Outcome, Safety and Quality Committee. These reports include domains of patient safety, patient experience and clinical outcome. During 2017/18 the Executive Board commissioned external experts and assisted with external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- External reviews of Serious Incidents
- GIRFT

In addition, the Board receives reports relating to complaints and serious incidents.

Quality Assurance Monitoring

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2017/18.

4.2 Participation in Clinical Audits and National Confidential Enquiries

Trust was eligible to participate in 57 of the 2017/2018 National Clinical Audits that was applicable to the Trust and met the Quality Accounts inclusion criteria.

Over the financial year the Trust participated in 50 of the eligible national audits, 5 have not yet started and 2 where the Trust had not participated although were eligible.

The two National Clinical Audits that the Trust had not participated are listed below:-

BAUS Urology Audits: Female stress urinary incontinence, this was due to lack of staffing in collecting data.

BAUS Urology Audits: Urethroplasty, this audit was not included in the 2017/2018 Urology Clinical Audit Forward Plan and action has been taken to ensure participation. Clinical audits are a mixture of National and local priorities which each directorate is responsible for as part of their Clinical Audit Forward Programme. The data collected for Quality accounts includes mandatory audits on the National Clinical Audit and Patient Outcomes Programme which directorates must participate in.

The National Audit of Breast Cancer in Older People (NABCOP) 2017/18 was a scoping exercise looking at national variation. We submitted a questionnaire about our unit and what treatment approach our MDT would take for 5 vignettes. There will be no data collected on Luton patients until 2018/19. This will be taken directly from the cancer registry.

Local Clinical Audits

The reports of 22 local audits, some of which were project managed by the Trust's Clinical Audit Department were reviewed by the Clinical Audit and Effectiveness Lead and Clinical Director. & Quality Depart. Clinical audit results are discussed at Clinical Audit Committee meetings and Directorate Governance meetings. National and clinical audit results are used primarily by Luton & Dunstable NHS Foundation Trust to improve patient care where gaps are found but are also used as assurance that the hospital is following best practice guidance. Staff undertaking clinical audit are also required to report any actions that should be implemented to improve service delivery and clinical quality

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	April 2017 to March 2018	All cases diagnosed with MI in a financial year	All those required
Adult Cardiac Surgery	National Institute of Cardiovascular Outcomes Research (NICOR)s	Eligible No			
BAUS Urology Audits: Cystectomy	British Association of Urological Surgeons	Eligible Yes Participated Yes	April 2017 to March 2018	BAUS audits operate a continuous data collection model. All patients eligible	
BAUS Urology Audits: Nephrectomy	British Association of Urological Surgeons	Eligible Yes Participated Yes	April 2017 to March 2018		105 cases.
BAUS Urology Audits: Percutaneous Nephrolithotomy	British Association of Urological Surgeons	Eligible Yes Participated Yes	April 2017 to March 2018		Nephrectomy cases: 0 - PCNL: 6
BAUS Urology Audits: Radical prostatectomy **BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec**	British Association of Urological Surgeons	Eligible No			
BAUS Urology Audits: Urethroplasty **BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec.**	British Association of Urological Surgeons	Eligible Yes Participated No	April 2017 to March 2018	All eligible cases	Not on Audit Forward Plan 2017/2018 – position rectified
BAUS Urology Audits: Female stress urinary incontinence **BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec**	British Association of Urological Surgeons	Eligible Yes Participated No	April 2017 to March 2018		No data submission on BAUS website due to lack of staffing for data collection.
Bowel Cancer (NBOCAP)	Royal College of Surgeons of England	Eligible Yes Participated Yes	April 2017 to March 2018	All patients with a confirmed cancer diagnosis for 'tumour group'	The data for the current year 01/04/17 to 31/03/18 is not required to be submitted until October 2018

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible	100% required
Case Mix Programme (CMP)	Intensive Care National Audit Research Centre (ICNARC)	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible	ICU=417 cases HDU=777 cases
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible No			
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	January 2017 to March 2018	All eligible cases	418 cases
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible cases	173 cases ERPT: 1 cases
Elective Surgery (National PROMs Programme)	NHS Digital	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible cases	500 cases
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	Eligible Yes Participated Yes	April 2017 to March 2018	All required	100% required
Falls and Fragility Fractures Audit programme (FFFAP) - Inpatients	Royal College of Physicians	Eligible Yes Participated Yes	April 2017 to March 2018	All NOF cases aged 60 and above	300 cases
Fractured Neck of Femur	Royal College of Emergency Medicine	Eligible Yes Participated Yes	August 2017 to January 2018	<50 for all eligible cases	51 cases
Head and Neck Cancer Audit (HANA) (TBC)	Saving Faces - The Facial Surgery Research Foundation	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible cases	All mandatory cases
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Inflammatory Bowel Disease Registry	Eligible Yes Participated Yes	April 2017 to March 2018 (managed by BSG via IBD Registry)	All required	100% required

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	Eligible Yes Participated Yes	October 2017 onwards	All L&D patients who have died (n=10)	10 cases
Major Trauma Audit	The Trauma Audit & Research Network (TARN)	Eligible Yes Participated Yes	April 2017 to March 2018 Hospital site level data x3 Clinical report submissions per annum National Quarterly Dashboard data is collected with differing deadlines and circulation dependent on hospital type.	All required	100% required
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity confidential enquiries (reports every second year)	Eligible Yes Participated Yes	April 2017 to March 2018	All required	100% required
	Perinatal Mortality Surveillance (reports annually)				Late Foetal losses -5 Terminations of pregnancy - 4 Stillbirths - 20 Early neonatal deaths - 22 Late neonatal deaths - 3
	Perinatal Mortality and Morbidity confidential enquiries (reports every second year)			All required	100% required
	Maternal Mortality surveillance and mortality confidential enquiries (reports annually)			All required	100% required
National Audit of Anxiety and Depression	TBC - to be commissioned by HQIP in 2017	Eligible No			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
National Audit of Breast Cancer in Older Patients (NABCOP)	Clinical Effectiveness Unit, The Royal College of Surgeons of England	Eligible Yes Participated Not Yet	1 Apr 2017 to 31 Mar 2018	All required	100% required
National Audit of Dementia	Royal College of Psychiatrists	Eligible Yes Participated Yes	2017/18	All required	100% required
National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	Eligible No			
National Audit of Psychosis	TBC – to be commissioned by HQIP in 2017	Eligible No			
National Audit of Rheumatoid and Early Inflammatory Arthritis	TBC – to be commissioned by HQIP in 2017	Eligible No			
National Audit of Seizures and Epilepsies in Children and Young People	TBC – to be commissioned by HQIP in 2017	Eligible No			
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	EligibleYes Participated Yes	April 2017 to March 2018	All eligible	117 cases
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Royal College of Physicians	Eligible Yes Participated Yes	January 2017 to July 2017	59	59 cases
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	London North West Healthcare NHS Trust	Eligible No			
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	Eligible Yes Participated Yes	April 2017 to March 2018	40	40

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
National Diabetes Audit - Adults	NHS Digital	Eligible Yes Participated Yes	25 to 29 September 2017	All required	100% required
National Emergency Laparotomy Audit (NELA	Royal College of Anaesthetists	Eligible Yes Participated Yes	2017/18	All required	100% required
National End of Life care audit	TBC – to be commissioned by HQIP in 2017	Eligible Yes Participated Not yet	N/A	N/A	The national care of the dying audit does not start until the summer. The Trust is awaiting National Guidance to start the audit.
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	The cut of for data entry is 8/6/2018	All eligible cases	233 cases as at 23/04/2018 to be completed by June 2018
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	EligibleYes Participated Yes	2017/18	All required	100% required
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Eligible Yes Participated Yes	April 2017 to March 2018	All patients with a confirmed cancer diagnosis for 'tumour group'	100% required
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible cases	500
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Royal College of Paediatrics and Child Health				
National Ophthalmology Audit	The Royal College of Ophthalmolog***ists***	Eligible Yes Participated Not yet	Data collection will run from 1 September 2016 to 31 August 2017	50 cases	To be initiated
National Vascular Registry	Royal College of Surgeons of England	Eligible No			
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	Eligible No			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Non-Invasive Ventilation - Adults	British Thoracic Society	Eligible Yes Participated Not yet	2017/18	All required	To be initiated
Oesophago-gastric Cancer (NAOGC)	Royal College of Surgeons of England	Eligible Yes Participated Yes	April 2017 to March 2018	All patients with a confirmed cancer diagnosis for 'tumour group'	100% required
Paediatric Intensive Care (PICANet)	University of Leeds	EligibleNo			
Paediatric Pneumonia	British Thoracic Society	Eligible Yes Participated Not yet	2017/18	All required	To be initiated
Pain in Children	Royal College of Emergency Medicine	Eligible Yes Participated Yes	2017/18	All required	100% required
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	Eligible No			
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	2017/18	All required	100% required
Prostate Cancer	Royal College of Surgeons of England	Eligible Yes Participated Yes	This data is submitted on a monthly basis to the Cancer Registry (Public Health England).	No set number required	HGD: 0 - The data for the year Jan to Dec 2017 comprises: 200 new cases
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	Eligible Yes Participated Yes	2017/18	All required	780 cases, which is an increase on the previous year of 759.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Serious Hazards of Transfusion	Eligible No			
UK Parkinson's Audit	Parkinson's UK	EligibleYes Participated Yes	2017/18	All required	100% required

Additional (non-mandatory) National Audits undertaken during 2017/18

Local Clinical Audits
In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of seventeen local clinical audits were completed during the reporting period which were project managed by the Trust's Clinical Audit Department (Appendix A).

4.3 National Confidential Enquiries

	Topic/Area	Database/	% return*	Participated Yes/No
1	Chronic Neurodisability	NCEPOD	20%	Yes
2	Young People's Mental Health	NCEPOD	83%	Yes
3	Cancer in Children, Teens and Young Adults	NCEPOD	100%	Yes
4	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

* The number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry

4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2017/2018 and who were recruited during that period to participate in research approved by a Research Ethics Committee was **809**. This research can be broken down into **185** research studies (**154** Portfolio and **31** Non-Portfolio).

Participation in clinical research demonstrates the Luton and Dunstable University Hospital's commitment to improve the quality of care we offer and to make a contribution to wider health improvement. Our clinical staff keep up-to-date with the latest treatment possibilities and active participation in research leads to improved patient outcomes.

4.5 Goals agreed with Commissioners of Services – Commissioning for Quality and Innovation

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. During 2017/18, a number of CQUIN schemes were agreed – some of which were national schemes and the remainder, locally agreed quality improvement initiatives.

A proportion of the Luton and Dunstable University Hospital NHS Foundation Trust income in 2017/18 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 Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available below.

Scheme	Description	Q1	Q2	Q3	Prediction for Q4
1. Health and Wellbeing	Improvement of health and wellbeing of NHS staff	**	**		
	Healthy food	**	**		
	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				
	Reduction in consumption of antibiotics per 1000 admissions	**	**	**	

Scheme	Description	Q1	Q2	Q3	Prediction for Q4
3.	Improving services for people with mental health needs who present to A&E				
4.	Offering Advice and Guidance				
5.	NHS e-Referral Service				
6.	Supporting Proactive and Safe Discharge				

The Trust monetary total for the associated CQUIN payment in 2017/18 was £6.9m. The 2016/2017 value was £5,900,000 and the Trust achieved 97% of the value.

4.6 Care Quality Commission Registration

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

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

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

No enforcement action has been taken against the Trust during the reporting period April 1st 2017 and 31st March 2018 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

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

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?
- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?
- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.
- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.
- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016. There has been no further inspections by the CQC during 2017/18 and the Trust has continued to engage with any queries raised through monthly CQC engagement calls and meetings.

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

their performance against CQC standards. Our Clinical Outcome, Safety and Quality Committee (COSQ) receive these assurance reports.

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

4.7 Statements on Relevance of Data Quality and Action to Improve Data Quality

The accuracy and completeness of the data we use to support the delivery of high quality care is of the utmost importance to the Trust.

The Trust has been making progress with data quality during the year 2017/18. There are many processes carried out by the Information Team, which identify data quality issues.

Listed below are a few of the processes that are either carried out on a routine or ad hoc basis by the Department:

- CCG challenges
- Monthly and weekly Outpatient data quality reports sent out to users e.g. attendance not specified
- Theatre reports
- Inpatient reports
- Referral reports
- Patient Demographics
- Benchmarking analysis – SUS dashboards
- Data Quality Improvement Plan
- Data Accuracy checks
- Completeness and Validity checks
- A&E wait - arrival – departure times

During 2017/18 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 and incorrect neonatal level of care.
- Increased the use of automated reporting to increase the visibility of any data quality problems and expanded our contacts within the departments
- Continued to work with Commissioners to monitor and improve data quality pro-actively in key areas.

NHS Code and General Medical Practice Code Validity

Luton and Dunstable University Hospital NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS number was:

- 99.3% for admitted patient care; 99.7% for outpatient care and 97.3% for A&E care.

The percentage of records in the published data which included the patient's valid General Medical Practice was:

- 100% for admitted patient care; 100% for outpatient care and 100% for A&E

care

Action Plan for Data Quality Improvement for 2018/19

Information Governance

- Data Quality Accuracy Checks - Maintain the number of audits on patient notes.
- Completeness and validity checks - Remind staff about the importance of entering all relevant information as accurately as possible via Email and liaising with IT Applications Training Team for individual ad hoc refresher training.

1) CCGs Challenges

- Continue to work with Outpatients, IT & Divisions to improve other areas of known data issues (Admission Method vs A&E Attendance)
- Continue to communicate with users the importance of recording the current GP at time of attendance or admission.
- Continue to improve the NHS Number coverage
- Continue to monitor Multiple Firsts and highlight areas that are consistently creating first appointments
- 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

2) Outpatients

- Continue to produce weekly and monthly lists identifying those patients with an attendance status of 'not specified'. Also work with the Outpatients, IT

and Divisions to reiterate the importance and financial impact of not recording information accurately
- Continue Regular Outpatient Data Quality meetings.

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

4) Waiting List
- Continue Regular Waiting List Data Quality meetings.

5) Theatres
- Changes in General Management has resulted in the current DQ reports stopping and new Theatres reports to be considered with the department and Finance.

6) Referrals
- Continue to send out referrals to users to rectify the referral source and highlight within the Outpatient Data Quality Meeting the importance of the source being entered

7) Patient Demographics
- Continue to monitor and update Invalid Postcodes, DBS errors and missing NHS numbers. Highlight within DQ meetings the importance of QAS and up to date GP information.

8) A&E
- Continue to improve the NHS Number coverage
- Continue Regular Outpatient Data Quality meetings.

9) SUS dashboards
- Work with Divisions to improve the completeness of the fields where the National Average is not being met
- Use the dashboard to identify areas that require improvement (e.g. Ethnic Group Collection in Outpatients and NHS Number in AE needs to improve

Other Data Quality meetings
The Information Team are holding regular data quality meetings with A&E, Theatres, Inpatients and Maternity (still to be confirmed).

Clinical coding error rate
The Luton and Dunstable University Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 9.5% was reported for primary diagnosis coding (clinical coding) and 7.75% for primary procedure coding. This demonstrates good performance when benchmarked nationally and achievement of level 2 attainment in the Information Governance Toolkit.

- that results should not be extrapolated further than the sample audited
- the services reviewed in the sample were General Surgery, Urology, Trauma and Orthopaedics, ENT, Ophthalmology, Oral Surgery Accident and Emergency, General Medicine, Gastroenterology, Clinical Haematology, Cardiology, Respiratory Medicine, Medical Oncology, Neurology, Rheumatology, Paediatrics and Geriatric Medicine.

Information Governance toolkit attainment levels
The Luton and Dunstable University Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2017/18 was 68% and was graded as satisfactory.

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes within an organisation.

Learning from Deaths
During July – December 2017 599 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:
- 281 in the second quarter;
- 318 in the third quarter;

By 31st March 2018, 546 case record reviews and 61 investigations have been carried out in relation to 599 of the deaths.

In 61 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
- 34 in the second quarter;
- 27 in the third quarter;

2 representing 0.3% 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:
- 2 representing 0.7% for the second quarter;
- 0 representing 0% for the third quarter;

These numbers have been estimated using the Structured Judgement Review Tool.

The first death occurred as a result of a delayed discharge following surgery for a fractured neck of femur. It would have been more appropriate for the patient to die in a more comfortable and appropriate alternative setting which the health care system was unable to provide. Following a Serious Incident Panel, this incident did not meet the serious incident criteria. The integrated discharge team have been made aware of this incident to work with care teams to improve the end of life discharge pathways.

The second death followed an elective total knee replacement and following a fall at home following discharge, underwent a second surgery. However, sadly the patient died due to a hospital acquired pneumonia. Following a Serious Incident Panel, this incident did not meet the serious incident criteria. However, it was acknowledged that the decision to discharge on the first post-operative day may have been changed with the benefit of hindsight. This was discussed at the fractured neck of femur mortality meeting where the personal protective equipment of infection control was discussed. It was agreed that prophylaxis was not required for all patients with a fractured neck of femur but that early consideration should be given to gastric acid management where re-establishment of feeding is delayed post operatively. This has been shared with the orthopaedic and orthogeriatric teams.

0 case record reviews and 0 investigations completed after 31st March 2018 which related to deaths which took place before the start of the reporting period.

5. A Review of Quality Performance

Part 3

5. A Review of Quality Performance

5.1 Progress 2017/18

A review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness indicators selected by our stakeholders. These indicators were selected in 2009/10 through a survey and the most popular indicators were selected. We have continued to follow the selected data sets and any amendments have been described below the table as they are still considered relevant and are reviewed annually by the Council of Governors through their External Audit review indicator section.

Performance Indicator	Type of Indicator and Source of data	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	3 **	1	1	1	N/A	The Trust has a zero tolerance for MRSA. During 17/18 there was an isolated case.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	106*	112*	108.7*	105.1*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	10	11	8	9	N/A	Demonstrating an stable position. Remains one of the lowest in the country
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	19	11	3	12	N/A	This has been a challenging year with winter pressures and the acuity of the patients.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	3	2	4	5	N/A	Maintaining low numbers
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.6	1.04	1.4	1.08	1.3 Apr-Oct 17 1.2 Oct 17-Mar 18	Maintaining good performance below the national average
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.4 days	3.2 days	3.2 days	3.2 days	N/A	Maintaining the LOS

Performance Indicator	Type of Indicator and Source of data	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	National Average	What does this mean?
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	4.25	4.32	4.06	3.97 4.73***	 6.63	Maintaining good performance.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (to November)	Clinical Effectiveness	79.5%	69.4%	78.3%	85.3%	Target of 80%	The Trust is now consistently achieving this target.
% of fractured neck of femur to theatre in 36hrs	Clinical Effectiveness Dr Foster	75%	78%	62%	76%	N/A	There is an increasing trend.
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	79*	69.7*	70.79*	50.8*	100	This is demonstrating the Trust as a positive outlier and improved performance on the previous year.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	109*	112.8*	89.56*	100.3*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness Dr Foster	6.7%	7.2%	7.09%*	7.00%*	N/A	The Trust is maintaining the position.
% Caesarean Section rates	Patient Experience Obstetric dashboard	27.8%	28.3%	32.9%	30.1%	25%	The Trust is starting to see a reduction in the C Section rates.
Patients who felt that they were treated with respect and dignity**	Patient Experience National in patient survey response	8.9	9.0	8.8	Not available until May 2018	Range 8.5 - 9.8	Demonstrating an improving position.

