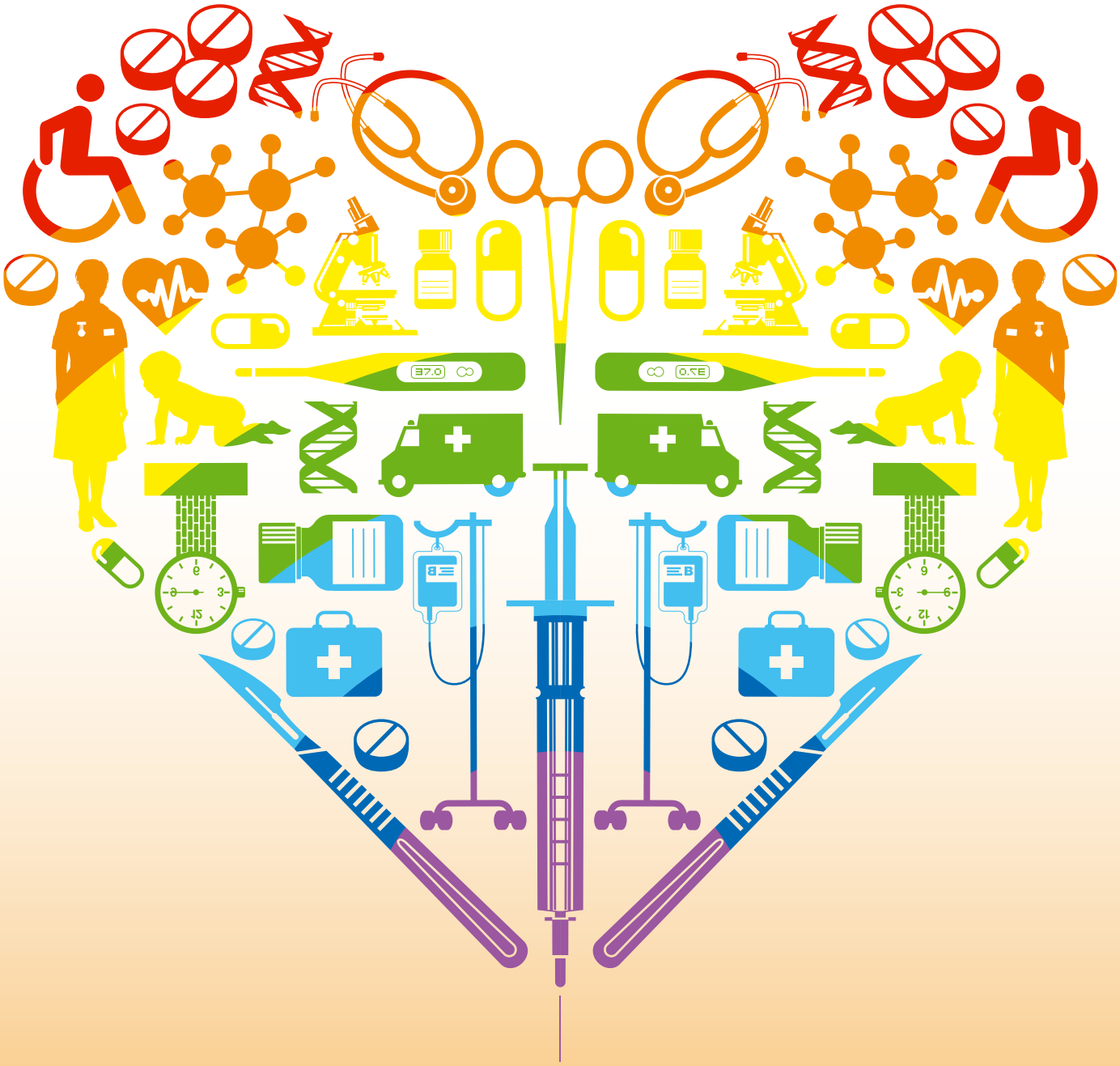
Luton and Dunstable University Hospital
NHS Foundation Trust



Quality Account 2019/20

for the period April 2019 to March 2020

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 2019/20 is included in this account alongside our priorities and goals for quality improvement in 2020/21and how we intend to achieve them.

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

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

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

About our Quality Account

This report is divided into sections.

- A statement on quality from the Chief Executive and sets out our corporate objectives for the coming year.
- Our performance in 2019/20 against the priorities that we set for patient safety, clinical effectiveness and patient experience.
- Our quality priorities and goals for 2020/21 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.
- Statements related to the quality of services that we have provided and includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.
- Our quality performance and includes performance against national priorities and local indicators. It also provides examples of how we have improved services for patients.
- A statement of Directors' responsibility in respect of the quality report.
- Comments from our external stakeholders.

About Our Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 729 overnight inpatient general and acute 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 99,000 admitted patients (excluding maternity and well babies),
- nearly 435,000 outpatients (including pre-operative assessments)
- nearly 159,000 Emergency Department attendees (including urgent GP led service)
- and we delivered nearly 5,200 babies.

We serve a diverse population most of whom are the 216,800 people in Luton (Luton Annual Public Health Report 2018), with other patients predominantly coming from Central Bedfordshire and then, to a lesser extent, Hertfordshire. Luton is an ethnically diverse town, meeting the criteria to be described as 'superdiverse' with approximately 55% of the population of Black, Asian and Minority Ethnic (BAME) origin, with significant Pakistani, Bangladeshi, Indian, Eastern European and African Caribbean communities (Luton Annual Public Health Report 2018). We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile.

The unemployment rate in Luton has been improving year on year over the past 5 years, but remains consistently behind the regional and national employment rates. The proportion of households earning less than 60 percent of the median wage is 20.7% in Luton compared with 17% nationally. Furthermore, the full time weekly earnings differ between people who simply work in Luton and Luton residents who also work in the town, creating further inequalities for those residing within the locality of the hospital. The health inequalities within our local area are highlighted by the variation in life expectancy across Luton - this varies by 11.6 years for men and 5.6 years for women between the least and most deprived areas in Luton and also shows a strong link with unemployment.

The L&D has developed a range of specialist services including cancer, obesity, neurophysiology and oral maxillofacial (jaw) surgery. We have the responsibility for treating the most premature and critically ill new-born babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

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

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

Division	Specialties	
Medicine	Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine Respiratory Medicine Diabetes and Endocrinology Gastroenterology	Cardiology Dermatology Heptology Neurology Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery - Colorectal - Upper Gastrointestinal - Vascular - Bariatric Surgery Urology Paediatric Surgery Trauma & Orthopaedic Hospital at home Critical Care	Plastic Surgery ENT Cancer Services Medical Oncology Ophthalmology Oral & Maxillofacial Surgery Anaesthetics Pain Management Orthodontics Audiology
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 2019/20 Divisional Directors, General Managers and Executive Directors met in the Executive Board.

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

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

Statement on Quality from the Chief Executive

This last year has perhaps been one of our busiest years at the Luton and Dunstable NHS University Foundation Trust, as we successfully merged with Bedford Hospitals NHS Trust to form Bedfordshire Hospital NHS Foundation Trust and towards the end of 2019/2020 dealt with the massive challenge of the coronavirus pandemic, I will touch on both later.

I am delighted that during the year 2019/20 we have maintained delivery against most of the national and local quality and performance targets and we have continued to focus our efforts on building a culture where safety, excellent outcomes and patient experience are our overarching concern with all staff understanding their role in the delivery of those objectives.

Whilst pressures and demands on the NHS and its services continue, I am particularly pleased to note excellent improvements around our complaints responses, the outcomes for patients across our pathway for fractured neck of femur and delivery of same day emergency care. Our good performance in ensuring our frontline staff receive their flu vaccination was not only maintained but surpassed, and this is important for safeguarding both our staff and patients.

The Trust, along with all other acute providers, also had a set of national quality indicators to deliver and, in an encouraging change to the methodology for these targets; they are now aligned with evidence based best practice. Our improvements across all these pathways are encouraging and will continue to be a focus for our clinical teams.

As you will note in the data, some of our improvements, for example the metrics around falls prevalence, show that the steady improvements we were making have stalled in the last quarter of 2019/20 and this is largely related to the impact that COVID-19 had on the hospital in the final quarter of the year, which also saw many of the quality indicators data collections paused nationally. I am very proud of the way our hospital workforce rose to the challenge of the pandemic and the continued hard work and dedication they show as we return to a new normality; it has been second to none and makes me proud to lead this organisation.

Finally, as we planned for our merger with Bedford hospital on 1st April 2020 we ensured partnership on future key priorities for both hospital sites. I am delighted we now have a single set of indicators which focus on the quality improvement needs for both of the Trust sites and will support partnership working across the organisation with a chance to learn from each other in the spirit of the "Best of Both" culture which we wish to deliver.

David Carter
Chief Executive Officer

Corporate Objectives 2020/21

The Trust's Strategic and Operational Plans are underpinned by seven Corporate Objectives that were established by the Shadow Board pre-merger with Bedford Hospital.

1. Establish a new organisation Bedfordshire Hospitals Foundation Trust following the merger of Luton and Dunstable University Hospital NHS Foundation Trust and Bedford Hospital NHS Trust
2. Deliver excellent quality and clinical outcomes and achieve national regulatory requirements
3. Secure and develop a workforce that meets the needs of our patients
4. Deliver the agreed Financial Plan
5. Support the delivery of the objectives of the BLMK ICS
6. Deliver the Luton and Dunstable site redevelopment programme
7. Deliver the capital schemes related to the Bedford Hospital site Three Year Plan

The Trust will respond to the recovery requirements from COVID-19 as part of the Recovery Planning programmes that are currently being developed and will be completed by the end of July 2020. This will impact on the strategic direction and the objective delivery.

Achievements in Quality Improvement Priorities 2019/20

The Trust's overarching quality strategy for 2018-2021 describes four key priority areas based on local, national and Integrated Care System priorities, they are:

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

Quality priorities for 2019/20 listed ambitious programmes of improvement work to ensure that the Trust continues on the journey to become an outstanding organisation for people who both use and work within our hospital.

The outputs from this work are listed below.

Priority 1: Improving Patient Experience

1.1 Provide a responsive, high quality complaints service

Why was this priority?

As part of our drive to improve the experience of our patients and their carers, we wanted to ensure that when they are concerned that their interaction or care within the hospital has not been to the standard they expect, that we respond to their concerns in a timely manner. Some of the timescales in which we were responding were taking too long, therefore we made it a priority to review the system and make sustainable improvements.

What did we do?

A new policy and standard operating procedure was introduced in 2019 along with a new tracking system, which provides a weekly update on the status of all complaints by Division. The response rates are RAG rated so that Complaints Leads, Managers and the central complaints team can monitor the progress of complaints. This enables them to identify where there are issues with responses and where necessary send out holding letters to complainants to explain why there is a delay. It also shows where the complaint is in the process so that appropriate chasing occurs.

The Chief Nurse set a target of 90% response within the timeframe, in order to stretch staff and secure a significant improvement in the timeliness of response rates. Although not always able to achieve the target, the teams have improved response times with delayed responses predominantly being related to the most complex complaints. Therefore the response time targets are under review, benchmarking ourselves with other Trusts and learning from the experiences of other organisations. In line with investigation times expected through the national serious incident framework, we are considering increasing the response target to 60 working days from 35 for the complex complaints. All other complaints will remain with a 35 working day target. The aim is to enable a more robust investigation and response that fully meets the expectations of the complainants and to be able to get the best learning from the incident under investigation. It also recognises the fact that, on occasions, the significant complex complaints may also be subject to a serious incident investigation and so, by having the same response time, allows us to provide one, coordinated and robust investigation.