Performance Indicator	Type of Indicator and Source of data	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	National Average	What does this mean?
Complaints rate per 1000 discharges	Patient Experience Complaints database and Dr Foster number of spells for the year	7.12	6.29	6.64	5.50	N/A	The Trust continues to encourage patients to complain to enable learning.
Patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	7.8	7.4	7.6	Not available until May 2018	Range 7.1 – 9.2	Demonstrating a slightly poorer position but still within range.
Venous thromboemolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95%	Achieved >95%	Achieved >95%	Achieved >95%	N/A	Maintaining a good performance.

(n) Denotes that this is data governed by standard national definitions
* Denotes calendar year
** Public Health England Healthcare Acquired Infection Surveillance Group identifies the number of MRSA bacteraemia "allocated" to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
*** 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.

5.2 Major quality improvement achievements

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

Improving Quality

During 2017/18 the L&D launched its Quality Strategy. In response to the need for an improvement in the safety domain during our CQC inspection, we asked the IHI to work with us to identify opportunities to improve safety and quality. Many of the recommendations made, have been included in the development of this strategy.

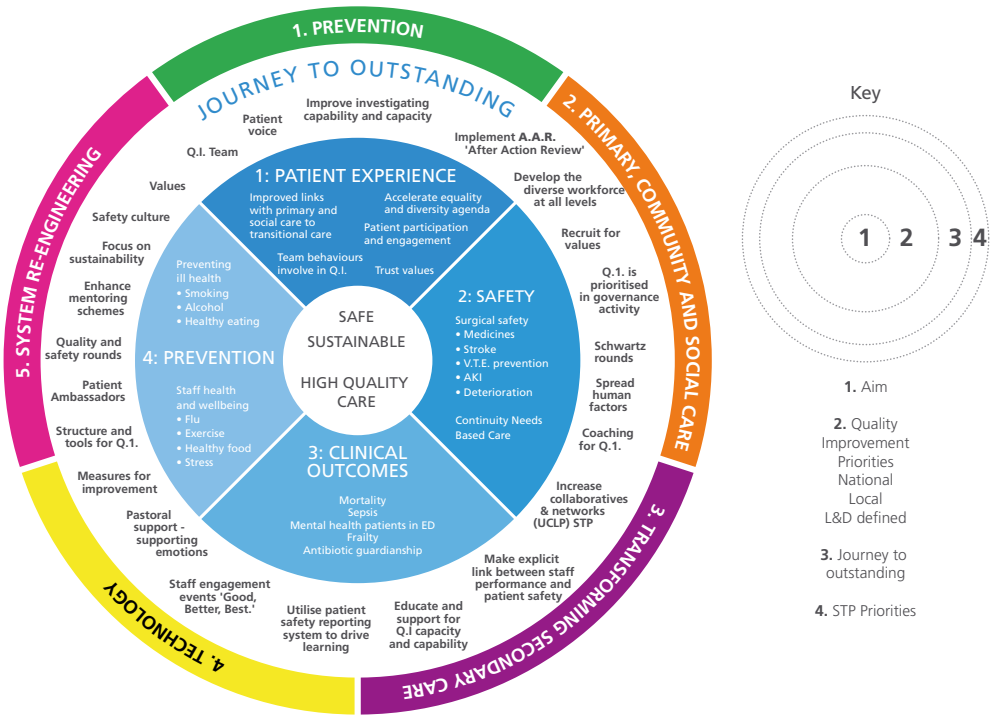
A number of events to engage with staff and service users has enabled a better understanding of the support and resources required to create a culture and proactive environment for QI, both through our Good Better Best event (bi-annual Trust-wide staff engagement event) and at an interactive workshop considering QI in more detail. The feedback from our staff and patients is that they want to become more involved in improving quality within the Trust and that they need the support to do so.

The L&D prides itself in the delivery of high quality, safe and sustainable services to our diverse, local community and those for whom we provide tertiary services. We aim to be the first choice provider for people who need to use local, acute hospital services. As a Trust with a track record for achieving success in our performance measures and targets, we have taken time since our 'good' CQC inspection to reflect on how we can grow in a different way to help create and build a hospital where quality, and the advancement of quality, is everyone's business. We commissioned a safety diagnostic from the Institute of Health Improvement (IHI) to assist us in doing this.

The *anticipated* merger with Bedford Hospital, provides a bigger opportunity to deliver 'outstanding' acute hospital services for Bedfordshire. We believe that, under the umbrella of a single NHS Trust, we can create greater momentum for improvement to benefit our community. This is a strategy for all and embraces the delivery and improvement of services from pre-conception and maternity, through children's services and into old age and the end of life.

To achieve this we will continue to put the needs of our patients, their carers and their families first and we will place greater priority to listening to the patient voice. We will expand upon our portfolio of projects that improve peoples' experiences of the Trust (patients, carers and staff), including those that improve on delivery of dignity and respect, fair treatment, access and inclusion, whilst we continue with our endeavours to further improve patient safety.

The Quality Wheel (figure 1) was initially presented to staff attending the Good, Better, Best Event in December 2016. The central aim is to deliver safe, sustainable, high quality care. Our Quality Wheel seeks to depict an 'at a glance' overview of our approach to Quality. Our quality priorities are articulated surrounded by a collection of enablers which will support our 'journey to outstanding'.



Around this aim sits four quality priorities:

- Patient Experience
- Patient Safety
- Delivering excellent clinical outcomes
- Prevention of ill health

To achieve the above we must also:

- Accelerate our 'Journey to Outstanding' through improving staff experience and engaging and enthusing staff in promoting a culture of continuous learning and quality improvement

These four priorities encompass a broad range of work streams, many of which are already in progress or soon to begin – the work to be undertaken is detailed in the Quality Priorities 2018/19 contained within this report. A number of enablers or building blocks are required to support the quality improvement to maximise benefit for patients, staff and the organisation. It is vital to get these in place and right for staff so that they are supported in their endeavours. It is also important that staff energy is directed towards quality improvement priorities and objectives that have been agreed by the Trust. By developing a culture of collaboration within and between teams and a collective leadership approach, we want our staff to be involved in agreeing our priorities and objectives.

Our Quality Impact Assessment process

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

The CIP / QIA processes:

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

The Trust's position for undertaking risk assessment is outlined in the Risk Management Framework. The Trust's top 5 risks for 2018-19 are detailed in the Annual Governance Statement. With regards to the risk assessment of CIPs and associated QIAs, this includes an outline of the programme in detail and the associated assessment of the likely quality impact and financial impact, in line with NHS Improvement recommendations. The Executive Board oversees the programme and assurance is provided to the quality sub-committee of the Board. Internal Audit periodically review the process.

The triangulation of quality with workforce and finance

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

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

The Trust continues to consider how information can be better presented to more clearly articulate to our Board and the public, the actions in place to address any areas requiring improvement. The Trust uses the information collated to effectively make informed, evidence based decisions about future developments.

Our Quality Improvement Implementation

A healthcare organisation's culture shapes the behaviour of everyone in the organisation and so affects the quality of care that together they provide. Research shows that the most powerful factor influencing culture is leadership.

Collective leadership - *"leadership of all, by all and for all"* – provides the type of culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across trusts (NHSI 2017).

The Trust strives to provide the culture for the delivery of high quality care and which fosters continual

improvement. Our feedback from the IHI recommended that we use a safety culture tool. We will use a culture assessment tool, such as the King's Fund CAT currently being rolled at Bedford Hospital and we will work to address any identified needs. Our aim is to provide an environment which enables staff to show compassion, to speak up, to continuously improve and an environment where people are always treated with dignity and respect, where there is learning and a clearer focus on listening and responding to the voices of our patients and staff.

The Trust will continue to deliver Human Factors education to more effectively support learning and quality improvement. We intend to strengthen the Human Factors offering to a number of staff within each Division and use this expertise to identify stronger solutions to problems when developing improvement/ action plans.

We will continue to deliver the Quality, Service Improvement and Redesign programme (QSIR) and develop a range of shorter courses and faster sessions as well as ensuring that all staff receive an introduction as part of their induction to the Trust.

The QSIR programme is just one element of a wide range of 'enablers' which have been built into our new quality strategy to support us on our journey to becoming an outstanding organisation for our patients and our staff. The programme engages our staff by harnessing local skills, knowledge and experience to improve the service delivered and builds our improvement capability. We want all staff to be able to identify opportunities for quality improvement and to be skilled in using a common language and processes to do so.

The Trust is now one year into our QSIR journey and we have trained 33 staff as QSIR practitioners since January 2017. The staff span the whole range of multi-disciplinary teams. Another 25 staff are currently on the programme (Cohort 3). In order to build up our faculty of teachers, two of our staff have attended the national ACT academy (NHSI arm of QSIR).

The QSIR programme is delivered in 5 days over 4 months covering 8 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

Until we have our own full complement of facilitators, we are fortunate to benefit from the support of our experienced QSIR trainer colleagues from UCL. The collaboration has been a real asset; the team have lent their valuable experience and ensured the success of the first two cohorts.

On October 2nd we brought QSIR practitioners together to share their quality improvement stories and to celebrate their successes. It was really inspiring to hear about the really positive contributions our staff had made. Guest speakers included Stephanie Reid from NHSi ACT Academy, Mark England the Director of Transformation at the STP and our own CEO David Carter. We hope to make this a regular feature in the Trusts celebration events.

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

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

5.3 Friends and Family Test

The organisation continues to participate in the Friends and Family Test (FFT), submitting information on a monthly basis to NHS England. We are also able to view other Trust's scores which enable us to benchmark our scores against both regional and national scores. As well as reporting on a monthly basis to NHS England we provide staff with weekly feedback from our patients and carers using the FFT scores. This enables staff to react in a timely fashion to what our patients are telling us rather than waiting for the monthly score to be reported. With the increased frequency, issues can be addressed quickly

reducing the likelihood of them escalating to more serious issues. The information continues to be reviewed for trends and themes across the organisation and at ward and department. There were no particular trends or themes noted from the information collected.

Response rates to the FFT have remained constant throughout the year and we continue to use varied methods to record the data, such as survey cards and iPads. Our volunteers continue to be a valued source to help collect the feedback, and as demand for the use of iPads has increased we have purchased additional units for the wards and departments. The challenge of collecting feedback in areas such as the Emergency Department has made us look at other ways of gathering the feedback from patients. We are investigating the use of text messaging, evidence from other organisations suggests that this might help to increase response rates by as much as 10%.

The FFT question has remained unchanged:

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

And we continue to collect information from the same clinical areas as last year for adult and paediatric services.

Those are;

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

A quarterly report of the patient experience feedback is reviewed at the Clinical Outcomes, Safety and Quality Committee and by the Patient and Public Participation Group.

Tables 1-4 show the percentage recommend scores across all areas of the Trust. These statistics are reported monthly to NHS England.

2017/18 has seen variable recommend rates for Friends & Family. The percentage of patients who would recommend our services has consistently shown that we equal or exceed the England NHS average, for all areas except maternity. Within maternity services, we have exceeded the England average for most months of the year and scores are currently rising. Where we have seen a drop in scores for a month teams have been notified and additional effort has been made and results have subsequently improved the next month. Weekly reporting has made it easier for teams to identify the change in score promptly, which allows improvements to be made to prevent the overall monthly score remaining lower.

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)	665,338	2,617,975	25.3%	96%	1%
Trust (Q1)	3,012	14,339	21%	96%	1%
England excluding independent providers (Q2)	667,099	2,634,048	25.3%	96%	2%
Trust (Q2)	3,491	16,262	21.5%	93.3%	2.3%
England excluding independent providers (Q3)	619,738	2,598,033	23.8%	95.6%	2%
Trust (Q3)	3,776	18,180	20.8%	95.3%	1.6%
England excluding independent providers (Q4)	409,300	1,757,60	23.60%	96%	2%
Trust (Q4)	2,995	11,565	26.1%	96.5%	1%

Table 2 Inpatients Percentage Recommend Scores 2017/18

% of Inpatient that would recommend 2017/18

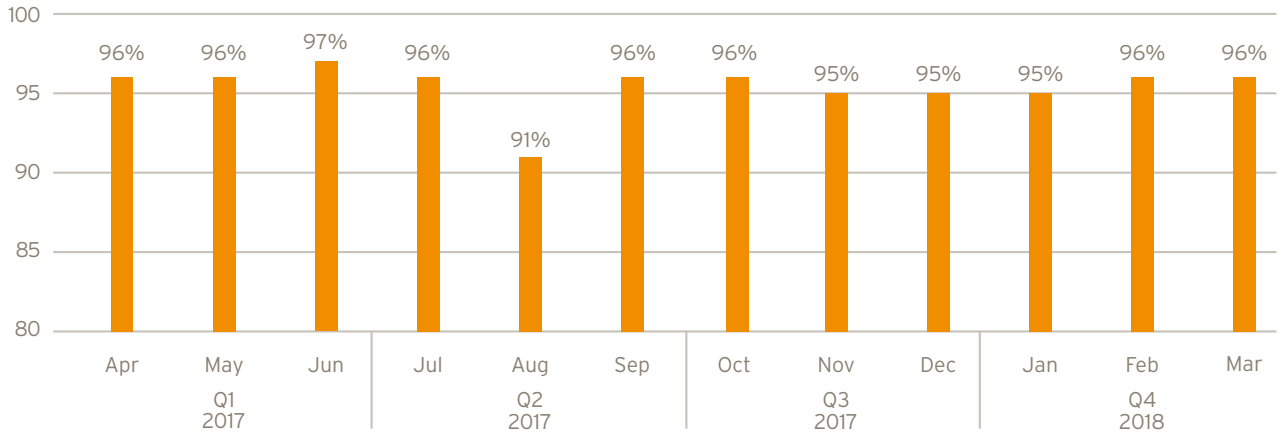


Table 3 Accident and Emergency Percentage Recommend Scores 2017/18

% of A&E patients that would recommend 2017/18

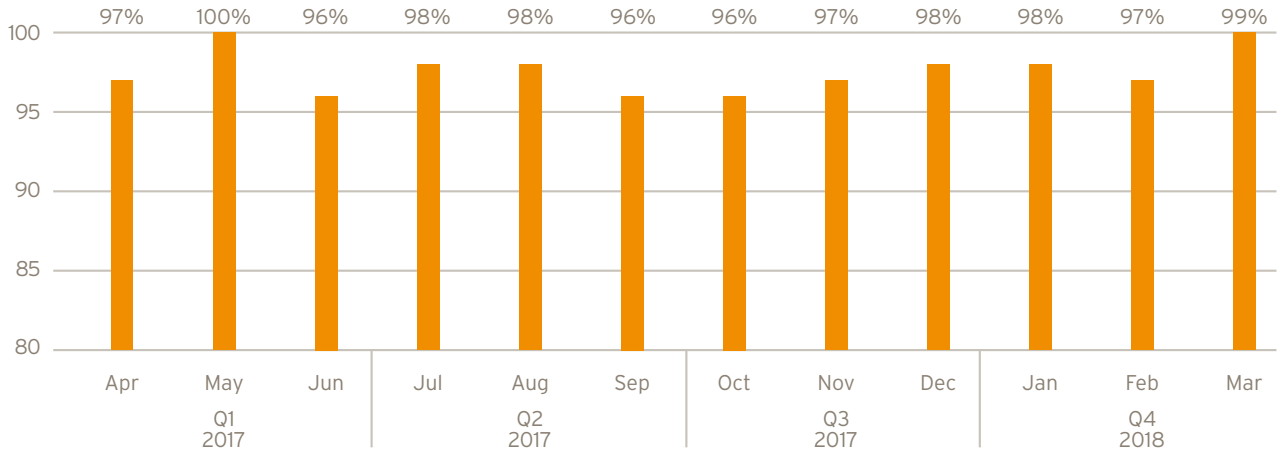


Table 4 Maternity Percentage Recommend Scores 2017/18

% of maternity patients that would recommend 2017/18

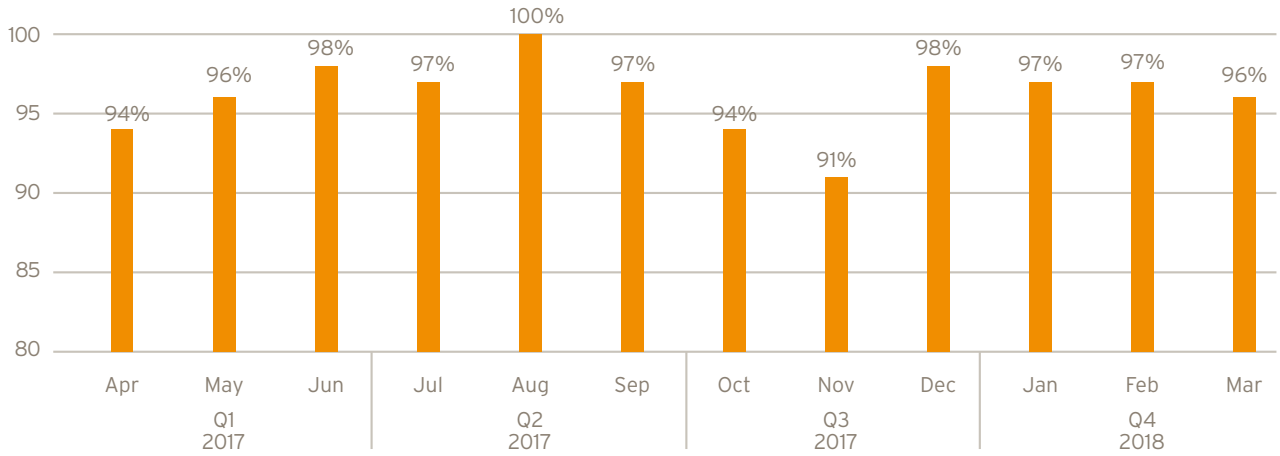
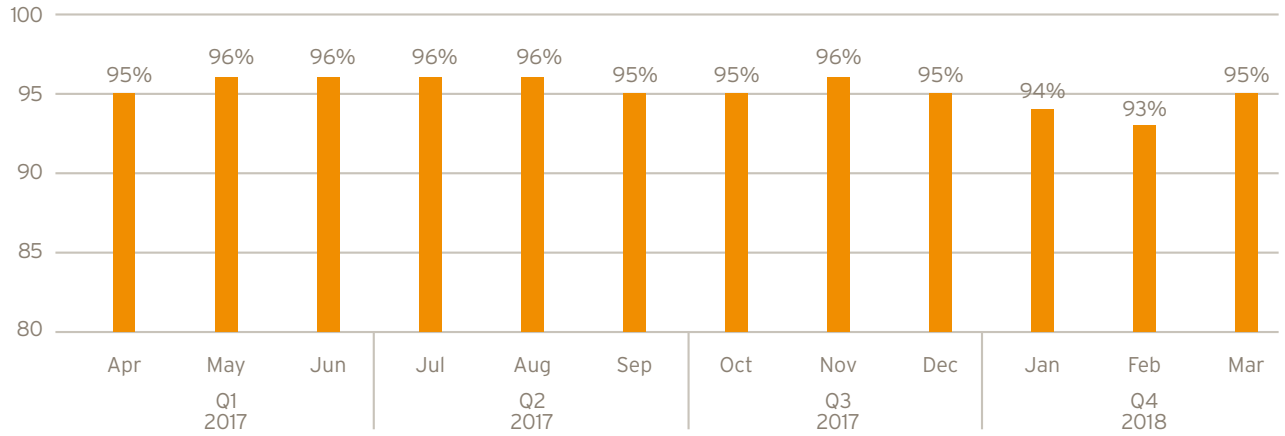


Table 4 Outpatients Percentage Recommend Scores 2017/18

% of oupatients that would recommend 2017/18



Patient Stories and Improvements following patient feedback.