How did we perform?

Average compliance rates for all complaints have improved as the year has progressed from the lowest point of 57% in May to 90% in November. The average complaints response rate for 2019/20 has been 76% for the year, which includes significant complaints.

Under the leadership of the Chief Nurse, the complaints team are continuing to work closely with the clinical service line management teams to improve response times. The themes and learning from complaints are also being used more robustly to feed into other quality improvement work across the Trust, for example the theme of communication has been very clearly linked to issues with discharge and so is being fed into the quality priority on discharge for 2020/21.

1.2 Improve our discharge processes to provide our patients with improved experience when leaving our hospital

Why was this priority?

Hospital discharge describes the point when hospital care ends with on-going care transferring to a home, community or other care setting. Therefore hospital discharge is not an end point but part of the on-going patient journey. The Trust recognised that failures in getting all the steps right to support our patients along this journey was leading to high levels of complaints not only from our patients but also some partners and therefore improvements to the quality of discharge for our patients was a priority for the year.

What did we do?

How did we perform?

During 2019/20, there were 15 complaints and 64 concerns raised about discharge issues. This demonstrates a reduction since 2018/19 when we received 25 formal complaints and 82 concerns. The charts below show there may have been multiple elements relating to discharge raised with the teams. PALS issues were referred to ward teams and social workers to resolve.

Three complaints were upheld, two partially upheld and the remainder were not upheld. There were two multiagency complaints which related to issues outside of our control.

The most common themes were planning and medication issues. Medication continues to be a recurring theme.

Complaints relating to Discharge 2019/20

Discharged too early	4
Discharged with incorrect/incomplete/ without TTO's	4
Discharge Arrangements (including lack of or poor planning)	8
Delay in planned discharged	3
Delay in discharge awaiting medication	2

Concerns raised with PALS relating to Discharge 2019/20

Delay in discharge awaitng medication	4
Delay in planned discharge	9
Discharge Arrangements (including lack of or poor planning)	40
Discharged with incorrect/incomplete/ without TTO's	8
Discharged too early	9
Failure of planned discharge	3
Inadequate discharge planning	11

Improvements to discharge planning will continue to be a priority for the Trust and as such, has been included as a quality priority for the next year.

Priority 2: Improve Patient Safety

2.1 Achieving 80% of older inpatients receiving key falls prevention actions

Why was this priority?

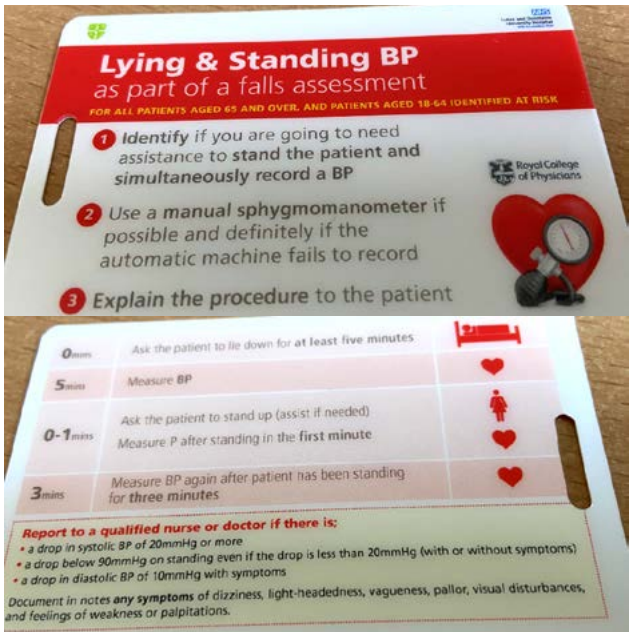
Taking these three key actions as part of a comprehensive multidisciplinary falls intervention could result in fewer falls, causing hip fracture or brain injury leading to improvements in safety, length of stay and reduced treatment costs. They are

- Lying and standing blood pressure to be recorded
- No hypnotics or anxiolytics to be given during stay OR rationale documented
- Mobility assessment and walking aid to be provided if required

What did we do?

A multidisciplinary team approach involving the Falls Clinical Nurse Specialist, Consultants, Therapists, Nurses, Pharmacists and the patient safety team were involved in a range of initiatives to educate, raise the profile and keep reminding staff of the actions required. A campaign ran specifically around falls but also as part of patient safety awareness week. Presentations on inductions, at ward manager's meetings, on the grand round.

Cards were produced for staff lanyards and are now given out to nursing staff on induction.Blood pressure equipment has been labelled with laminated signs to serve as a reminder of the need for lying and standing blood pressure.