Story One

Multi Team Working

RN had an appointment in the fracture clinic, at a time when the Hospital Transport Service was in transition to a new provider. RN was expecting to be collected by ambulance transport and was ready from 13.00, but transport did not arrive.

RN contacted PALS for help. The team checked iPM and RN was coded as a Did Not Attend, despite the fact that he had spoken to the staff and they said get to the clinic when he could. PALS also contacted the hub, and explained the situation to the member of staff.

The Team asked for advice for RN, who was waiting at home with a painful swollen leg. The PALS team contacted clinic and A&E for advice, and then called the patient back to advise him to attend A&E, if he felt it was an emergency. Unfortunately, he couldn't get to A&E, by any other means other than by hospital transport, and as he said it was not life threatening, he did not want to call 999. He was concerned that he did not want to leave it as he feared he may be getting a wound infection. The PALS Team continued to raise concerns about this patient and after a few challenges contacting administration, spoke to the consultant's secretary, who in turn spoke with the consultant. The consultant requested immediate attendance at hospital and along with the PALS Team, Patient Experience Manager and the Transport Services Manager, the gentleman was seen a few hours later in the hospital and treated successfully.

Lesson Learned

1) Communication from administration teams to inform staff of changes to secretarial staff to ensure people have the right contact details.
2) Answering patient calls and returning messages in a timely fashion is important. Changes to phone coverage by secretaries has since been implemented
3) Involve clinicians with discussions relating to a difficult clinical query as they can make the final judgement for urgent treatment, which cannot be made by secretary or PALS team.

Overall Outcome: Good communication with all teams including transport resulted in a quick solution to a patient who needed to be seen urgently and given appropriate treatment

Story Two

Discharge Planning

LH contacted PALS in April 2017 with concerns that she was not being discharged from hospital. It was prior to the Easter Bank Holiday weekend and she was deemed fit for discharge and she was desperate to go home. LH understood that her discharge was being delayed because her GP was refusing to pay for a drug she needed to take home.

Contact was made with the Hospital at Home Team

but as her ongoing care was under the remit of the district nurse team, they were unable to help.

The PALS Team then contacted the Integrated Discharge Team, Team Leader who assisted. The Team Leader contacted the PALS Team back to say that the information given to PALS was incorrect and in fact LH's GP was not licensed to prescribe the drug which she needed. The drug had to be supplied from the Hospital and needed to be prescribed by a Consultant who would oversee the management of the patient. The Team Leader arranged for a consultant to write up her TTA's and arranged for district nurses to visit the patient at home that evening and 3 times a day after that until treatment finished.

The patient was discharged from the ward later that day, and she was extremely happy that she would be spending Easter at home and not in hospital.

Lessons Learned:

1) Adequate planning is needed to enable discharge for patients particularly on bank holiday weekends
1) Appropriate information should be given to patients relating to their medication, and staff should check that patients understand the information given.

Overall Outcome: Good communication and fast team working with various hospital services gave a positive outcome for the patient, for which she was extremely grateful.

Improvement One

Patient Essential Care Packs

Patients are sometimes admitted to hospital at short notice, which means they often come ill equipped for their stay. Evidence indicates that nurses spend more than 25 minutes per day obtaining essential items, but if patients have to go without these items it may have a negative impact on their wellbeing, as well as their experience.

Patient Essential Care Packs provide patients with the key items needed to make their stay more comfortable and can be tailored to what patients feel is essential for them. Our packs were made up to contain items such as toothpaste, tooth brush, comb, shower gel, flannel, eye mask, ear plugs and essential information contained in the Welcome Booklet, Patient Advice and Liaison Service (PALS) and prevention of falls leaflets.

. The following areas were included in the pilot project

- Emergency Admissions Unit 1 (EAU 1)
- Emergency Admissions Unit 2 (Ward 4)
- Surgical Admissions Unit (SAU)
- Paediatric Admissions Unit (PAU)

Patient Feedback

"When I was admitted unexpectedly I was desperate to brush my teeth. When I was given the pack it made me feel comfortable because I could brush my teeth. It is a really good idea"

"I was really surprised to receive the pack and it really helped me, especially the eye shield and ear plugs, as the ward was quite noisy"

"Items were sufficient enough for a short stay. Thank you"

Staff Feedback

"The patients really appreciate it and were surprised it was free, some asked if they had to pay for it!"

"The staff found them really helpful as it saved them time running around to get all the bits and pieces together"

"We did not have eye pads and ear plugs on the ward and these went down really well with the patients"

"The packs were really helpful particularly for the patients who have been sent to the ward via their GP"

Further packs have been ordered and long term funding options are being explored as this pilot was supported by Charitable Funds. As the feedback has been positive there is clear value in continuing with the packs.

Improvement Two

Pets as Therapy (PaT) Dogs

It has long been accepted that animals can be very therapeutic in aiding recovery and to improve wellbeing for people who have been ill. Research has shown that stroking a pet can not only reduce blood pressure but also reduce psychological responses to anxiety. The presence of pets can also promote social interaction and relaxation. It has been a project driven by Senior Nurses in the Trust to introduce the PaT Dogs programme to assist with the wellbeing of

patients, in particular for those on our Medicine for the Elderly and Stroke Wards.

Two dogs were introduced into the Trust this year and are now members of the Volunteers Team. The owners (and their dogs) have to undergo special assessment and training so that they can visit people in hospitals, hospices and other organisations.

At the moment the dogs do not visit the wards, but patients who are able to can see them in the Therapies Hub. They are proving to be a great hit, not only with patients, but also with staff! We have also already witnessed some positive outcomes from the visits. One patient who had suffered a dense stroke and only spoke one word, "yes", was introduced to the dogs. One of them put their head on his leg and he attempted to lift his hand and said "paw". We know that the PaT Dogs are going to prove to be very popular with everyone in the Trust.

National Inpatient Survey 2017

The report of the L&D inpatient survey was received in June 2018 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 2017 were surveyed. The Trust had a response rate of 38% against a national average of 41%..

Results of the national in-patient survey 2017

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

Note all scores out of 10
* No score available for 2017

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.

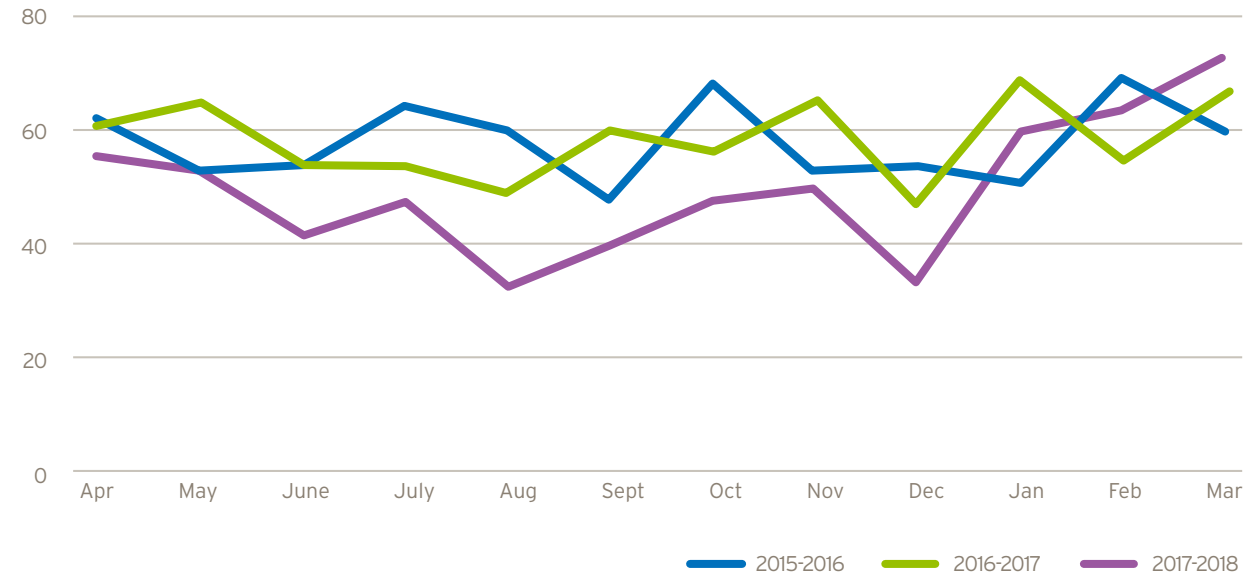
5.5 Complaints

During 2017/18 the Trust concentrated on developing processes which allow the learning from complaints to be shared with staff and we have continued to welcome patient feedback. There has been a continued focus to ensure that we are answering complaints and concerns efficiently and in a timely manner. We continually use this information to improve our services.

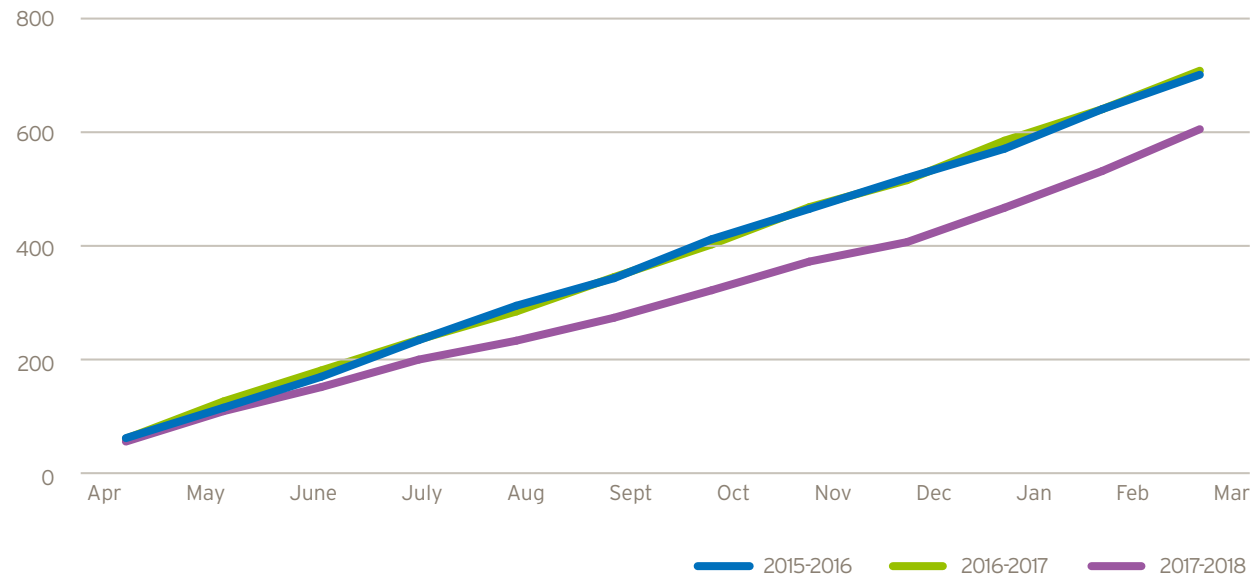
Our Trust has made significant efforts to resolve people's concerns quickly, via our PALS Team. Service Managers have been pro-active in contacting complainants to help resolve their complaints informally, thereby reducing the need for them to follow the formal complaints process.

During 2017/18 we received 601 formal complaints compared to 704 in 2016/17 and 696 in 2015/16. There has been a decrease in formal complaints due to early intervention by the Service Managers, although it is recognised that there is a heightened public awareness of the option to complain.

Formal Complaints - 2015/16 to 2017/18



Formal Complaints received in 2017/18 compared with 2016/16 and 2016/17



Improvements were made to the categorisations of complaints themes, to enable better learning and reporting. By implementing the use of the recommended coding from NHS Digital, investigations can be focussed around the specific themes. These changes were implemented from 1st April 2017, so we currently have 12 months of data. This will help us to better understand the nature of our complaints so that we can deal with them well in a timely way. This will also enhance our internal and external reporting, highlighting specific areas where we can improve.

We have also improved the method by which we acknowledge complaints. We endeavour to acknowledge all complaints within 3 working days and have achieved an average of 97.5% throughout this financial year with 100% acknowledged within the 3 day lead time in 7 out of the 12 months. It is not always possible to formally acknowledge a complaint within 3 days if the complaint has been raised via the hospital's website and not all relevant details are available. The information required when submitting a complaint has now been highlighted on the hospital website to reduce any unnecessary delays.

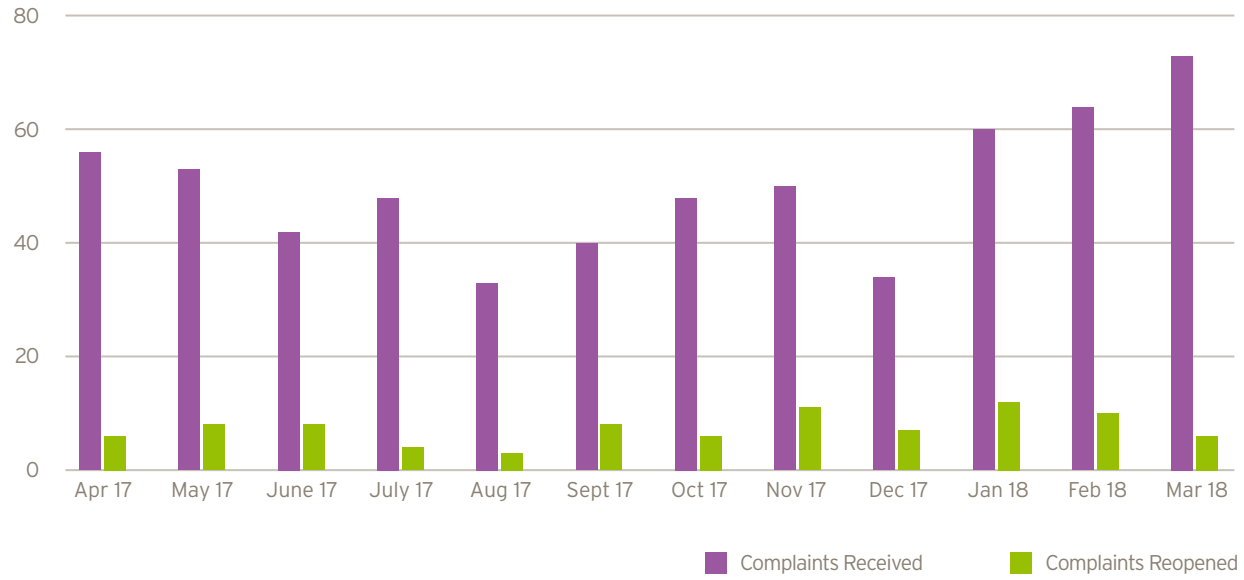
We aim to respond to complaints within 35 days but this has proven difficult to achieve in some cases, often because of reasons outside of the investigators control. The Patient Affairs Team currently sends out a weekly report of breached responses to the divisions but to

help us meet the target in 2018/19 we have developed a tracking system to monitor complaints through each stage of the complaints process.

The monitoring and tracking of complaints handling is now part of the Divisional Performance Meeting monitoring agenda and the Board maintain oversight and are committed to increasing the response times.

In 2017/18 we re-opened 89 complaints. The graph below shows the number of formal complaints re-opened in comparison to the number received each month. Our aim for 2018/19 is to continue to reduce the number of re-opened complaints by ensuring 'first time right' responses.

Formal Complaints received versus reopened for 2017/18



Learning from Complaints

This year we have strengthened our complaints process to ensure that we are learning from complaints to improve the services we provide. Complaints that are justified and partly justified and where recommendations have been made, there is an action plan that is monitored by the divisions with assurance provided to the Complaints Board. Below are examples of some of the improvements made during 2017/18:

- A few of our complaints that were made especially within the Medical Inpatients were about the PIPA boards above patient's beds – (they are the above bed boards used in the hospital). For example, staff were not aware a patient was deaf and therefore spoke to them as if they were a hearing person. A board would have allowed the icon to be placed on it so all staff were aware. As a result of this complaint, boards are now in place on the wards with icons and more boards have been ordered.

- We received complaints about the waiting area within Surgical Short Stay Unit (SSAU). The concerns raised were that the waiting area for patients going to theatre is not ideal and challenged the need to provide a comfortable and relaxing environment. As a result of such complaints, there was a discussion with Nursing Staff managing the area and revisited options to improve the environment. The division plans to use the capital equipment budget or charitable funds to improve the chairs and facilities in the unit.

- We have introduced a red flag system in the surgical division for clinic letters to be typed urgently where a patient needs imaging prior to a scheduled appointment or procedure. This has meant that patient experience is improved; delays prevented, and avoid waste of NHS resources.

Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. The top themes of complaints related to clinical treatment, appointment delays and cancellations, communication and attitude of staff.

In 2017/18 all complaints were thoroughly investigated by the General Manager for the appropriate division and a full and candid response was sent to the complainant.

The majority of complaints were resolved at local resolution level, with seven complainants requesting that the Parliamentary and Health Service Ombudsman (PHSO) review their complaints. Four complaints are still under investigation by the PHSO and awaiting a draft report and for three of the complaints; we have received a draft report from the PHSO with a decision not to uphold the complaints. We are currently awaiting the final report to close them.

In 2018/19 we aim:

- To continue to promote informal and prompt resolution of concerns at a local level and involvement by Service Managers to contact complainants there by reducing the number of formal complaints and improving patient experience.
- To continue to raise the profile of complaints within the Trust via newsletters and training.
- Where investigators are having difficulty completing investigations due to circumstances outside their control they will be asked to work closely with the Patient Affairs Team and to keep complainants updated in a timely manner and negotiate extensions where appropriate.

Compliments

During the reporting period over **4,840 compliments** were received about our staff and our services.

Below are some extracts taken from the compliments we received:

Thanks to everyone in A&E
Last Friday morning my elderly mother was brought to you having fallen in the night and cut her arm, which wouldn't stop bleeding. Everyone in the Accident department was kind and patient with her -even to the extent of over-hearing Mum saying she was hungry and appearing with a choice of sandwiches! I've been to a number of A&E's with Mum over the years, the treatment has always been 1st class but the kindness you all showed her last week was amazing - thank you.

Excellent handling of my case (breast cancer)
My experience of the breast cancer services at the L&D is second to none. From detection through a routine breast screening test to biopsy, further investigation in November/December, mastectomy in January and offer of immediate breast reconstruction I have experienced nothing but excellence. All the nurses involved were very competent, efficient and always cheerful which, I am sure, helped me recover more quickly. I feel extremely lucky to live near and have easy access to what I would class as a 5 star NHS service provided by its hard-working, very competent and dedicated staff.

Thank you
I would like to say a big thank you to all the staff who work in the maternity department of the hospital. From the early weeks of pregnancy to the safe delivery of my son this week, every member of staff involved has been amazing.

Thank You to the Cardiology Department
Two days ago I had a pacemaker fitted and I would like to express my thanks to the wonderful staff for their care and attention whilst in the unit. The attitude of everyone was exemplary and the care second to none and I would like you to convey my deepest thanks to everyone in the Cardiac Unit. As a hospital, you should be very proud of them. Many thanks.

Compliments to catering department
I've been an inpatient since Wednesday and have been pleasantly surprised by the high quality of the food I have been offered. Of note, the food has always been well presented and I have been particularly surprised that it has always been piping hot. Of particular note I had the chicken curry one evening which was absolutely delicious. Your ward housekeepers have been helpful and courteous. So thank you to all the team and congratulations on a high standard.

5.6 Implementing the Priority Clinical Standards for Seven Day Hospital Services

The delivery of seven day services across England is a priority for NHS England (Keogh 2013)* There are 10 Quality Standards and four priority clinical standards that Trusts must implement to have an impact on safety and mortality
The aim is to deliver standards to 90% of patients by 2020

- Clinical standard 2 - Time to first consultant review
- Clinical standard 5 - Diagnostics
- Clinical Standard 6 – interventions / key services
- Clinical standard 8 – On-going review

A Seven Day survey is carried out twice a year in April and September. The survey focuses on measuring the Trust compliance with the four priority standards and the survey reviews approximately 210-280 cases that was initially a prospective survey but is now a retrospective case note review.

The Trust is making progress and is set to achieve the standards.

5.7 Performance against Key National Priorities 2017/18

		2014/15	2015/16	2016/17	2017/18	Target 17/18
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	10	11	8	9	6
MRSA	To achieve contracted level of 0 cases per annum	3*	1	1	1	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	100%	100%	99.9%	100%**	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	91%	88.4%	88.6%**	89.2%	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.5%	95.8%	96.4**	96.3%**	93%
	Cancer	Maximum waiting time of 31 days for second or subsequent treatment				
	Surgery	98.9%	98.6%	100%	100%**	94%
	Anti-cancer Drugs	100%	99.8%	100%	100%**	98%
Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	96.9%	96.3%	93.2%	91.9%	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.6%	98.6%	98.8%	98.4%	95%
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	N/A	N/A	0.7%	3.4%	<1%

* The Trust has maintained low rates of MRSA throughout but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
** currently to February 2018 - March data to be added in May 2018

5.8 Performance against Core Indicators 2017/18

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
	Published Mar 17 (Sep 16 -Sep 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

The Luton and Dunstable University Hospital considers that this data is as described for the following reason:
- This is based upon clinical coding and the Trust is audited annually.
- The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- Mortality rates remain as expected and other benchmarking, including HSMR remains one of the Trust quality priorities for 2017/18 and 18/19.

The Mortality Board maintains ongoing oversight of any indicators that flag as an outlier including palliative care coding in which the Trust is in line with the national average.

Indicator: Readmission rates

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 - 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2017/18	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*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:
- This is based upon clinical coding and the Trust is audited annually.
- The Trust does not routinely gather data on 28 day readmission rates
- The Luton and Dunstable University Hospital has taken the following actions to improve this percentage, and so the quality of its services, by:
- We will continue to work with our commissioners to prevent unnecessary readmissions to hospital through admission avoidance services available for patients to access. These include Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team, the Hospital at Home service, provider support in the Emergency Department and the integrated models of care

*The most recent available data on NHS Digital is 2011/12 uploaded in December 2013.

Indicator: Patient Reported Outcome Measures (PROMs) scores

PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.

	Reporting period	L&D Score	National Average	Highest score (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
	2015/16	**	0.1	0.13	0.037
	2016/17*	**	0.099	0.152	0.016
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14	0.369	0.436	0.545	0.342
	2014/15	**	0.442	0.51	0.35
	2015/16	**	0.45	0.52	0.36
	2016/17*	0.38	0.44	0.53	0.33
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

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
Results are monitored by the Clinical Audit and Effectiveness Group
Results are monitored and reviewed within the surgical division

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

- Reviewing these results in both high level committees and within the surgical division.
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings.
- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

* Relates to April 16 to March 2017 (most recent data published by NHS Digital)
** Score not available due to low returns

Indicator: Responsiveness to the personal needs of patients during the reporting period

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

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

	Reporting period	L&D Score	National Average	Highest score (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	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
The source of the data is the National In-Patient Survey.

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

- Continued implementation of Electronic Prescribing system and that has improved timeliness of available medications for patients to take home
- On-going refurbishment programme to assess the high risk environmental areas that need attention particularly toilets and bathrooms
- On-going monitoring of patient feedback from the Patient Experience Call Centre and Friends and Family feedback

*The most recent available data on NHS Digital is 2016/17 published August 2017

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%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
The source of the data is the National Staff Survey.

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

- The hospital runs with a clinically led, operating structure.
- The Chairman and Non-Executive Directors have a programme of clinical visits and the experiences of each visit is reported to the Clinical Outcomes, Safety and Quality Committee.
- Transforming Quality Leadership Group in place and supports areas across the Trust through a 'buddy' process.
- Ongoing engagement with staff through bi-annual engagement events and monthly team briefing

* Not available on NHS Digital website

Indicator: Risk assessment for venous thromboembolism (VTE)

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (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%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- There is a robust process for capturing the evidence of completion

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

- The hospital has and will continue to ensure that all clinical staff are aware of the importance of timely VTE risk assessment of patients. This is undertaken at induction and through clinical bedside teaching.
- We have implemented an electronic solution to the risk assessment process that has had a significant impact. By March 2018 the Trust was at 99.8% compliance.
- We undertake root cause analysis on all patients who develop a VTE.

Indicator: Clostridium difficile infection rate

The rate for 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Rate for 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	5.1	15.1	62.2	0
	2015/16	5.4	14.9	66	0
	2016/17	3.6	13.2	82.7	0
	2017/18	3.9+	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 9 C.difficile for 2017/18

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

- maintaining C.difficile high on the training agenda for all healthcare staff
- rigorously investigating all cases of C.difficile through the RCA mechanism and actioning all learning points identified
- assessing all patients suspected of C.difficile infection when alerted
- uncompromisingly isolating suspected cases of C.difficile when first identified
- attending the CCG Infection Control Network with its potential for shared learning
- monitoring high standards of environmental cleaning (including equipment) and exploring other mechanisms of reducing C.difficile contamination further

*Data not available on NHS Digital
+ Local Data

Indicator: Patient safety incident rate

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.

	Reporting period	L&D Score	National Average	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	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	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

- 31 Serious Incidents were reported in 2017/18 compared with 22 in 2016/17, 32 in 2015/16 and 46 in 2014/15 (excluding pressure ulcers). Two incidents were downgraded in 2017/18 by the CCG on receipt of the investigation findings which identified that there were no acts or omissions in care that contributed to the outcome for the patient.
- The Trust reported 4 Never Events in 2017/18 under the following Department of Health criteria - a wrong implant/ prosthesis, insulin overdose, a wrong site surgery, nasogastric feed into the lung
- The Trust is contractually required to notify its Commissioners of a Serious Incident within 2 working days of identification – in 2017/18 this target was met in 28 out of 29 cases (96%) compared to 18 out of 22 cases (82%) in 2016/17.

- The Trust is also contractually required to submit an investigation report for all Serious Incidents within 60 working days of the notification. During 2017/18 this target was met in 28 out of 29 cases (96%) compared to 17 out of 19 cases (89%) in 2016/17. One incident is on a "stop the clock".
- The Trust continues to review its systems and processes to ensure it can meet the contractual requirements going forward.
- The Trust was 100% compliant with the Duty of Candour contracted requirements.

Learning from incidents is shared through Divisional Governance, Grand Rounds and Safety Briefings. Patient Safety Newsletters are issued to all staff each quarter and include a focus on learning from Serious Incidents. Examples of learning:

- Introduction of a step by step guide to prepare and administer insulin in every preparation area
- Review and modify the process for producing and destroying handover sheets for clinicians
- Changing the way patients with potentially difficult airway management are cared for during surgery
- Improve the reporting of potentially life changing results from imaging
- Improve the telephone triage advice recorded for patients ringing the maternity unit for advice

*Data not available on NHS Digital
** NRLS amended their calculation from per 100 bed days to per 1000 bed days in 2013 so no comparable historical data available

5.9 Embedding Quality – Workforce factors

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

Recruitment and Resourcing

In light of the ongoing national skills challenges facing the NHS the Trust has maintained its focus on recruitment across all staff groups. The Trust has continued to attend career fairs at local schools, Universities and other organised events to promote the various careers available within the NHS.

The Trust have also implemented a new applicant tracking and recruitment software system which has reduced time to hire and improved the recruitment experience for both applicants and recruiting managers.

Registered Nurses
The national shortage of registered nurses remains a key challenge for the Trust. During the past year the Trust introduced a designated nurse recruitment team to ensure a proactive and effective response to demand. As well as continuing with cohort recruitment, regular advertising the Trust has continued to deliver its strategy to recruit both EU and non EU nurses. However this method of recruitment provides challenges around the International English Language test (IELTS) and OSCE (Observed Structured Clinical Examination) which overseas nurses need to pass before they can gain their NMC registration. Subsequently the length of time for these nurses to commence in post remains protracted due to the amount of time it takes for all the stages to be completed and for the Nursing and Midwifery Council to process the applications for registration. The Trust has developed a fast track OSCE training programme which has reduced the length of time to gain NMC registration

Recruitment of newly qualified nurses continues bi-annually, and we remain the main source of employment for Bedfordshire University nursing students. The Trust also welcomes applications from nursing students who have trained at other Universities.

Acorn Preceptorship Programme
After three years training student nurses and midwives qualify and then face many challenges as they manage the transition into a Registered Nursing (RN) or Midwifery (RM) role. The Trust recognises that this can be quite daunting, one day they are classified as a student and the next as a registered practitioner, Within the Trust there is excellent provision to support the newly qualified RN/RM with the practical skill training as well as guidance and advice that form the detailed well established preceptorship programme. From September 2017 newly qualified staff are presented with a commemorative acorn badge as part of their preceptorship journey to thank them for choosing to start their careers with the L&D. When they complete the preceptorship programme this is formally recognised with presentation of a certificate marking the transition to registered practitioner.

Assistant Practitioners
Building on the previous year's successful use of band 4 Assistant Practitioners (AP) these roles have been incorporated into teams across the Trust .The staff are vital in supporting our registered nursing staff to deliver safe, quality patient care. The band 4 AP's are supported to move through the registered nurse training pathway to help the Trust to 'grow our own' which goes some way towards mitigating the national shortfall of newly qualified nurses. The Trust has 35 expressions of interest from staff to undertake their nurse training as part of this scheme.

Healthcare Assistants
The Trust has undertaken more frequent recruitment campaigns over the past 12 months to ensure that all vacancies are kept to a minimum. Cohort based recruitment involve assessments and interviews on the same day to maintain the high calibre of new recruits and to streamline the recruitment process.

Needs Based Care
The Trust has commenced recruitment to posts that enable the transition to a Needs Based Care (NBC) model of delivery that has continuity of care as its key principle. This has resulted in the introduction of a number of new consultant, specialist and other front line posts. Recruitment to these posts will continue up to October 2018 in order to ensure our patients receive the right care, in the right place and at the tight time based on their clinical need.

Agency Collaboration
The Trust has continued to work collaboratively with trusts across Bedfordshire and Hertfordshire on joint tendering and common processes to ensure best value for the use of agency staff without risks to patient safety. The project continues to deliver savings to the Trust and provide consistency within the local agency market.

Consultant Job Planning
The Trust recognises the importance of ensuring alignment between meeting patient demand and the availability of senior medical staff. Following last year's project to ensure consultant job plans are up to date and representative of service needs, work has continued to embed related processes and to ensure job plans remain fit for purpose in the context of 7 day, 24 hour working. The Trust's Job Planning Assurance Group has continued to meet regularly to provide oversight and scrutiny of all job plans and a final approval process which has been designed to ensure a fair and consistent approach across the Trust. Job Planning work has also been extended, this year, to embrace a team based approach where appropriate.

Communicating and engaging with our staff
The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2017 Staff Survey showed that the Trust scored above average for its overall staff engagement score. The percentage of staff reporting good communication between senior management and staff, placed us in the top (best) 20% of Trusts.

Organisation and Management interest in and action on health and wellbeing, also placed us in the top (best) 20% of Trusts.

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

Examples of staff communications and engagement include:

- Monthly staff briefings are led by our Chief Executive. We share information on key operational issues and gain feedback from staff
- Executive Team present to new staff at induction monthly.
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets quarterly with our Council of Governors, which includes nine elected staff governors
- Quarterly public Trust Board meetings
- Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust
- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there

has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

Staff Involvement Group
The focus of this group is on developing a culture of staff involvement, open communication and partnership working with factors that have a real impact on staff such as reward and recognition, security, health and wellbeing. The membership of the group is diverse and members are active in taking forward themes from the staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.

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

Engagement events 2017
Our fifth 'Good, Better, Best'' staff engagement event was a great success. More than 80% of our staff participated during the week in July 2017. The focus of the event was Quality Improvement Patient Safety and Patient Experience. The Quality Improvement faculty was launched and the Trust development of the Quality Strategy and sought feedback from staff attending on the Trust values that would be developed.

The Quality Strategy was launched at the Good, Better, Best Christmas staff engagement event was held in December 2017 with more than 2000 members of staff attending the sessions. Themes this Christmas included presentations on the Quality Strategy, the launch of the new Trust vision and progress towards the values, an update on the collaboration with Bedford Hospital and gave us an opportunity to thank staff for their hard work and dedication over the year.

Our Volunteers
Our Volunteer Strategy focuses on maximising the potential of volunteering here at the Luton and Dunstable Hospital, making sure that we are utilising the vast and diverse array of talent in the local community and doing all that we can to bring that into the Trust. We aim to achieve our objectives by delivering a high quality volunteer journey that maximises the reciprocal benefits for both the Trust and our volunteers.

The Voluntary Services Manager is responsible for overseeing external organisations such as the RVS, Carers in Bedfordshire, Hospital Radio and also organisations or businesses wishing to offer one day volunteering. She is a member of the National Executive Committee of NAVSM (The National Association of Voluntary Services Managers – NHS) and contributes to the Special Projects team, which has recently published and distributed their 'Good Practice Guide' to VSMs across the NHS. She also assists in organising the NAVSM annual training seminar.

We currently have 272 volunteers working alongside our paid staff in a variety of roles.

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

Our volunteer base is made up as follows:

Age (years) 2017 / 2018	Number of Volunteers	%
80 and over	16	5.90
66 - 79	128	47.23
50 - 65	58	21.40
25 – 49	49	18.08
18 - 24	18	6.64

This very much reflects previous years but this year saw an 8% rise in the number of volunteers registered.

Generally, those in the 18 – 24 age category use their volunteering experience to help them gain an insight into healthcare which in turn supports their applications for health related courses. We see a higher number of younger volunteers at the beginning of each academic year, and by the summer the numbers are reduced. Of a total of 58 leavers in 2017 /2018, 8 went on to further education. A further 4 of those leavers secured employment in the Trust.

THINK SOMETHING IN HERE MISING ON WORD FILE?

29.88% of volunteers are from a BME background, which is an increase of 4.51 % from last year - although it is still slightly under representative of our local community. An opportunity in 2017 to work with a local Imam to engage our Muslim community resulted in the recruitment of three further Muslim Chaplaincy volunteers.

During 2017 / 2018:

- Our Trust volunteers gave us a total of over 23,000 hours, which is the equivalent to 12.3 full time band 2 staff.
- 74 new volunteers were recruited and there were a total of 58 Leavers.

A number of external organisations joined us to give their support as part of their Employee Volunteering Programmes. In May, Nationwide Building Society returned and they transformed the Wilmot Dixon Courtyard Garden into a useable area for staff to relax away from the busy stresses of everyday life. In July we were joined by Employees from TUI who gave the garden in the NICU parents' bungalow a much needed makeover, and also by Allianz whose staff braved torrential rain to repaint the walkways outside the pre-assessment unit.

Volunteer Support for the Medical Education OSCS Exams has resulted in a sizeable donation to Voluntary Services. This will be used to support the cost of Uniforms and Volunteer 'Thank You' Events.

Two of our volunteers were externally recognised for their support and contribution to the patient experience. David Macdonald (Main Reception Volunteer) was invited to attend the Queens Garden Party in May as a result of the award he received at last year's Cheering Volunteering Awards Ceremony. Pearl Hinds (Children's Playroom Volunteer) was the recipient of a 'Luton's Best Award'.

New roles this year include the Introduction of a PAT Dog to provide therapeutic intervention for patients requiring Occupational Therapy and also those with Dementia. Also new in 2017 we have a volunteer supporting staff in the post room and have recruited a gardener to help maintain outside areas designated for staff relaxation. We continue to expand the areas in which we have admin support and now have 51 admin volunteers in 40 different areas

We held our annual Long Service Awards event in December which was attended by 100 Volunteers. A sit down meal was followed by 5, 10 and 15 year awards which were presented by the Trust Chairman, Simon Linnett and then a 30 year Long Service Award presented by the High Sheriff of Bedfordshire, Vinod Tailor, to Bernadette Lana, one of our Chaplaincy volunteers.