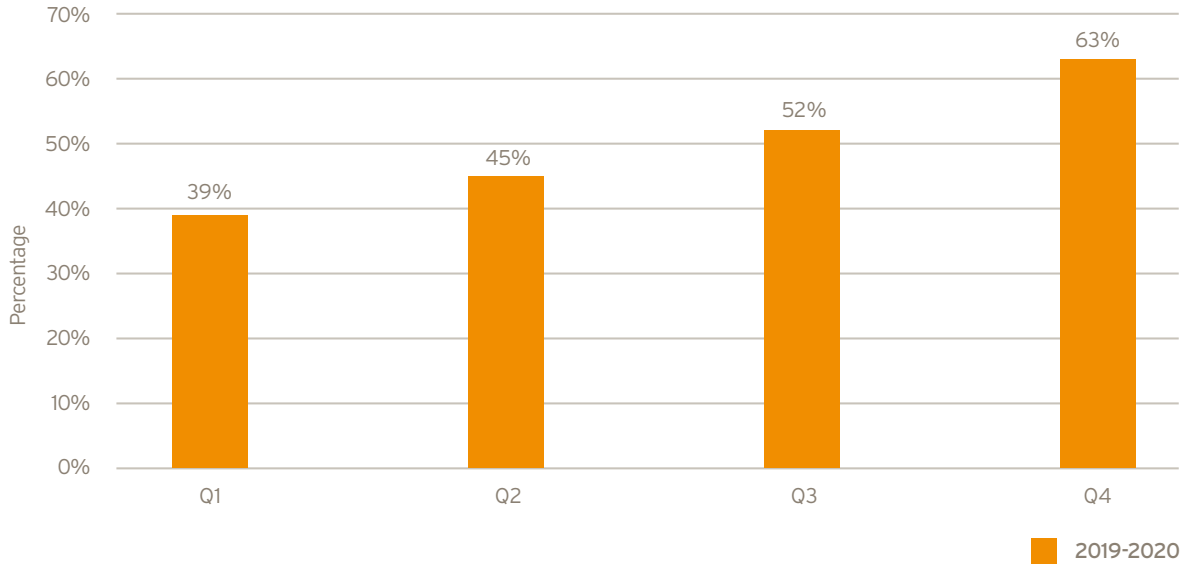


A specific proforma was developed until such time as the new electronic solutions will bring together the recording of the key falls interventions.

How did we perform?

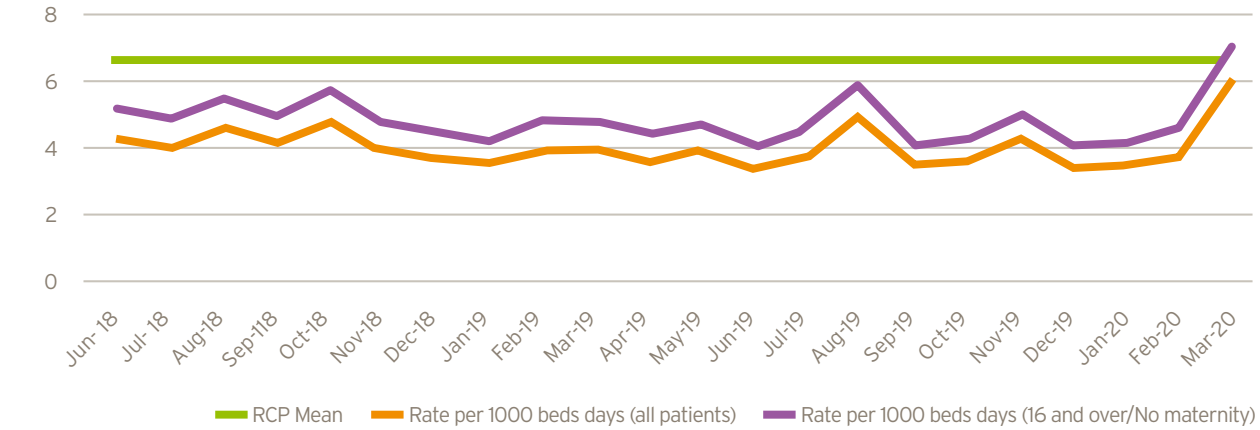
The chart below shows the progress made over the year with the increasing percentage of patients aged 65+ who received all three key falls prevention actions

Patients aged 65+ who received all three key falls prevention actions



Until March* 2020, the Trust has continued to experience a lower falls rate than the national mean. The implementation of the three key falls prevention actions has been implemented to become an established part of our care. Whilst we did not achieve the interventions in 80% of patients as intended, positive progress has been made throughout the year. This will continue to be monitored within the Trust through regular audit and the results will be reported quarterly via the NHS data collection portal.

Falls Rate per 1000 Bed Days



* Significant rise in falls in March has been attributed to increased patient acuity and reduced staffing levels as a result of COVID-19. The wards experienced challenges in providing enhanced observation for high risk patients due to the increased need for isolation in combination with the donning and doffing of PPE in the context of high rates of staff absence.

2.2 Improve compliance rates for statutory and mandatory training, particularly for medical staff, particularly infection control and safeguarding

Why was this priority?

During our last Care Quality Commission inspection the inspectors noted in their report that the Trust needed to improve performance in respect to staff attending mandatory training. This was therefore a key focus for improvement during the past year with specific focus on infection prevention and control and Safeguarding children and vulnerable adults to ensure our staff deliver safe care with up to date information and training.

What did we do?

- Infection control in relation to 'bare below the elbows' was noted as a concern by CQC and there has been an energetic campaign by the Infection Control Team to improve and maintain compliance. Compliance with infection control mandatory training had improved following the inspection to 89% by March 2019, and by the end of March 2020, compliance was at 85% showing a slight decline in compliance.
- We reviewed each mandatory module to identify if we could increase the numbers of spaces to ensure that there was sufficient provision for classroom training. Course availability is closely monitored and additional sessions are scheduled, as required.
- Non-compliance is reported to the Board via the Clinical Outcome, Safety and Quality Committee and a specific report identifies those staff who are more than 3 months overdue.
- There is a report at Divisional and Cost Centre level so that managers can alert their staff to complete all their training as soon as possible.
- Additional reports are provided in relation to Resuscitation Training and Safeguarding Children Level 3 as these were areas of specific concern.
- Since January 2019, there have been monthly meetings with divisional general managers to discuss areas of non-compliance with support provided, as necessary.
- The Chief Medical Adviser and the Chief Executive wrote to all consultants to inform them that study leave applications would only be agreed if mandatory training was up-to-date.
- Access to e-learning has improved with the general use of Chrome rather than Internet Explorer and the fact that the system no longer relies on Java and Flashplayer. The Training and Development Department has also promoted the ESR App for mobile devices which is particularly helpful for those staff who may not routinely work in an office.
- Junior doctors who rotate into the L&D have been supported to improve their compliance in partnership with Medical Education. Their training records from other Trusts are also taken into account.
- Progress is being made towards Manager Self-Service on ESR which will improve communications and enable managers to more readily access their staff training records. This is a project in partnership with IBM so progress is dependent on external factors such as the availability of ESR technical support.