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 2017/18 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 awareness raising events.

In June 2017, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place, which proved to be very popular. Awareness raising stands and activities included: Chair based fitness exercise demonstrations by Active Luton, Chi Kung Tai Chi demonstrations, 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 among other initiatives.

This year, 76.1% of our frontline staff were vaccinated against flu, which was 4.7% higher than the year previous and also a higher uptake than the national average amongst other NHS Acute Trusts.

The Wednesday walking activity (30 minutes of a brisk walk) that first started in 2009 continued to take place every Wednesday lunchtime.

The Occupational Health team were successful in retaining their accreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the Faculty of Occupational Medicine. SEQOHS accreditation is the formal recognition that an Occupational Health

Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

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

Health Checks for staff
The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. 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 520 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary referrals made.

Fruit 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.

2017 National staff survey summary of results

1. Introduction

The NHS National Staff Survey was undertaken between September and December 2017. All NHS Hospitals in England are required to participate in the survey. The data collected is used by the CQC for the Benchmark reports across all NHS Acute Trusts.

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

The key findings are presented in the feedback reports under the following nine themes:
- Appraisals & support for development
- Equality and diversity
- Errors and Incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

This year the Trust opted to perform a full survey. 4005 questionnaires were distributed in paper format only.

Completed questionnaires were sent directly to the Trusts independent survey contractor, Quality Health, for analysis.

This report gives an overview of the survey findings. A summary report of the complete results will be made available on the Trust intranet.

The survey report provides vital feedback from staff about working in the Trust.

As in previous years, there are two types of key finding:

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

2. Response Rates

2017 National NHS Staff Survey		2016 National NHS Staff Survey		Trust Improvement
Trust	National Average*	Trust	National Average*	
w54%	44%	43%	43%	11%

* Acute Trusts

The official sample size for our Trust was 4005, and we had 2126 members of staff take part.

3. Staff Engagement

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

	2017 National NHS Staff Survey		2016 National NHS Staff Survey		Change since 2016 Survey	Ranking, compared to all acute Trusts
	Trust	National Average		National Average		
Overall Staff Engagement	3.87	3.79	3.90	3.81	No significant change	Above (better than) average
KF 1 Staff recommendation of the Trust as a place to work or receive treatment	3.84	3.75	3.88	3.76	No significant change	Above (better than) average
KF 4 Staff motivation at work	3.99	3.92	4.01	3.94	No significant change	Highest (best) 20%
KF 7 Staff ability to contribute towards improvements at work	72%	70%	75%	70%	No significant change	Above (better than) average

4. Key Findings

A summary of the key findings from the 2017 National NHS Staff Survey are outlined in the following sections:

4.1 Top Ranking Scores

Top 5 Ranking Scores	2017 National NHS Staff Survey		2016 National NHS Staff Survey		Change since 2016 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 24 Percentage of staff/colleagues reporting most recent experience of violence	79%	66%	72%	67%	No significant change	Highest (best) 20%
KF4 Staff motivation at work	3.99	3.92	4.01	3.94	No significant change	Highest (best) 20%
KF 12 Quality of appraisals	3.33	3.11	3.40	3.11	No significant change	Highest (best) 20%
KF 6 Percentage of staff reporting good communication between senior management and staff	40%	33%	36%	33%	No significant change	Highest (best) 20%
KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	51%	45%	54%	45%	No significant change	Highest (best) 20%

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

The L&D was ranked as being in the top 20% (best) when compared with other Acute Hospital Trusts for the following indicators

- Organisation and Management interest in and action on health and wellbeing
- Staff satisfaction with the quality of work and care they are able to deliver
- Staff satisfaction with level of responsibility and involvement
- % agreeing that their role makes a difference to patients/service users

We were ranked as being above or better than average on the following:-

- Staff recommendation of the organisation as a place to work or receive treatment
- Quality of non-mandatory training, learning or development
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- % of staff feeling unwell due to work related stress in last 12 months
- % of staff attending work in the last 3 months despite feeling unwell because they felt pressure
- % able to contribute towards improvements at work
- Effective team working
- Recognition and value of staff by managers and the organisation
- Support from immediate managers
- Staff satisfaction with resourcing and support

4.2 Bottom Ranking Scores

Bottom 5 Ranking Scores	2017 National NHS Staff Survey		2016 National NHS Staff Survey		Change since 2016 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 16 % of staff working extra hours***	75%	72%	79%	72%	No significant change	Highest (worst) 20%
KF 20 % of staff experiencing discrimination at work in the last 12 months	17%	12%	15%	11%	No significant change	Highest (worst) 20%
KF 22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	15%	18%	15%	No significant change	Highest (worst) 20%
KF 25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	31%	28%	33%	27%	No significant change	Highest (worst) 20%
KF 15 % of staff satisfied with the opportunities for flexible working plan	48%	51%	50%	51%	No significant change	Lower than average

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

	2017 National NHS Staff Survey Trust	National Average	2016 National NHS Staff Survey Trust	National Average
% working additional paid hours	47%	35%	48%	35%
% working additional unpaid hours	57%	57%	63%	57%

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

- % appraised in the last 12 months
- Effective use of patient/service users feedback
- % witnessing potentially harmful errors, near misses or incidents in the last month
- % experiencing physical violence from staff in last 12 months

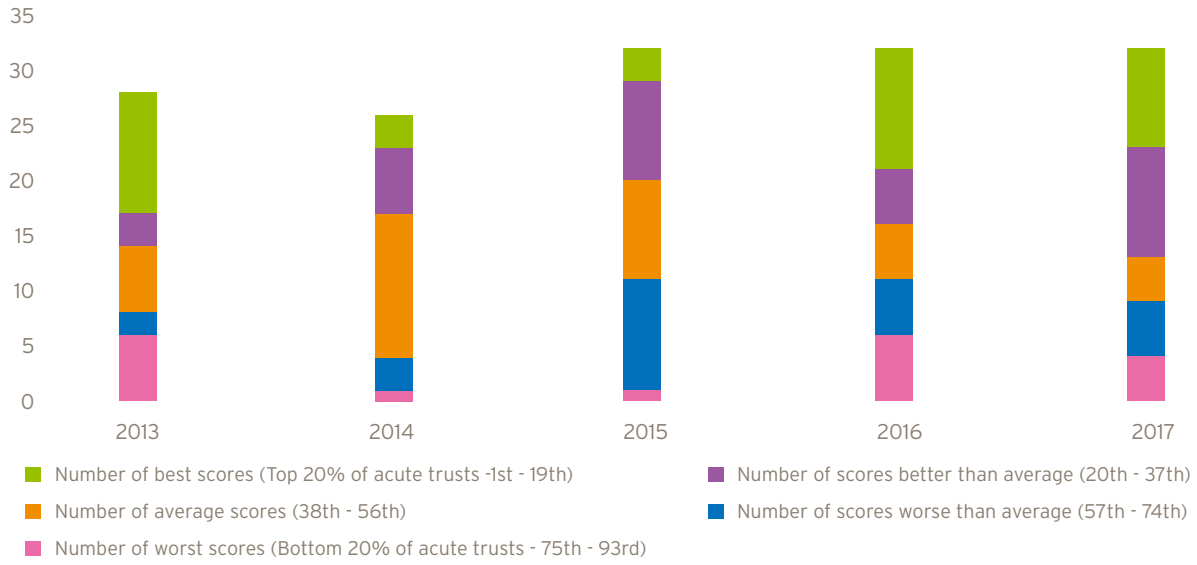
Of the total 32 reported key findings, all 32 can be compared to 2016 and all were deemed by the survey providers as not demonstrating a real statistical change.

Key findings over the past five years

The following graph indicates the key finding ratios over the previous five years. It should be noted that in 2013 there were just 28 key findings and 29 in 2014. From 2015 onwards there have been 32.

There are 93 Acute Trusts, and where our results are reported as placing us within the top 20 % of Trusts, this would give us a ranking of somewhere between 1st and 19th. Better than average, would be 20th – 37th, average 38th and 56th, worse than average 57th and 74th. Where reported as being in the bottom 20% of Trusts, this would place us 75th – 93rd.

Key findings over the past five years



Next Steps

The results will be analysed further to identify areas for improvement and hot spots, to target for action, in particular:

- Discuss the results at the Staff Involvement Group meeting and agree the appropriate action which will include:
  - Concentrating on some successes – with an aim to continue and improve on these;
  - Agree actions for areas where the results are in the bottom 20% of Acute Trusts, the Trusts bottom five ranking scores and other areas of concern
  - A static display of the results will be available in areas where there is evidence of a high staff footfall.
- A summary of the results will be shared with the Executive Team, Trust Board, Council of Governors, General Managers/Divisional Directors and will also be available on the intranet.
- An article and brief summary of the results will appear in the staff newsletter.
- The results will be available on the Intranet and an Everyone e-mail sent with a link to the results

Action

Violence and Harassment

- The Trust reviewed the data and other intelligence that identified there was an issue related to reported incidents involving confused patients on the ward. As a result new training was put in place to support staff dealing patients with cognitive impairment.
- The Trust implemented 'Baywatch' which ensures that the nurses who are observing patients, such as those with dementia, are clearly identified and that patients and visitors are aware that those nurses cannot leave the bay.
- The Managing Conflict Policy has been reviewed and a new scheme including exclusion letters and Action Against Abuse signage is being rolled out and awareness training planned.
- A targeted Trust approach will be presented through the Staff Engagement Event in July 2018 that will equip staff with support mechanisms.
- Staff working extra hours
- The Trust reviewed the data and most of the extra hours identified were paid hours. As part of the Trust rolling out the results, outlier departments are being asked to review if there are any concerns in relation to working these extra paid hours.

Flexible Working

- The Trust has a policy in place and each request is considered on a case by case basis.

Discrimination

- The Trust has an Equality, Diversity and Human Rights Committee and have set up a task and finish group specifically looking at these issues. During Equality and Diversity Week (14-18th May) the Trust will be having a weeklong series of activities to raise awareness about the issue.
- The Trust began a process in July 2017 using the Engagement Events, to establish a new set of values.

5.10 Improving the quality of our environment

The Trust actively engages with patients through the Patient Led Assessment of the Care Environment (PLACE) initiative.

An annual inspection, led by a nominated patient representative, is undertaken as directed by the Department of Health. In addition to the annual inspection, monthly inspections are undertaken, again led by a patient representative and supported by Non-Executive Directors of the Trust. Information received from inspections is used to improve the patient environment and patient experience.

In the year, a number of schemes of work have been undertaken to improve facilities for our patients, this includes:-

- Updating outpatient areas
- Refurbished and extended the Oral and Maxillo Facial department
- Improvement to the neo-natal accommodation
- Expanded endoscopy

Looking forward into 2018/19, the Trust already has advanced plans to make further improvements to the hospital estate with the:-

- Installation of new MRI scanners
- Construction of a new Endoscope Decontamination
- Refurnished accommodation offsite to provide services in the centre of Luton
- Upgraded electrical infrastructure

In the coming year, a number of schemes of work for the hospital estate are planned to take place. The works underpin our commitment to keep patients safe at all times; these works include the replacement of the automatic fire detection system, reinforcement works to power supplies and replacement of old heating systems.

5.11 Quality and Business Strategy

One of our key approaches to delivering high quality sustainable is to ensure all of our projects are subject to a Quality Impact Assessment. These formal assessments are made at Executive and Divisional level and assurance is provided to the Finance, Investment and Performance Committee and where appropriate, the Clinical Outcome, Safety and Quality Committee.

We have also continued to market its services to GP's and held a range of events to promote our services, where expert speakers have drawn good attendances. We continue to ensure we have clear processes in place to refer to clinically, the quickest place to see patients, and can clearly evidence and promote the quality of our services. We continue to inform GPs of key service developments and engage with them regarding any concerns and issues to ensure we continually improve.

5.12 Review of Quality Performance - how the Trust identifies local improvement priorities

The hospital agreed the Corporate Objectives, and these include the quality objectives. The Trust Governors, that include staff and public representatives, were engaged with the development of these objectives. This is through the Council of Governors meetings and their selection of the indicator to review annually. The Quality Priorities for 2018/19 were agreed through a stakeholder engagement process to develop the Quality Strategy that was launched at our Staff Engagement Event in December 2017 where over 2000 staff attended and received the information.

The list of clinical indicators which were developed and added to in previous years remain included. People identified those indicators most important to them and also stated the elements of care that they would want the Trust to concentrate on improving.

Amendments to the quality priorities have been considered by staff in management executive based on performance and improvement needs. Where there has not been progress made, these have remained a quality priority for 2018/19.

Quality is discussed and monitored at quarterly monitoring meetings with our local Clinical Commissioning Groups. There remains a high level of agreement among the various groups of people that have contributed to determining priorities.

6. Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- • the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 2017 to March 2018
  - papers relating to Quality reported to the board over the period April 2017 to May 2018
  - feedback from commissioners dated 23rd May 2018
  - feedback from governors dated 28/3/2018
  - feedback from Healthwatch Luton received [not received at time of signing]
  - feedback from Luton Overview and Scrutiny Committee – [not received at time of signing]
  - feedback from Central Bedfordshire Social Care Health and Housing Overview and Scrutiny Committee received 22/5/18
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/7/2018, 25/10/2017, 23/1/2018 and 16/4/2018
  - the 2017 national patient survey [not received at time of signing]
  - the 2017 national staff survey 8/3/2018
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 16th May 2018
  - CQC Inspection Report dates 03/06/2016

- 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

23rd May 2018
Chairman

23rd May 2018
Chief Executive

Note: An Equality Analysis has been undertaken in relation to this Quality Account

7. Comments from stakeholders

Statement from Luton Clinical Commissioning Group (LCCG) and Bedfordshire Clinical Commissioning Group (BCCG) to Luton & Dunstable

NHS
Bedfordshire
Clinical Commissioning Group

NHS
Luton
Clinical Commissioning Group

University NHS Foundation Trust (LDUH) on Quality Account 2017- 2018

Luton Clinical Commissioning Group (LCCG) and Bedfordshire Clinical Commissioning Group (BCCG) welcome the opportunity to comment on the 2017 /18 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), 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) reviewed the account to enable development of our commissioning statement.

We have been working closely with the Trust during the year, gaining assurance on the delivery of safe, effective and responsive services. In line with the NHS (Quality Accounts) Regulations 2011, and the Amended Regulations 2017, 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.

The CCG would like to commend the Trust for embedding the quality priorities set out for 2017/2018 into the current systems and processes to ensure the hospital maintained: over 90% compliance with the 3 day anti-biotic review in all clinical areas, a falls rate of below national average including a reduction in the number of falls that resulted in harm, a cardiac arrest rate below national average and a high focus on mortality resulting in a reduction in Hospital Standardised Mortality Ratio (HSMR) during this period.

Over the last year, LDUH has supported the ambitions of the Five Year Forward View (FYFV) directly, through working collaboratively with Bedford Hospital Trust (BHT), to progress the anticipated merger of two Trusts in support of the local areas Sustainability and Transformation Plans. The Trust has also continued to work closely with their local Mental Health provider, East London NHS Foundation Trust (ELFT), to improve the services for people with mental health needs, and this has seen a 47% reduction in frequent attenders to A&E for patients presenting with mental health. The CCG would like to acknowledge the effort the Trust has put towards improving the quality and outcomes for this cohort of patients.
We acknowledge the work undertaken by LDUH in 2017/18 in launching the Quality Strategy in response to the need for an improvement in the safety domain identified during the CQC inspection. The CCG acknowledge the work LDUH have undertaken with the Institute for Health Improvement (IHI) to identify opportunities to improve patient safety and quality.

We commend the quality of the work the Trust has undertaken through staff and service user engagement events, to better understand the support and resources required to create a culture and proactive environment for Quality Improvement (QI), both through the Good Better Best event and the Interactive workshop to evaluate QI in more detail. The CCG look forward to working with the Trust as they continue with the QJ implementation strategy in 2018/19.

We recognise the commitment of the Trust in submitting cases to the National Confidential Enquiry (NCEPOD), however, the CCG would like to understand the number of cases that were eligible for investigation, and how the recommendations are to be used to complement national and local clinical audit. With this in mind, the CCG acknowledge the commitment by the Trust to undertake audit, and we look forward to working in partnership to ensure that the recommendations following the audit findings are implemented to improve patient safety, clinical outcomes and patient experience.

Luton CCG and other associate CCGs support the Trust's quality priorities and indicators for 2018/2019 as set out in the annual account. In doing so, we advise that the Trust include the data used as the baseline to support the choice of these priorities. Luton CCG will

monitor the progress of the Trust robustly in driving forward the the 2018/2019 initiatives of and improvements to ensure high quality healthcare and outcomes for population Luton and Bedfordshire.

Luton Clinical Commissioning Group

Nicky Poulain
Accountable Officer
Luton Clinical Commissioning Group

*It should be noted that these comments were made on a draft of the L&D Quality Account received April 2018.

Healthwatch Luton response to the Quality Account/ Report for 2017 for Luton and Dunstable NHS Foundation Trust

Healthwatch Luton are happy to respond to the Luton and Dunstable Hospital Quality Accounts for 2017. Generally, Healthwatch Luton report effective relationships with the Trust and its staff. Healthwatch Luton can feedback their patient feedback to a direct contact (Director of Nursing and Patient Experience Manager) and maintain an established relationship with the PALS department. Healthwatch Luton provide a Provider Feedback report on feedback gathered on all areas of the hospital to L&D on regular intervals.

It is recognised that the Trust is proactive in gathering the view of patients via patient surveys, Friends and Family Tests and interviews, and the number of compliments they receive is to its credit. Learning from complaints and incidents is evident, and it would be suggested patient stories are an effective way to reflect these views.

The report is written well and in plain English for the most part. The layout is good and the tables are easy to read. The Trust could however pay greater attention to the use of technical and specialist language in the report which for some public may be confusing. A glossary of terms make the report more accessible to a wider range of audiences and we are delighted to see one added to the report.

Progress against the key priorities is reported in detail and shows positive achievements, and it is recognised that the Trust's Care Quality Commission rating identifies areas for improvement as well as where the Trust fairs well.

It is encouraging to see stepped priorities for areas such as end of life, dementia and stroke patients.

Patient experience

The Quality Account reflects Healthwatch Luton's (HWL) views of the hospital and in particular around patient experience. HWL have received nearly 500 feedbacks from patients without targeting the hospital as a venue to gather feedback from, and this is mainly positive. The main positive areas highlighted from our feedback relevant to the QA are effective treatment and care when you arrive at the hospital, positive staffing attitudes, and generally good diagnosis and assessments.

Healthwatch Luton have run and Enter and View report on the hospital and highlighted areas relevant to patient experience, to which the hospital has responded to our recommendations.
We are very supportive of the Luton and Dunstable Hospital and feel the management of this service adopt a very friendly and professional relationship with Healthwatch Luton, benefiting the community using the service.

Central Bedfordshire comment on the Luton and Dunstable University Hospital NHS Foundation Trust

Quality Account 2017/18

The Social Care Health and Housing Overview and Scrutiny Committee:-

- Recognises that the waiting time targets for A&E are one of the best in the country.
- Welcomes the proven cooperation between the hospital and Central Bedfordshire Council in the effective discharge of patients through the work of the integrated discharge team.
- Welcomes the 47% reduction in A&E attendance of mental health patients.
- Expressed some concern about the medication errors and the less than full take up of flu vaccinations by staff.
- Together are determined to reduce the adverse costs of smoking, alcohol misuse and the preponderance of obesity.
- Looks to see positive results in fragility care given the new unit only became operational in February 2018.
- Looks to see that even more patients, year on year, are satisfied with their treatment.
- Support the priorities through 2018/19 and the need to monitor improvement though measured success.
- Concern and the need to look further at ways of reducing the apparent incidents of harassment and a bullying of staff.
- Looks forward to seeing the business plan for merger realised.

Comments from Luton Borough Council Health and Social Care Review Group

L&D Hospital NHS Foundation Trust Quality Accounts 2017-18

Comment	Response
Review the order of the document	This has been reviewed and made clearer within the Quality Account requirements from NHS Improvement.

8. Independent Auditor's Assurance Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Luton and Dunstable University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.
- We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
- The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.
- Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18*.

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 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 23 May 2018;
- feedback from governors, dated 28 March 2018;
- feedback from Central Bedfordshire Social Care Health and Housing Overview and Scrutiny Committee received 22 May 2018
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national staff survey, dated 08 March 2018;
- Care Quality Commission Inspection, dated 03 June 2016
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 16 May 2018; and

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 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Luton and Dunstable University Hospital NHS Foundation Trust for our work or

this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Luton and Dunstable University Hospital NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
London

25 May 2018

9. Glossary of Terms

Term	Description
Acute Kidney Infection (AKI)	A painful and unpleasant illness caused by bacteria travelling from your bladder into one or both of your kidneys
Anticoagulation	A substance that prevents/stops blood from clotting
Antimicrobial	An agent that kills microorganisms or stop their growth
Arrhythmia	Irregular Heartbeat
Aseptic Technique	Procedure performed under sterile conditions
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
CAUTI	Catheter Acquired Urinary Tract Infection – this is where the patient develops and infection through the use of a catheter
CCG	Clinical Commissioning Group.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
Continence	Ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.
CQUIN	Commissioning for Quality and Innovation – these are targets set by the CCG where the Trust receives a financial incentive if it achieves these quality targets.
DME	Division of Medicine for the Elderly
Elective	Scheduled in advance (Planned)
EOL	End of Life
Epilepsy	Recurrent disorder characterised by seizures.
EPMA	Electronic Prescribing and Monitoring Administration system in place.
Grand Round	A lunch time weekly meeting with consultants and junior medical staff to communication key issues and learning.
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow.
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
HSMR	Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate.
Laparoscopic	Key hole surgery
Learning Disability	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
LIG	Local Implementation Group
Meningococcal	Infection caused by the meningococcus bacterium
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
MUST	Malnutrition Universal Screening Tool is a nutritional assessment that is carried out on inpatients to ensure that they are maintaining their body weight
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged

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
Myringotomy	A surgical procedure of the eardrum which alleviates pressure caused by the build up of fluid
Needs Based Care	Inpatient adult wards are organised by patient need rather than age for example a cardiac ward, respiratory ward.
Neonatal	Newborn – includes the first six weeks after birth
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	Degenerative disorder of the central nervous system
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
Prevalence	The proportion of patients who have a specific characteristic in a given time period
Red and Green	The Red:Green Bed day is a visual management system to assist in the identification of wasted time in a patients journey. If it is red, the patient has not progressed, green they have.
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.
SEPT	South Essex Partnership University NHS Foundation Trust
SHMI	Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit.
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply
Syncope	Medical term for fainting and transient loss of consciousness
Two week wait	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins

Research – Glossary of terms

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

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

Appendix A - Clinical Audits Reports

Title/Topic
GENERAL PAEDIATRICS INTERNAL HEALTH RECORD KEEPING AUDIT 2016/2017
N = 20

Directorate/ Specialty
Paediatrics

Project Type
Audit

Completed
April 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure compliance with standards set out by NHSLA, CQC and local guidelines
- Findings:
- 54% of standards fully compliant
- 8% of standards with high compliance
- 14% of standards with moderate compliance
- 24% of standards with low compliance

Key Recommendations/Actions:
- Disseminate results at induction of junior doctors.
- Get all documents printed with relevant details (areas of poor compliance) on BOTH SIDES
- Integrate name of admitting Consultant into printed sheet.
- Arrange for automatic importing of all results or importing with one mouse click.
-

Title/Topic
RE - AUDIT OF FAMILIAL HYPERCHOLESTEROLAEMIA
N =

Directorate/ Specialty
Biochemistry

Project Type
Audit

Completed
May 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- The aim of the re-audit was to provide evidence against the following quality standards from QS41:

1. Adults with a total cholesterol above 7.5 mmol/l before treatment have an assessment for familial hypercholesterolaemia.
2. People who are given a clinical diagnosis of familial hypercholesterolaemia because they have high cholesterol and family history or other signs are offered DNA testing as part of a specialist assessment.
3. Adults with familial hypercholesterolaemia are offered drugs to reduce the low-density cholesterol (bad cholesterol) in their blood to less than a half of the level before treatment
4. People with familial hypercholesterolaemia are offered a detailed review of their condition at least once a year.

-

Findings:
- The findings from this re-audit provide evidence of compliance with the Quality statements in QS41 – Familial Hypercholesterolarmia, including statements 1, 3, 5, 6 and 8

Key Recommendations/Actions:
- No findings to action

Title/Topic
HEALTH RECORDS KEEPING AUDIT 2016/ 2017 MEDICAL MULTIDISCIPLINARY
N=40

Directorate/ Specialty
Medicine Multidisciplinary

Project Type
Audit

Completed
July 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:

- To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings.

Findings:

- Overall the Audit for Health records shows a high compliance rate with the majority of clinical standards. 49/56 (87%) of the total number of standards were recorded as highly or fully compliant, whilst only 6/56 (11%) were amber with moderate compliance and 1/56 (2%) were red of low compliance.
- The health records audit conducted for the period of February 2015 showed only 48/66 (72%) of the total number of standards as being fully or highly compliant. Whilst 9/66 (14%) were of moderate compliance and a further 9/66 (14%) were of low compliance. In comparison our results show a vast improvement in compliance with the standards. However despite these improvements there are still a few areas which have been highlighted that require intervention and improvement.
- For optimal continuity of care all aspects of patient's records need to be identifiable by staff with the patient's name, hospital number, date of birth, and NHS number. The implications of unlabelled patient records can lead to delays in providing patient care. Our records show that these standards (Q 5, 6, 7) are of moderate compliance.
- One of the areas of poor performance identified is the notable lack of height measurement in all the health records reviewed (Q 10.1). Height in addition to weight is an important parameter when it comes to calculating body surface area for drug administration. It is understandable that there may be difficulties in calculating height for patients due to risk of falls or immobility. Nonetheless various alternate methods can be implemented to accurately estimate height which can be done through education and training.
- All patients must have their drug allergy status filled in on EPMA to prevent drug errors. Our audit shows this standard (Q30.6) to be of moderate compliance. Similarly, discharge letters should contain accurate documentation and reasoning of regular patient medications which have been amended during their hospital stay. Many patients on discharge are followed up in the community by various health care teams and this information can often only be conveyed through discharge summaries. Our audit shows this standard to be of moderate compliance (Q 37.2)

Key Recommendations/Actions:

- To regularly review patients notes and ensure they are correctly labelled
- Education and training of staff members on how to estimate height using arm span and ulna length. Review notes to ensure these parameters are documented
- Review previous patient notes, check admission clerking, contact patient's regular GP
- Education and training of junior doctor of the importance in continuity of care in mentioning medication amendments on discharge letters. Liaise with pharmacists when discharging patients.

Title/Topic
ENT INTERNAL HEALTH RECORD KEEPING AUDIT 2016/2017
N = 20

Directorate/ Specialty
ENT

Project Type
Audit

Completed
August 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure compliance with standards set out by NHSLA, CQC and local guidelines
- Findings:
-
- 35% of standards fully compliant
- 42% of standards with high compliance
- 15% of standards with moderate compliance
- 8% of standards with low compliance

Key Recommendations/Actions:
- On-call SHO to ensure all patients seen in A&E have a completed A&E proforma before they move to the ward, or to clerk directly into specialities page of the A&E proforma and inform A&E doctor.
- For more stable patient's referred from, but not seen in A&E, when discussing with the referrer doctor, ensure they have clerked the patient before transfer to SAU.
- Patient height and weight usually done by A&E in stable patients. But when not possible, this should be done when the patient is stable. Records for height and weight must be checked routinely by nursing staff when patient arrives on the ward, and any missing data should be highlighted for collection.
- Poor compliance with entries showing evidence of involvement of the patient/carers in the care plan/actions (where applicable). Document patient agreement/disagreement; Document carer details if seen with carer; Allow opportunity to ask questions and discuss management plan.
- Poor compliance with name of the healthcare professional clearly documented ad their job title clearly documented. This will be emphasised at induction before new SHO's start the post.
- All relevant clinical investigation reports should be copied into discharge letters, as opposed to "See ICE" or "As per ICE".

Title/Topic
RE-AUDIT OF THE ADMINISTRATION OF IVT INJECTIONS IN OPHTHALMOLOGY
N = 15

Directorate/ Specialty
Ophthalmology

Project Type
Re-Audit

Completed
August 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Re-measure compliance with the revised protocol of administration of intravitreal injections. Specifically to:
- Identify whether the Ophthalmology Department are adhering to the revised protocol
- Identify areas where compliance with the protocol need to be improved
- Identify areas of good practice

Findings:
- Full compliance (100%) with 80% of standards
- Moderate compliance (87%) with 10% of standards
- Poor compliance with 10% of standards

Key Recommendations/Actions:
Re training of staff and sharing during:
- Ophthalmology Service Line Meeting: 10/07/17
- Medical Retina meeting: 09/06/17
- Clinical Governance Meeting Ophthalmology: 21/07/17
- Ophthalmology Nursing team meeting daily team briefs
- Quarterly audits next due on 18/09/2017

Title/Topic
SAFE EFFECTIVE DISCHARGE AUDIT
N=40

Directorate/ Specialty
Corporate

Project Type
Audit

Completed
August 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- To measure compliance with standards set out within the local Discharge Policy and to review completion of the Discharge Checklist.

Findings:
- 25% of standards fully compliant
- 18% of standards with high compliance
- 15% of standards with moderate compliance
- 42% of standards with low compliance

Key Recommendations/Actions:
- Improve the quality of discharge plans being clearly documented within the clinical records to include conversations had with patients and/or their advocates .Action: Correspondence to be sent to nursing staff, discharge planning staff and nursing staff to remind them of the importance of clear documentation of discharge plans made.
- Improve documentation to evidence medications have been explained including pain management to the patients or patients advocate prior to discharge taking place. Action: Copy of Audit findings to be disseminated to Matrons and Ward Managers and findings of discharge audit to be discussed at safety briefings on all wards. Presentations to be given at ward sisters and Matrons meetings.
- Improve documentation to evidence that wound care is explained to patient prior to discharge. Action: Tissue Viability Service to discuss findings of Audit at training sessions given and relay the importance
- Improve the number of referrals being made to the continence service on discharge and evidence products are given on discharge. Action: Presentation to be given at Ward sisters meeting to discuss increasing the number of referrals made to the continence service.
- Information regarding dietary advice given prior to discharge. Action: Presentation to be given at Ward sisters meeting to discuss increasing the number of referrals made to the continence service.
- Easy read versions of information leaflets about discharge to be given were necessary on discharge. Action: To review current easy read leaflet and update accordingly.
- Improve the quality of referrals being sent out to community teams. Action: Community referral for care homes to be devised and uploaded onto evolve for staff to access.
- Improve the use of the discharge checklist on discharge. Action: Discharge Checklist at the time of audit was being reviewed and a new version was implemented. Alongside this the Adult Safeguarding Lead will discuss the importance of using these at all training sessions given.
- Update nursing and medical staff on the findings from this audit. Action: Presentation to be given at Ward sisters meeting and Grand round.
- Update L&D staff and partners on the results of this Audit. Action: Complete a presentation at a learning event where representations from all partners are present.

Title/Topic
GYNAECOLOGY RECORD KEEPING AUDIT 2017
N = 20

Directorate/ Specialty
O&G

Project Type
Audit

Completed
August 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure compliance with standards set out by NHSLA, CQC and local guidelines

Findings:
- 53% of standards fully compliant
- 5% of standards with high compliance
- 9% of standards with moderate compliance
- 33% of standards with low compliance

Key Recommendations/Actions:
- Improve standard of discharge letters, missing test results, documentation of medication, clinical narrative and patient information. Action: Support for junior doctors to complete discharge letters in a timely way to ensure important information is not omitted. Post op patient letters to be written by the person performing the op or senior to ensure accuracy is improved
- Legibility of handwriting to be improved, printing of names or use of stamps requires to be more widespread, especially amongst medical staff. Action: Staff need to be made aware of the difficulties of interpreting handwriting and importance of clear legible documentation
- Missing patient information on parts of records, i.e. no name, hospital number. Action: All staff entering information in records to be made aware o importance of documentation. Use of Evolve to print off the continuation sheets

Title/Topic
TRUSTWIDE PAIN SURVEY 2017
N = 133

Directorate/ Specialty
Anaesthetics

Project Type
Survey

Completed
August 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure the efficacy of the action plans formulated within previous surveys.
- Inform the ongoing development of pain management care for all in-patients at the Luton and Dunstable Hospital NHS Foundation Trust.

Findings:
- Pain scores were recorded with every observation in 92% of cases. This continues to be the case within this audit. However we have examined this further and looked at the Women's and Children's directorate in more detail. We have shown that the maternity department have the least amount of pain scores completed. With the rest of the hospital completing pain assessment 100%.
- It is clear that the introduction of Ward Ware into the hospital has had a big impact on pain assessment documentation. However, the women's and children's directorate (specifically Maternity Dept.) do not have Ward Ware due to specific needs for documentation in these areas. Karlsten (2005) and Gordon (2008) found that regular documentation enforces some kind of action, and this subsequent management was found to lead to improvements in patient satisfaction. However, simply having a pain score documented is not sufficient; patients' and nurses' pain reports have been found to be incon→gruent (Chang 2010).
- I think we need to be mindful of this research. It is important for health care professionals to understand the subjective nature of pain. They also have to understand, reflect on and challenge their own inherent attitudes and beliefs regarding a person in pain. This is reflected regularly in our pain teaching. This is an area which would benefit from further audit, to investigate and demonstrate improvements in nurses and patients pain reports. The hypothesis being that the more congruent nurses and patients are in the pain assessment, the better the outcomes and management of pain will be. This will have an impact and improve patient satisfaction and develop

the therapeutic relationship.

- Sixty nine percent of patients surveyed reported they experienced pain during their admission. This is a reduction from previous surveys; however this does not show any particular relevance as patient's main compliant and reason for admissions to hospitals can be pain. It is how we manage it that is the important indicator.
- Fifty three percent experiencing pain described it as unbearable in the 2015 survey. We have shown a 17% improvement in the amount of unbearable pain. Overall 69% in 2017 experienced pain compared to 75% in 2015.
- A question we believed was important to add within this audit was to find out if the patient's pain is acute or chronic. We inputted this data as patients often do not understand the terminology. This is important. The management of acute and chronic pain are very different. We may not offer traditional methods of analgesia and would opt to provide information and support for services within the community. We can see that chronic pain 21% of patients surveyed had a chronic pain condition. 15% reported it as unbearable pain and 70% medium pain. We will consider in the next audit asking this group of patient's different questions regarding their pain management experience in the hospital setting.
- We know acute pain is usually associated with an underlying physiological (labour pain) or pathological (postoperative pain) process. Therefore it is understandable that many of our patients are admitted with a painful problem. It may be recurrent, with or without a background of ongoing chronic pain, (e.g. sickle cell disease, rheumatoid arthritis). Particularly after surgery, patients will be subjected to degrees of pain and we need to be able to assess this pain, commence pain strategies preoperatively if possible and implement strategies to minimise the pain so that the patient is able to deep breath, cough and mobilise comfortably postoperatively. The RCoA pain management audit recipes (2012) states, effective pain control relies on recognition of an analgesic need by regular assessment and appropriate treatment. Regular assessment can be tied in with routine physiological observations. In most patients pain control plans should result in good pain control. Identifying patients in whom that plan has not been entirely effective should lead to improved methods. Patients identified as having moderate or severe pain should have this managed and dealt with. Where this does not occur further investigation is indicated. This audit would be a useful aid to check compliance with regular pain assessment, quantifies the prevalence of significant pain, and identifies patients in whom subsequent assessment indicates that the pain was not effectively brought under control.
- Ninety two percent of patients reported that staff asked if they were in pain compared to 90% in the previous survey. However, it is interesting as this differs as 100% of patients had a pain score documented on Ward Ware. This shows a small difference in patients self-report and what is documented.
- Ninety five percent of patients felt that staffs were understanding and sympathetic about their pain, compared to seventy five percent on the last survey. The action plan from the previous survey was to increase education in surgical and medical wards in the form of workshops to improve assessment skills. On pain ward rounds we worked with the nurses on an informal basis to help improve communication with patient around pain assessment.
- The audit still shows a lesser amount of sympathy and understanding was offered within the medical directorate compared to surgery however a significant overall improvement has been achieved compared to last year's results.
- Suggestions were made by staff to reduce pain in 97% of cases, of which, painkillers was suggested in the majority (78%). The previous survey identified suggestions were made by staff to reduce pain in 89% of cases. Pain killers were suggested in 72% of cases. 3% of patients felt nothing was suggested compared to 11% from the previous survey. This is a decrease from the last audit.
- An overall improvement of 8% compared to previous survey in staff making suggestions to improve pain.
- Fifty one percent of patients reported that they received pain medication immediately after it was requested compared to 62% in the previous survey. Thirty seven percent of patients reported they waited for an acceptable amount of time compared to 19% from the previous survey. Overall the survey shows an improvement as 88% of patient waited an acceptable time period to get their analgesia compared to 81% on the last survey. A reason for this improvement could be due to the EPMA system being fully implemented across the trust. 10% felt they had to wait a long time to receive pain medication compared to 19% on the last survey. Since the last survey we have worked hard to improve education for staff regarding timely administration of analgesics.
- There has been improvement (from 66% to 73%) in the percentage of patients reporting that a nurse/doctor returned to check on their pain following pain relief. The worst performing area continues to be the medical directorate. 76% of patients reported that the nurse or doctor re-evaluated the pain after an intervention was made. 24% said the nurse/doctor did not evaluate. Although comparing to the other

directorates they are still the worst performing area they are showing a significant improvement. Again we have worked hard at our training programmes especially across the medical directorate with informal ward based education.