How did we perform?

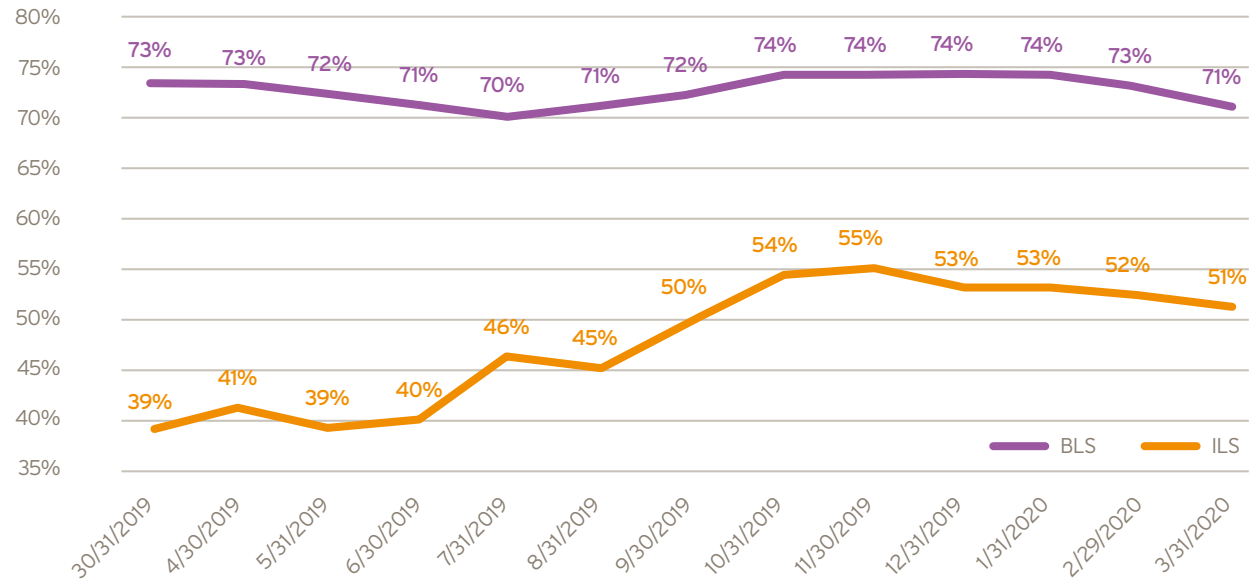
Chart showing compliance with mandatory training as at 31st March 2020

Division	Directorate	Fire	Change (+/-)	Infection Control	Change (+/-)	Safe Moving Theory	Change (+/-)	Information Governance	Change (+/-)	Safeguarding Adults	Change (+/-)	Safeguarding Children	Change (+/-)	Conflict Resolution	Change (+/-)
Corporate	Organisational Development	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%
Diagnostics, Therapeutics and Outpatients	Breast Screening	100%	0%	100%	0%	100%	0%	100%	25%	100%	0%	100%	0%	100%	0%
	Imaging	100%	14%	100%	7%	80%	-13%	100%	7%	93%	0%	87%	1%	93%	0%
	Pathology, Pharmacy & Therapies	65%	-10%	82%	7%	71%	2%	82%	7%	82%	1%	76%	1%	82%	19%
Medicine	Acute Medicine	80%	47%	80%	30%	100%	33%	80%	47%	80%	-3%	80%	13%	60%	10%
	Emergency Medicine	63%	10%	69%	16%	81%	28%	63%	16%	75%	22%	81%	8%	81%	8%
	Medical Inpatients	69%	7%	75%	-2%	81%	4%	75%	13%	69%	7%	63%	9%	88%	19%
	Medical Specialties	78%	3%	81%	2%	86%	5%	78%	6%	81%	-3%	80%	8%	78%	11%
Surgery	Anaesthetics	93%	19%	98%	14%	98%	11%	93%	9%	98%	22%	98%	24%	100%	11%
	Breast Surgery	100%	25%	100%	0%	100%	0%	100%	25%	100%	0%	100%	25%	100%	0%
	Cancer Services	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%