- Ninety six percent of patients felt nursing staff helped manage their pain compared to 89% in the previous survey. This is an improvement from the last survey having only 4% patients not feeling that nurses have done all they can to manage their pain.
- Fifty percent of patients experienced pain during the night, of which 84% felt it was managed appropriately. The previous survey identified 61% of patients experienced pain during the night, of which, 70% felt it was managed appropriately and 30% felt it was not managed appropriately. Patients do tend to experience more pain at night time. This is a common problem for anyone suffering with pain, this may be due to environment factors for example: sleeping in a different bed, noise levels, no distraction. However it is important we ensure the patient is listened to and treated appropriately. We can see there has been a significant improvement in pain management at night compared to the last survey.
- Sixty one percent of patients felt overall their pain was managed very well, 30% felt it was managed reasonably well, 8% felt it could have been managed better and 1% felt it was not managed well at all. So overall 91% patients felt their pain management was treated appropriately compared to 74% on the previous survey. We have seen a significant improvement and patients are reporting that they are satisfied with their pain management overall.

Key Recommendations/Actions:

- Pain score in Maternity department not always documented.
- Differing documentation in Maternity than the rest of the Trust – discuss with senior management within directorate to improve documentation.
- Discuss findings of audit at matrons meeting to enable feedback.
- Identify dedicated pain link nurses for maternity wards
- Continue training in importance of pain assessment and management.

Re-assessment of pain management intervention in medical directorate.

24% said the nurse/doctor did not evaluate their pain management in medical directorate. Although improvement has been seen compared to last survey.

b) 5% of patients felt the hospital staff were not understanding and sympathetic about pain. A lesser amount of sympathy and understanding was offered within the medical directorate. Although improvement has been seen compared to last survey.

- Discuss findings of audit at matrons meeting to enable feedback.
- Re-confirmation of pain links on medical wards and encourage attendance to pain update meetings.
- To implement PIPPA signs for patient bedside to remind/encourage staff to assess, treat and re-assess pain.
- Continue to deliver training across medical directorate including informal sessions.

85% of patients with chronic pain reported moderate to unbearable pain. Add into Stat training and other pain teachings a reminder to fill in nursing assessment and care plans – section 2. Pain assessment. Allowing staff to understand patients pain in more detail, does the patient already take pain killers before admission? What is their normal pain score? etc.

- Snap shot audits to monitor the use of the nursing assessment booklet and whether staff are filling the pain section out.
- Re-consider the questions for the following audit for patients with chronic pain

Title/Topic

PAEDIATRIC ENDOCRINE PATIENT SATISFACTION SURVEY
N = 7

Directorate/ Specialty

Paediatrics

Project Type

Survey

Completed

August 2017

Aims, Findings, Key Recommendations/Actions

Main Aims:

The main aims of the survey are:

- To identify levels of patient satisfaction amongst paediatric endocrine patients
- To ensure the service provided at the L&D meets the needs of families and to ensure problems are kept to a minimum
- To identify further specific areas for improving patient experience and services to meet current demand

Findings:

- Forty three percent of parents stated they are seen on their appointment time 'all of the time'. Forty three percent stated 'most of the time', the remaining 14% (1 patient) stated they are 'never' seen on their appointment time
- Seventy two percent of parents were happy with their child's appointment arrangements 'all the time'. Fourteen percent were happy with arrangements 'most of the time', and 14% were happy 'sometimes'
- All parents felt Endocrine doctors are friendly 'all the time'
- All parents felt able to ask questions 'all the time'
- All parents felt Doctors explained the treatment plan in a way that could be understood 'all the time'
- Eighty six percent of parents felt there is good communication regarding their child's latest treatment plan between the Doctors at their London hospital and the Doctors here 'all the time'. Fourteen percent felt this was the case 'most of the time'
- All parents felt clinic staff are approachable and friendly 'all the time'
- All parents received their child's appointment for investigation within an appropriate time following their clinic appointment
- All parents received a letter and information regarding their appointment
- All parents felt information they had received regarding the investigation was understandable and easy to read
- All parents felt that on admission staff talked to them and their child regarding what was involved in the Cortisol profile test
- All parents stated their child's Cortisol investigation started soon after their arrival to the ward
- Most parents (86%) felt their child's cannula or the investigation was inserted skilfully 'all the time'. The remaining 14% felt this was the case 'most of the time'
- Sixty percent of parents stated the play therapist was available for their child's cannula procedure 'all the time'. Twenty percent stated this was the case 'sometimes' and the remaining 20% felt this was the case 'never'
- Twenty nine percent of parents found their child's cannulation procedure frightening 'all the time; 14% found it frightening 'most of the time'; 29% found it frightening 'sometimes'; and 29% 'never' found the procedure frightening
- Most parents (67%) felt there was enough play and distraction for their child 'all the time', and 33% felt this was the case 'most of the time'
- Most parents felt the nurse looking after their child was friendly throughout their stay 'all the time'; 17% felt this was the case 'most of the time'
- Eighty three percent of parents felt the service is flexible to allow for holidays 'all the time'; 17% felt this was the case 'most of the time'
- All parents felt they understood their child's emergency regime
- Most parents (72%) felt they were able to administer their child's emergency hydrocortisone injection; 14% felt they were unable to and the remaining 14% were not sure if they were able to administer the injection
- All parents felt they have received adequate training on the emergency regime
- Most parents (86%) felt confident to administer the emergency injection; 14% (1parent) did not feel confident
- Thirty three percent of parents felt they have adequate support in the community ;most of the time'; the remaining 67% felt this was the case 'sometimes'
- Eighty six percent of parents stated their child has a School Care Plan
- Half of parents felt their child's school understood their condition, whilst the other half felt their child's school did not understand
- Forty three percent of parents felt they are given enough verbal and written information regarding their child's condition 'all the time'. Forty three percent felt this is the case 'most of the time', and 14% felt this is the case 'sometimes'
- Just over half of parents (57%) are aware of all the charities offering support, with the other half not aware

- Twenty nine percent of parents were aware of patient information days run by charities, whilst 71% were not aware of these
- Forty three percent of parents felt they would like more psychological help in dealing with their child's condition

Key Recommendations/Actions:

- To incorporate school visits into job description for newly diagnosed children or those with issues at school regarding their condition
- Increase parents awareness of charities and organisations they can choose for further support
- Need for more psychological support for families affected

Title/Topic

SURVEY OF PARENTAL PERCEPTION OF THEIR CHILD'S ENDOCRINE CONDITION & TREATMENT
N = 10

Directorate/ Specialty

Paediatrics

Project Type

Survey

Completed

August 2017

Aims, Findings, Key Recommendations/Actions

Main Aims:

The main aims of the survey are:

- To identify parents perception of their child's endocrine condition and treatment
- To improve our understanding on how families in our region cope with childhood endocrine conditions
- To identify specific areas for improving the service through better understanding

Findings:

- Ninety percent of parents stated they were given verbal information at the time of diagnosis. Seventy percent felt they were given written information. Ten percent felt they were told about a website for more information, and 20% felt they were given a leaflet AND a website or more information. None of the parents felt they weren't given any information at the time of diagnosis
- Ninety percent of parents felt the information they received when their child was diagnosed was adequate
- Most parents would have preferred the information given in English (70%). The remaining would have preferred it in Bengali/Urdu.
- All parents felt they fully understood their child's diagnosis
- None of the parents felt their language was a barrier to understanding their child's condition
- All parents understood why their child takes prescribed medication
- Most parents (90%) had an Endocrine Nurse Specialist for their child. The remaining 10% (1 parent) was not sure
- All parents were aware of whom to call in case of an emergency
- Eighty nine percent of parents stated they call the Doctor/Endocrine Nurse Specialist for advice. Of these, most (87.5%) contacted them occasionally and the remaining contacted them regularly
- Forty four percent of parents stated they/their child has seen a psychologist/family therapist because of

the Endocrine condition. The remaining 56% had not been seen by psychologist/family therapist
- Thirty three percent of parents felt they would have liked more psychological support when their child was diagnosed
- Forty percent of parents stated other members in their family have the same condition
- Thirty percent of parents stated they were related by blood to their spouse/partner
- Eighty percent of parents felt people in their family/community think that this is only a medical condition; 20% felt their family/community thought that the endocrine condition can spread between people; 30% of parents felt their family/community thought that this is because of fate/destiny
- Eleven percent of parents stated they felt isolated all the time; 56% stated they felt isolated some of the time; 33% did not feel isolated at all
- Forty five percent of parents felt they received support from their extended family/relatives regarding their child's condition; 11% received support from their friends; 33% received support from both family and friends and 11% stated they received no support
- Seventy five percent of parents would have liked to have been introduced to other parents with a child with the same condition
- Eighty percent of parents felt the medical information given to them may affect the way they treat and manage their child with the condition; 20% of parents felt their child's age may have an affect
- Only 1 parent (10%) stated they use other therapies or their child and this was 'special prayers'. This was used 'before their child saw a doctor'
- No parents were using other treatments other than NHS-prescribed treatments
- Thirty three percent of parents felt it would help if health professionals had a better understanding of their cultural, religious and health beliefs whilst managing their child's endocrine condition

Key Recommendations/Actions:
- Set up parent and teenage support group sessions
- The need for a psychologist - To be considered by service providers for future
- Ensure written information is provided and parents are aware of support from charities

Title/Topic
TRAUMA & ORTHOPAEDIC INTERNAL HEALTH RECORD KEEPING AUDIT 2017
N = 20

Directorate/ Specialty
T&O

Project Type
Audit

Completed
September 2017

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure compliance with standards set out by NHSLA, CQC and local guidelines

Findings:
- 10% of standards fully compliant
- 46% of standards with high compliance
- 25% of standards with moderate compliance
- 19% of standards with low compliance

Key Recommendations/Actions:
- A high number of failed standards were due to a mix o hand written notes and electronic records (which proved most accurate). Action: to complete the transition to fully electronic notes and eliminate written notes

Title/Topic

ESSENCE OF CARE RESPECT & DIGNITY TRUSTWIDE AUDIT 2016/2017
118 Patient Questionnaires
16 Data Collector Questionnaires

Directorate/ Specialty

Corporate

Project Type

Survey

Completed

November 2017

Aims, Findings, Key Recommendations/Actions

Main Aims:

- To provide information about patients' experiences of respect and dignity during their stay or visit. It also aims to identify compliance with the benchmark and local guidance, and then highlight any problems as well as areas of good practice with a view to making improvements

Findings:

- 94% of patients felt they had enough privacy when being examined and treated always, 5% felt this was the case sometimes and 1% felt they were not given any privacy
- 98% of patients felt curtains were well fitting and long enough to provide adequate privacy.
- 73% of patients stated staff always knock/ask before entering their bed area/room. A further 22% stated staff sometimes knock/ask before entering. 5% stated staff do not knock or ask before entering
- 93% of patients felt they always had enough privacy when using the commode or toilet. Eighty nine percent of patients felt they always had enough privacy when washing by their bed.
- 89% of patients always felt their personal space/bed area was respected and protected.
- Only 73% of patients stated that staff always introduced themselves on initial contact, and 81% stated that staff discussed what name they would like to be called by.
- 89% of patients felt they were always given enough privacy when discussing their condition or treatment. A further 9% felt this was the case sometimes
- 29% of patients felt that information about them was shared inappropriately, i.e. in a way that could be overheard or overseen.
- Most patients were either always (92%) or sometimes (8%) happy with the way in which staff communicated with them.
- 99% of patients felt they have been supported by staff to maintain confidence and a positive self esteem.
- 97% of patients felt they have been listened to and have been supported to express their wants and needs.
- Most patients (99%) felt their modesty was maintained when moving between wards/ departments.
- 99% of patients felt they have been treated with dignity and respect throughout their time in hospital, and 100% of patients were overall satisfied with their experience with regards to respect and dignity.
- 55% of wards/areas were divided into male/female sides/ends.
- 83% of areas stated their patients were in single sex bays
- 86% of areas stated their toilets/washrooms were single sex
- Most toilets/bathrooms were lockable.
- 94% of areas had a nurse call bell in place in toilets/ washrooms which patients could access in case of an emergency.
- 94% of areas felt their toilets/washrooms were well maintained and cleaned regularly.
- Only 88% of areas had a room for patients and relatives where discussions could be carried out in private.
- 46% of areas do not have privacy signs on bed curtains.
- 20% of areas stated they do not have sufficient supplies of night clothes on their ward
- In 81% of areas all staff were aware of respect and dignity guidelines and in 19% some staff were aware of the guidelines.

Key Recommendations/Actions:

- Reinvigorate the 'hello my name is' campaign
- Include in daily safety briefing for 2 weeks (preferred name to be documented in handover and on the patients board above the bed/chair)
- All nurses to have a whiteboard marker in their pocket to facilitate them writing their name on the patient status board – to be checked each morning by the nurse in charge. Implement as part of new paperwork launch
- Ensure use of 'Dignity Curtains'
- Remind staff and board round / safety brief
- Ensure domestic / housekeeping staff are aware
- Remind all ward visitors (therapists, volunteers) to ask permission before entering
- Obtain patients permission for medical students to attend ward round
- Procurement to source products such as 'modesty pants'. These are to be available in a variety of sizes
- Patients relatives / visitors are to be encouraged to provide the patient with their own clothes

Title/Topic

AUDIT OF EMERGENCY THEATRE UTILISATION 2017/2018
N= 114

Directorate/ Specialty

Anaesthetics

Project Type

Audit

Completed

December 2017

Aims, Findings, Key Recommendations/Actions

Main Aims:

- To assess the utilisation of emergency theatre.
- To establish whether there is effective use of the emergency space on a daily basis .
- To establish the interval between the time of booking and time patient arrived into theatre (anaesthetic room)
- Identify the number of patients booked per day.
- Identify the number of patients booked per speciality.
- Identify the reasons why surgery was not performed/ cancelled.

Findings:

- During the three week audit period, the overall number of recorded emergency bookings was 114.
- Out of these, 104 (91%) patients had their surgery performed and 10 (9%) patients were recorded cancelled.
- General Surgery had the highest number of cases booked (53/114) 47 %.
- Both Max Fax and Gynaecology Unit booked (21/114) 18 %.
- The lowest number was Trauma (2/114) 2% .
- There is a dedicated theatre for trauma patients on a daily basis. However, the 2 trauma cases identified were undertaken during out of hours and the other during the day due to less activity in emergency theatre.
- Findings show that almost 53% of the cases were performed within 0-14 hours.
- Of a total of 104 cases performed, the highest number 17/104 (16%) cases were operated upon between 0-2 hours and majority of them are general surgery.
- 11/104 (11%) patients waited in excess of 18 hours which was significantly high.
- Reasons for delay were not available on booking forms thus, limited the project lead to analyse the findings of this project.
- Reasons why surgery was cancelled were due to a combination of factors. "Patient opened his bowels" (1/10), "Patient operation no longer needed" (1/10) "Rescheduled for elective list, "Patient case is difficult" (2/10), "no surgeon available" (1/10), "Procedure done in the ward" (2/10), (3/10) reason for cancellation were not documented.
- Maximising theatre utilisation is obviously desirable in our emergency department. Our emergency theatre was utilised appropriately during the audit period in spite of the unpredictable nature of emergency cases .However potential improvements can be made, including accurate documentation of delays. Once delays are identified, further changes can be implemented to counter these. Another audit should be performed to measure other factors that were not covered by this exercise. Using a proforma for each case booked will be useful for future audit to ensure accurate data collection and analysis.

Key Recommendations/Actions:

- The audit identified there were few delays in utilisation of the emergency theatre. However, there was no documentation regarding the reason for the delays. Actions include:
- Re- design the booking form to include a section for other necessary information for future references.
- Re-audit and focus on the reasons for delay.
- Present the audit findings at the Clinical Governance Meeting.

Title/Topic
QUALITY OF ADULT SAFEGUARDING REFERRAL FORMS
N = 20

Directorate/ Specialty
Corporate

Project Type
Audit

Completed
January 2018

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Review the quality of referrals into the Trusts Adult Safeguarding Team and if the information given identified that staff had fulfilled their duties and worked effectively to ensure that adults at risk of abuse or harm attending the Luton and Dunstable University Hospital were identified and that an appropriate referral was completed to the Adult safeguarding Team.

Findings:
- 33% of standards fully compliant
- 17% of standards with high compliance
- 17% of standards with moderate compliance
- 33% of standards with low compliance

Key Recommendations/Actions:
- Timely referrals to the Adult Safeguarding Team. **Action**: Add additional training on the quality of referrals and the timeliness of these into the ongoing Level 3 Adult Safeguarding Training Programme.
- Lack of contact details for the individual at risk and no documented evidence that the individual was consulted prior to referral being submitted. **Action:** Review of the current Datix referral process for Adult Safeguarding.
- **Update:** *referral process has now been adapted and changed to ensure contact details, capacity/consent are mandatory fields.*
- Documentation of the immediate actions taken by staff to safeguard the individual at risk. MSP compliance. **Action:** Add additional training on the quality of referrals, MSP and the documentation of staff responses to safeguard the individual at risk into the ongoing Level 1,2 & 3 Adult Safeguarding Training Programme.
- Perpetrators details to be logged where possible although it is noted staff may not always be able to access this information. **Action:** Adult Safeguarding Team to continue to review all Datix referrals and identify any details that are available prior to sending to the Local Authority to ensure correct information is given at the initial referral stage.

Title/Topic
GENERAL SURGERY/UROLOGY INTERNAL HEALTH RECORD KEEPING AUDIT 2017/2018
N = 20

Directorate/ Specialty
General Surgery/Urology

Project Type
Audit

Completed
January 2018

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure compliance with standards set out by NHSLA, CQC and local guidelines

Findings:
- 59% of standards fully compliant
- 16% of standards with high compliance
- 10% of standards with moderate compliance
- 15% of standards with low compliance

Key Recommendations/Actions:
- Inclusion of correspondence/referral details from referrers in the health record has dropped from 85% to 50%. **Action: For presentation at General Surgery CGM and induction for junior doctors**
- Electronic discharge letters show low compliance with record keeping in 4 areas. **Action: For presentation at General Surgery CGM and induction for junior doctors**

Title/Topic
RE-AUDIT OF THE ADMINISTRATION OF INTRAVITREAL INJECTIONS IN OPHTHALMOLOGY
N = 95

Directorate/ Specialty
Ophthalmology

Project Type
Re-Audit

Completed
January 2018

Aims, Findings, Key Recommendations/Actions
Main Aims:
Re-measure compliance with the revised protocol of administration of intravitreal injections. Specifically to:
- Identify whether the Ophthalmology Department are adhering to the revised protocol
- Identify areas where compliance with the protocol need to be improved
- Identify areas of good practice

Findings:
- Full compliance with all of the standards

Key Recommendations/Actions:
- No risks identified – fully compliant with all standards

Title/Topic
OMFS INTERNAL HEALTH RECORD KEEPING AUDIT 2017/2018
N = 20

Directorate/ Specialty
OMFS

Project Type
Audit

Completed
January 2018

Aims, Findings, Key Recommendations/Actions
Main Aims:
- Measure compliance with standards set out by NHSLA, CQC and local guidelines

Findings:
- 80% of standards fully compliant
- 7% of standards with high compliance
- 3% of standards with moderate compliance
- 10% of standards with low compliance

Key Recommendations/Actions:
- All notes written for inpatients must have a recorded time with date of note entry
- For all cases the type of anaesthesia must be recorded. If Consent 3 forms are being used then clinicians must specify if local anaesthesia is being used by crossing out or marking the relevant notation. If Consent form 1 is to be used the appropriate box regarding anaesthesia must be ticked.
- Record a reason for admittance where relevant e.g. emergency setting or inpatient procedure if relevant to the GP.
- Record 'No drugs on admittance" if there are no drugs on admittance for inpatients.
- Include any investigations and results carried out that may be of beneficial use to the GP or for further monitoring.
- Include the discharge destination as home for inpatient cases.
- Include arrangements for follow up if required.
- Mention drugs on discharge on the discharge letter for inpatients and if writing an external

Title/Topic
TRAUMA EMERGENCY THEATRE UTILISATION AUDIT
N = 26

Directorate/ Specialty
T&O

Project Type
Audit

Completed
January 2018

Aims, Findings, Key Recommendations/Actions

Main Aims:
- To establish whether there is a delay in starting the first trauma case of the day over a 2 week period (prospectively). Reasons for delays were also assessed.

Findings:
- 46% of patients had an overall journey time of more than an hour to 1.5 hours
- Reasons for delay included incomplete paperwork on the ward, patients not ready (gown etc.), delays in assessment of patients and huddle starting on time
- Patients not always optimised overnight and a 'golden patient' was not identified

Key Recommendations/Actions:
- Send for patient at 8 am (senior anaesthetist can see patient in theatres if not seen)
- Golden patient identified by night orthopaedic team and handed over to ward staff to ensure patient ready (handover sheet with specific instructions designed
- Night anaesthetic SpR sees golden patient – if anaesthetic issues noted, another patient then optimised

Title/Topic
INTRAVENOUS FLUID THERAPY IN CHILDREN & YOUNG PEOPLE IN HOSPITAL (NICE NG29)
N = 42

Directorate/ Specialty
Paediatrics

Project Type
Audit

Completed
February 2018

Aims, Findings, Key Recommendations/Actions

Main Aims:
- The main aims of the audit are to improve IV fluid management in children.
- Specifically to:
- Identify local compliance with NICE recommendations (NICE Guideline 29)
- Identify areas where practice needs to be improved

Findings:
- IV Fluids are used across the whole range of ages of children who present to the Paediatric Department
- In general, patient's weights are used to calculate fluid requirements, and the Holliday-Segar formula was used in all bar one case (98%)
- However, the way this was calculated was only documented in 14/42 (33%) cases
- In 4/12 and 5/42 cases, hypotonic saline was used for fluid resuscitation and maintenance respectively. This is not in line with guidance to use isotonic crystalloid preparations for both purposes
- In only 20/41 (49%) cases were U&Es measured when starting fluids AND after 24 hours. The majority of failures were when the U&Es were not repeated after 24 hours which, in some cases, was because fluids were stopped soon afterwards
- There were slightly more who had a blood glucose measured (22/42 = 52%) which is surprising given we so often perform blood gases.
- Fluid balance was only recorded in 60% (25/42) patients at 24 hours, and 34% (14/41) at 12 hours. 11/42 (26%) cases did not have hourly I/O recordings on the charts.
- When it comes to the main notes, on commencing fluids, more could be documented in the notes including assessment of fluid status (19/41 or 46% not recorded) and blood results (over 50% not recorded). As time progresses, there was a 12 hourly reassessment of the fluid prescription in 71% cases, hydration levels in 61% cases and a decision of whether oral fluids can be started in 91% cases. Documentation is important to explain the rationale behind our decision-making.

Key Recommendations/Actions:

- Hypotonic saline being used for resuscitation and maintenance. **Action:** Reminder posters, teaching session
- U&Es and glucose not consistently being taken or recorded at start of therapy or every 24 hours. **Action:** Reminder posters, teaching session
- Fluid balance at 12 and 24 hours must be accurately recorded. **Action:** Nursing staff involvement

Title/Topic

Protected Mealtime Audit 2017
N=20 wards

Directorate/ Specialty

Corporate

Project Type

Re-audit

Completed

October 2017

Aims, Findings, Key Recommendations/Actions

The objective of this audit is to:

1. Repeat audit the current practice of Protected Mealtimes during a lunchtime period

This audit aims to highlight specific areas such as:

1. Visible or audible evidence of Protected Mealtimes being in progress with outside ward stands, posters or patient and relative information or Bell ringing inside the ward to alert the beginning of PM.
2. Preparation of the patient and their surroundings taking place before the mealtime
3. The timings of the meal service and the number of staff involved
4. Activity and personnel on the ward during Protected Mealtime
5. If relatives or Ward Volunteers were present (and if helping) at mealtime
6. If there was sufficient knowledge and understanding about Protected Mealtimes
7. For this audit five patients were asked their views about the standard of the meals and drinks provided during their stay in hospital, and if they had received assistance when meals and drinks were provided (if needed)
8. Any areas of positive and negative care seen during the audit period

Main Findings and actions to be taken

- 75% of all meal services started at the time stated on the trust meal schedule (NEW question)
- 75% of the meal times corresponded to the time stated on the board outside the ward (NEW question)

Improvements seen in this audit

- Number of visible Protected Mealtimes signs outside wards (55% instead of 26% in 2016)

Ward managers/ward staff

- Number of wards with closed doors during Protected Mealtimes (previously 74% now 80%)

Ward managers/ward staff

- Number of patients who are now given the opportunity to wash their hands/use wipes prior to their meals (90% instead of 79%)

Engie Ward Housekeepers

- Assistance given to re-position or assist patients in sitting up or out for meal times (85% instead of 74%)

  Ward staff
- The wards using a bell to signify the start of Protected mealtimes (60% instead or 37%)
- Ward staff /Engie Ward Housekeepers
- The number of wards where all or some staff were involved in the meal service has improved from 47% in 2016 to 70% in 2017

  Ward staff
- Number of staff and visitors alerted to the PM as they arrived on a ward has increased 10% to 60%

  Ward staff
- A reduction in the cleaning being observed during meal service 25% instead of 32% in 2016 –

  Engie – Domestic staff
- Thirty five per cent of wards in the audit benefit from a volunteer meal time assistant in their area.

  Voluntary Services
- Sixty five per cent of areas staff were aware and knew about PMI. This was an improvement from the 2016 audit.

Areas unchanged from the previous audit in 2016

- Clinical Activity taking place during the meal service remains high and unchanged at 70%

Areas needing improvement & those who can support the improvements:

- Increase the number of PM floor stands outside ward areas.

  Ward managers / Matrons & staff
- Patients table areas needing clearing before meal services (84% down to 60%)

  Ward managers/staff
- The number of areas where all staff were involved in the meal service has declined from 47% in 2016 to 5% in 2017

  Ward managers / staff
- The number of patients being offered support and encouragement with eating has reduced to 85% from 94%. More Volunteer Meal time assistants available?

  Ward managers / staff / Voluntary services
- More staff and visitors are to be alerted to the fact that it is PM in order to minimise disruption to the ward during mealtimes –

  Ward managers / Staff
- Cleaning of ward areas not to take place during meal service –

  Engie / Estates
- Continued audit of compliance with meal times against trust schedule - Engie / Estates
- Meridian set up to be amended to show result in Red, amber or green (RAG) rating an some questions have been set up incorrectly on the system.
- Jacqui A-J and Patient Experience to work together to amend

Conclusion

Many areas of Protected mealtimes philosophy had improved in this audit since the earlier audit in January 2016 which is to be commended to all those making that possible. Those include all areas mentioned on page 21.

Since the earlier audit in January 2016 there have been changes in the distribution of the catering and drinks service from in house to contract catering. The distribution of drinks and meals are now performed by the ward Housekeepers provided by Engie.

This may have had an impact on the engagement of the nursing staff (RN's and in particular Health Care Assistants) in the distribution of the meals and an unfortunate reduction in the number of patients being offered helped with their meals. We should however be mindful that 85% of patients were either offered help with meals or didn't require assistance which is the principle reason for the protected mealtime philosophy. The patient satisfaction survey demonstrated that 9% of patients felt that they would have like or needed assistance.

Protected meal times is a time for focusing on meal distribution and assistance for the patients but this audit demonstrates that clinical activity continues in 70% of all areas at lunch time.

The principle reason for PM is to increase nutrient intake of hospitalised patients and a recent systematic review and meta-analyses of Protected Mealtimes in hospital and nutritional intake Porter et al (2017) concluded that due to the small number of observational studies and the quality of evidence of the effect of the intervention on nutritional intake there was insufficient evidence for widespread implementation in hospitals.

However they did acknowledge a meta-analysis of mealtime assistance in hospitals which concluded a statistically significant improvement in daily energy and protein intake in favour of those receiving mealtime assistance (Tassone et al 2015). With this in mind proving adequate support to our patients is essential.

One finding in this audit is that more wards are requesting assistance from Mealtime volunteers

to support the wards and the patients. However in conversation with the Voluntary Services manager this has been proving difficult in recent months to attract volunteers to this specific role within the trust.

The NMC (2015) make it quite clear that the "fundamentals of care such as nutrition and hydration" are a priority in everyday care of our patients. Food and hydration are an essential treatment for patients and should form an important part of the day with support for those requiring assistance.

Whilst it isn't a registered nurses responsibility to feed all their patients at every mealtime it is important that they identify those who are "nutritionally at risk patients" under their care and co-ordinate nutritional care at mealtimes particularly if they are busy with medication rounds or other clinical work at this time.

That said this audit demonstrates that not only does the legacy of the Protected Mealtimes philosophy remain in the trust but improvements have been demonstrated in many areas. The patient side of mealtime assistance is good (85%) but this has been one of the areas which has seen a decrease since the previous audit in 2016. In order to improve outcomes and to provide a quality service for our patients' good nutritional care must remain a priority for all patients (BAPEN 2010).

Title/Topic

PLANNED CAESAREAN SECTION AUDIT
(Registered title "LSCS Audit- RCOG Maternity Indicators")
(n=1351)

Directorate/ Specialty

O&G

Project Type

Audit

Completed

February 2018

Aims, Findings, Key Recommendations/Actions

Main Aims:

- To understand how many Elective Caesarean Sections are performed for maternal request including those women who have had 1 previous caesarean where the clinical picture does not indicate medical need.
- To identify High risk groups for caesarean section and to explore the reasons for the decisions leading to caesarean section in order to focus the appropriate changes to reduce the rate where it is most relevant.
- To establish if there are significant factors or groups including indication for caesarean that increase risk.

Findings:

1. 32% of all Deliveries in the 3 month audit were caesarean section
   - 14.2% of total deliveries were Elective Caesarean Sections
   - 4.5% of total deliveries were Emergency Caesarean Sections
   - 11% of total Deliveries were Urgent Caesarean Sections
   - 2.5% of total Deliveries were scheduled Caesarean sections.
2. From the total Elective Caesarean Sections performed, the greatest percentage – 60% - were performed due to previous LSCS
3. Only 12% of those women having an Elective Caesarean for previous had been seen in a VBAC clinic, however, 62% or records did not have the information available.
4. Of the 6 indications for Elective caesarean advised by the NICE guidelines, we were performing 93% of elective caesarean within guidelines. However, 57% of women with at least 1 previous caesarean section had a repeat caesarean. This needs to be reviewed as we should be looking at why these women were choosing not to have a VBAC.

Key Recommendations/actions:

- To launch and raise awareness of the newly implemented guideline for elective caesarean section for maternal request to ensure the community Midwifery Teams are aware of the pathway of referral as they are the first point of contact and information for pregnant women.
- All cases of caesarean section for maternal request would benefit from attending the dedicated clinic to explore 'birth options' and reasons behind choice as well as provide appropriate information and counselling.
- To implement an Elective Caesarean pro-forma to collect data on why women are specifically choosing caesarean for any reason other than a medically advised reason i.e. placenta praevia
- To audit the use of the VBAC pro-forma to ensure this is being utilised for every woman who has had up to 3 previous caesarean sections as per NICE guidelines.
- Ensure that all women who meet the agreed criteria are referred to the VBAC clinic
- All these appropriate cases for VBAC at the VBAC clinic will receive appropriate counselling and support with use of standardised proforma.
- For the high number of women choosing a repeat Elective Caesarean Section after only 1 previous caesarean, looking at how we can appropriately counsel women to make an informed choice (these women would be suitable VBAC).
- Audit the number of women who choose to come to Luton and Dunstable University Hospital for Elective Caesarean Sections for maternal request having been declined this at their booking hospitals

Aims & objectives

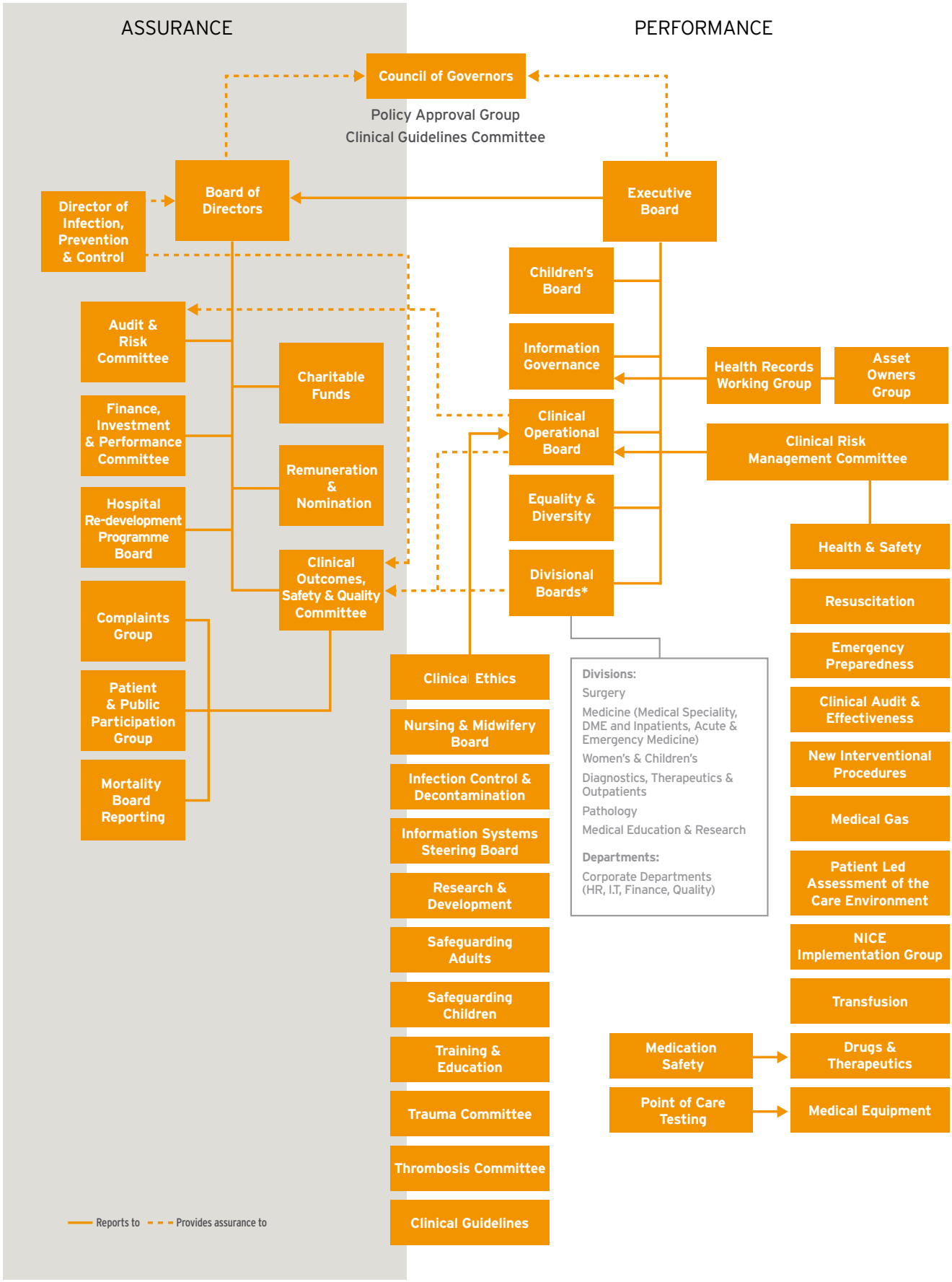
- To establish why a woman had been referred to the clinic and whether or not a debriefing post-delivery had taken place.
- To establish whether or not a plan had been put in place following the clinic appointment.
- To establish final mode of delivery.

Findings & discussion

- 47% of the cases had a referral form and just 53% had a reason documented for that referral.
- 68% of referrals were made by obstetricians, whilst only 11% were made by midwives.
- 89% of cases didn't have a debrief following their caesarean/traumatic experience.
- 53% of women who attended clinic had a plan agreed for birth.
- 68% of women referred to the clinic delivered on delivery suite with 16% on MLBU and 5% in theatre.
- 37% had an SVD, 11% had an instrumental, 16% had a LSCS and 26% had an ELSCS.
- Documentation needs to improved, in order for staff to understand rationale for referrals to the clinic. Midwives need to know how to make referrals and if possible offer it where appropriate.
- The option to debrief post birth needs to be offered routinely to help women understand what happened at their delivery, and to reduce the anxiety that may accompany this and their decision making for future births. Women need to be invited back if appropriate plans hadn't been put in place at the first appointment to reassure women and try to prevent another traumatic experience.

Appendix B – Trust Committee Structure

Luton and Dunstable Hospital Governance and committee structure



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

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