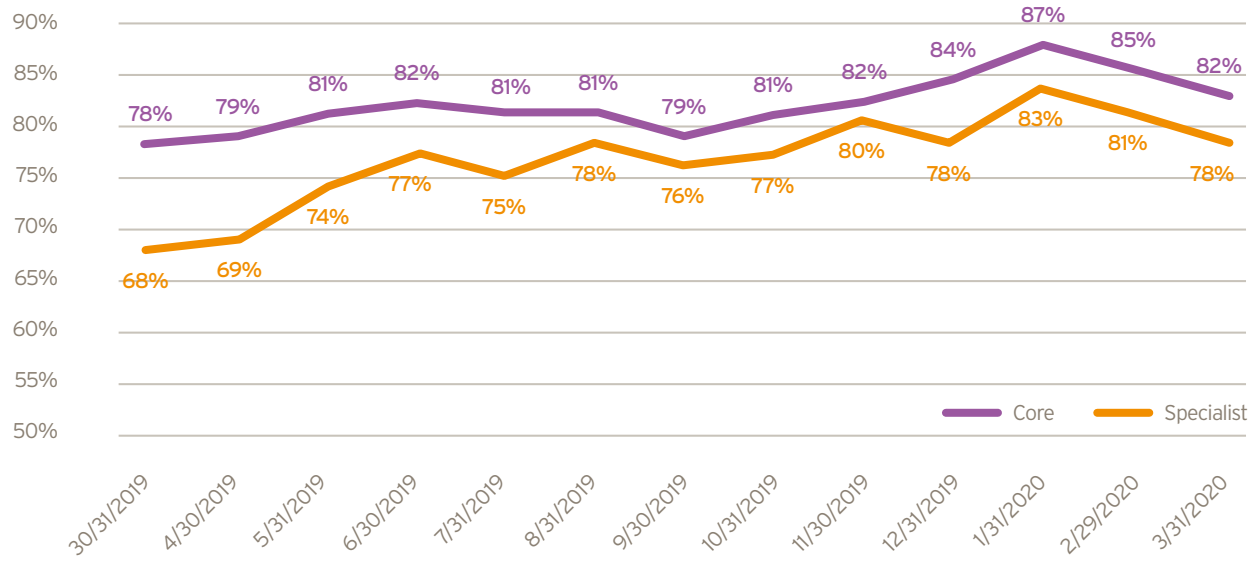
Division	Directorate	Fire	Change (+/-)	Infection Control	Change (+/-)	Safe Moving Theory	Change (+/-)	Information Governance	Change (+/-)	Safeguarding Adults	Change (+/-)	Safeguarding Children	Change (+/-)	Conflict Resolution	Change (+/-)
Surgery	Colorectal	86%	0%	86%	-14%	86%	0%	71%	-15%	86%	0%	71%	0%	100%	14%
	ENT	75%	-3%	88%	44%	100%	33%	75%	8%	88%	55%	100%	67%	88%	21%
	Intensivists Medical	100%	50%	100%	37%	100%	25%	100%	37%	100%	12%	100%	0%	100%	37%
	OMFS	82%	26%	91%	47%	82%	38%	82%	26%	55%	11%	55%	-1%	64%	-3%
	Ophthalmology	100%	27%	100%	9%	100%	0%	100%	27%	92%	1%	92%	10%	92%	19%
	Orthodontics	86%	15%	100%	14%	100%	14%	100%	0%	100%	0%	100%	0%	86%	29%
	Orthopaedics	93%	6%	100%	0%	93%	-7%	93%	-7%	100%	13%	93%	6%	93%	20%
	Pain Service	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%
	Upper GI	75%	25%	88%	25%	100%	37%	75%	25%	75%	0%	88%	13%	100%	62%
	Urology	86%	19%	86%	-14%	86%	-14%	71%	4%	86%	-14%	86%	-14%	100%	17%
Women's & Children's	Gynaecology	90%	1%	90%	1%	90%	12%	90%	12%	100%	11%	90%	12%	80%	13%
	NICU	87%	1%	87%	-13%	100%	0%	87%	-6%	100%	7%	100%	0%	93%	0%
	Obstetrics	100%	19%	95%	32%	95%	32%	89%	26%	89%	26%	84%	9%	100%	31%
	Paediatrics	90%	15%	76%	-9%	95%	10%	90%	10%	86%	6%	100%	0%	90%	0%

The Trust is proud to have progressed the mandatory training dashboard to a much more positive picture. The intention is to provide continued focus on maintaining the compliance and improving those specifically where compliance is rated as 'red' meaning that the compliance is in the lowest segment.

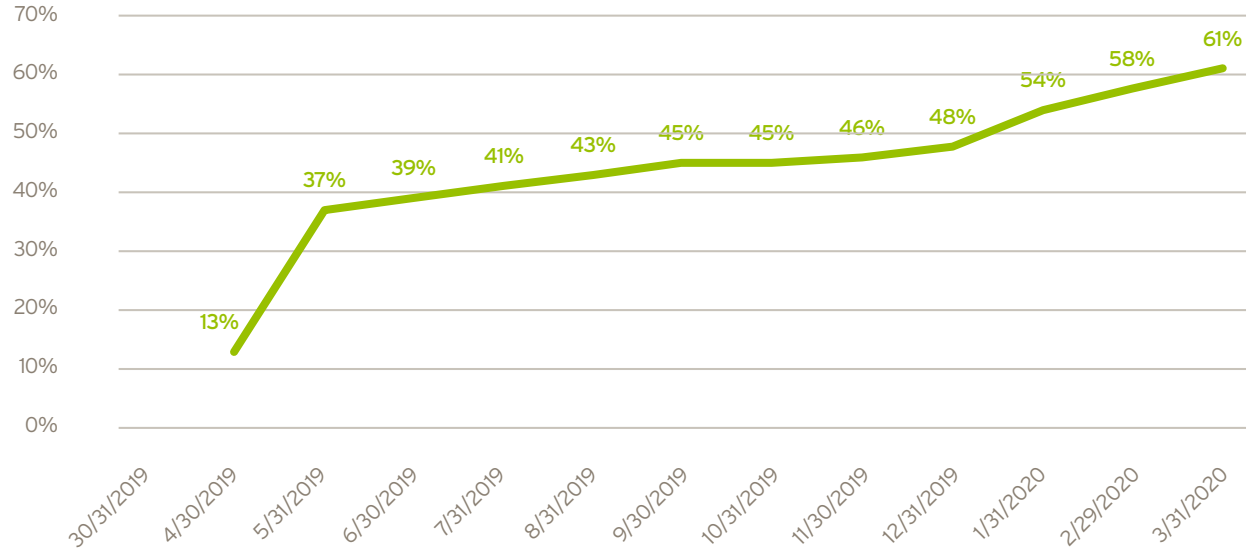
Resuscitation Training BLS and ILS Compliance



Safeguarding Children - Level 3 Compliance



Preventing Radicalisation (Level 3 – Healthwrap)



Resuscitation and Safeguarding Training were highlighted as areas of particular concern during the CQC inspection report of December 2018. There has been a steady improvement with compliance with ILS training from 39% in March 2019 to 51% in March 2020; Safeguarding training compliance has improved from 68% to 78% for specialist training and 78% to 82% for core training, and from 13% to 61% for the Healthwrap training. It is notable that a decline in compliance for training does tend to dip in the period after Christmas as staffing of wards during winter pressures makes it more difficult to release staff for training.

Priority 3: Deliver Excellent Clinical Outcomes

3.1 Developments to further improve our fractured neck of femur (hip) pathway

Why was this priority?

We had challenges in respect to outlier alerts in relation to mortality rates and outcomes for our fractured neck of femur pathway. We therefore continued to make this a key focus of improvement work through 2019/20 with increased attention on embedding sustainable improvements.

What did we do?

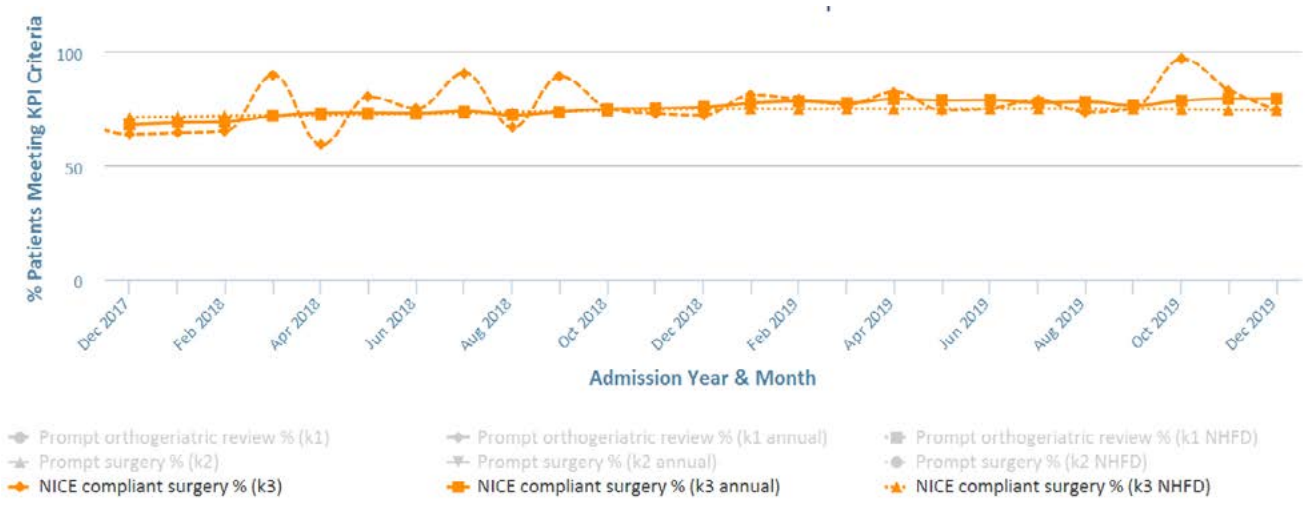
- Undertook a gap analysis using NICE guidance and quality toolkit, benchmarking data from National Hip Fracture Database, learning from a serious incident review into an avoidable death and a thematic review of deaths from 2017 to establish a quality improvement plan for hip fracture
- Developed a Hip Fracture Quality Improvement Board chaired by Dr James Ramsay, Associate Medical Director, and involving all key senior stakeholders to oversee delivery of the quality improvement plan
- Set up a number of clinically led task and finish groups, each focussing on an element of the hip fracture pathway. Key deliverables included:
  - Embedding fast track pathway and safety checklist to reduce time to arrival of patients on the hip fracture ward and ensure senior medical review of unwell patients prior to admission
  - Developing anaesthetic protocols, in particular promoting use of nerve blocks
  - Developing analgesia protocols to reduce opiate usage
  - Improving data quality and capture of patient comorbidity details
  - Anaesthetic rota changes to facilitate improved pre-operative optimisation
  - Improving rates of surgery that were compliant with NICE standards
  - Improving mobilisation post operatively
- Re-launched a monthly morbidity and mortality meeting, chaired by Dr Adrian Pradere, Consultant Anaesthetist
- Fixed slot in the orthopaedic clinical governance half day for hip fracture case discussion and sharing of key learning points from mortality reviews

How did we perform?

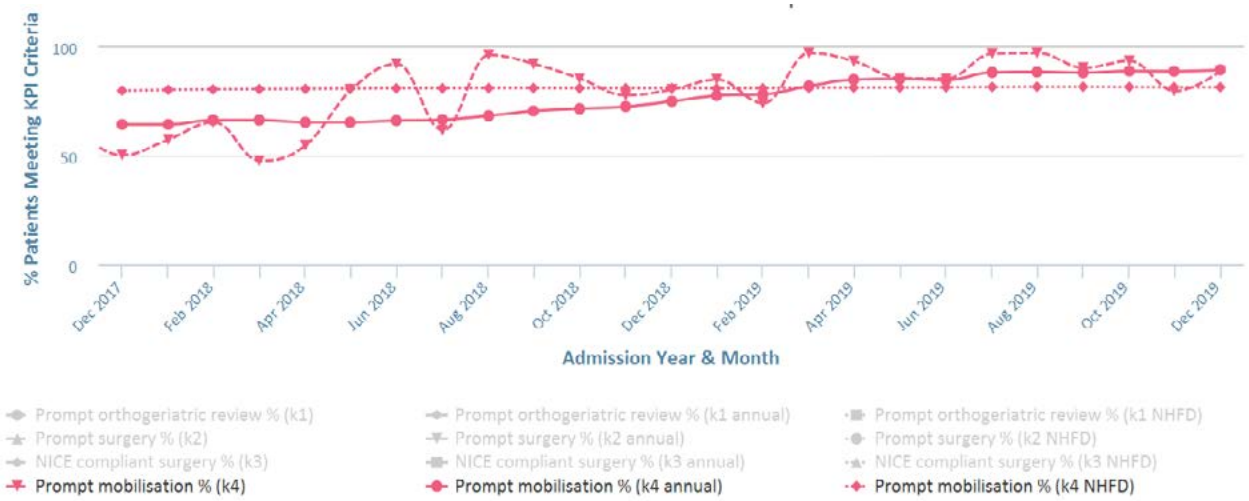
- Development of Quality Improvement programme for pathway for fractured neck of femur – in place
- Design an improved multi-disciplinary pathway monitored by key performance indicators - pathway improvements are being delivered on a continuous basis

KPIs 12 months to Dec 2019

NICE compliant surgery 79% (vs 74% nationally)



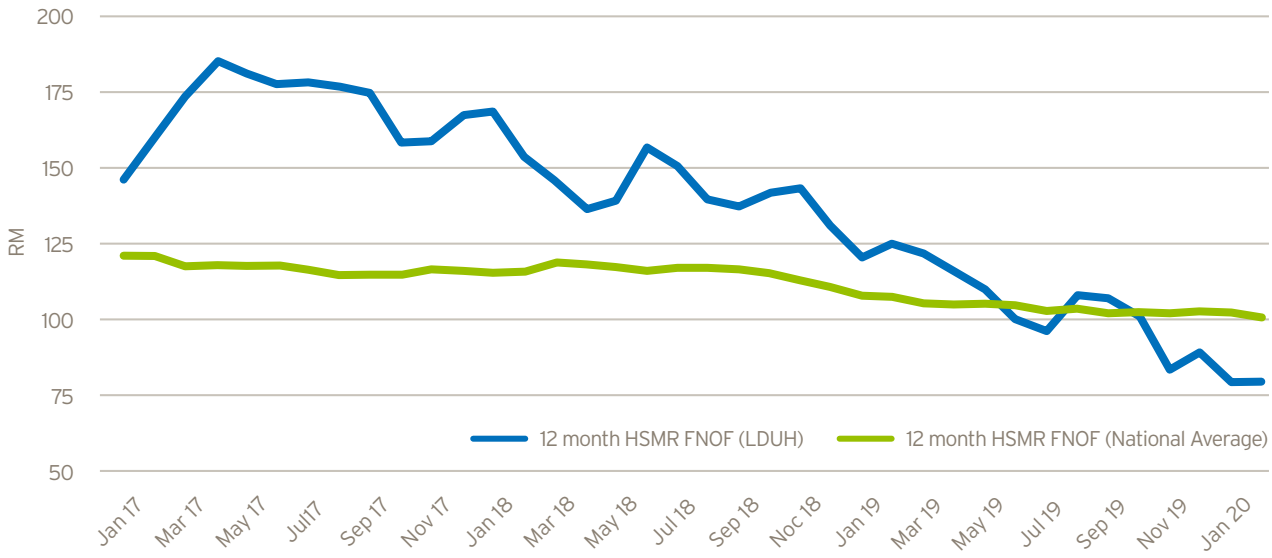
Prompt mobilisation post-op 89% (vs 81% nationally)



Achievement of best practice 80.5% (vs 58% nationally)

HSMR 12 months to February 2020 78.98 (vs 99.93 nationally) demonstrating a sustained improvement for mortality rate related to hip fracture pathway

HSMR (Hospital Standardised Mortality Ratio)



3.2 Ensure compliance against all 4 key clinical standards in respect to 7 day services

Why is this priority?

- The 7 day services programme is designed to ensure that patients admitted as an emergency, receive high quality consistent care whatever day they enter hospital. The latest exercise to demonstrate compliance with key clinical standards indicated that we still had particular areas which need to be a key focus for improvement
- **Standard 2:** All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hrs from time of admission to hospital.
- **Standard 5:** Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:
  - within 1 hour for critical patients
  - within 12 hours for urgent patients
  - within 24 hours for non-urgent patients
- **Standard 6:** Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. (Interventional radiology)
- **Standard 8:** Patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hrs, seven days a week, unless it has been determined this would not affect the patient's care pathway

What did we do?

We reviewed our staffing models and the establishment of a unified clerking process is in progress to provide a greater senior presence for emergency admissions across the Trust.

The unified clerking process is being reviewed to include a brief consultant review before patients are transferred to wards from the Emergency Department.
We have been focusing on documentation in the patient record to evidence specific pathways and the need to date and time stamp entries in notes has been raised in order to provide more robust evidence of the reviews which were happening but had not always been timed/dated.

How did we perform?

Standard 2	All emergency admissions must be seen by a Consultant within 14 hours of admission to hospital.	86% (target 90%) The Trust achieved the highest compliance to date with only a 1% difference between weekdays and weekends. Weekends achieved the higher percentage.
Standard 5	Inpatients must have access to consultant-directed diagnostic services within specified timeframes 7 days a week	100% The Trust remains fully compliant with this standard.
Standard 6	Inpatients must have Consultant-directed interventions either on-site or through formally agreed networks, 24 hours a day, 7 days per week	The Trust is compliant with 6 out of 8 interventions, the exception being interventional radiology. There is on-going discussions with East and North Hertfordshire Hospitals and Addenbrookes to create a consortium with the aim to create a hub-and-spoke service model.
Standard 8	A) inpatients reviewed by Consultant once daily for 7 days per week (unless this would not affect the patent's pathway) B) Patients with high-dependency needs should be reviewed by a Consultant twice daily	A) 86% (target 90%) For those patients identified as requiring once daily reviews, the Trust continues to demonstrate a higher percentage compliance during weekdays. B) 100% The Trust remains compliant in performing twice daily reviews for patients with high dependency needs.

3.3 Same Day Emergency Care – pulmonary embolus; tachycardia with atrial fibrillation; community acquired pneumonia

Why is this priority?

Roll out of Same Day Emergency Care (SDEC) is part of the NHS long term plan and – pulmonary embolus (PE), tachycardia with atrial fibrillation (AF) and community acquired pneumonia (CAP) are all conditions from the top 10 conditions with which patients present in a SDEC setting. These are selected due to the fact that a focus on a limited set of clear actions can be taken by the Trust to improve same day treatment. This will reduce pressure on the hospital's beds; improve length of stay and the patient's experience.

What did we do?

Best practice pathways were established and in place for patients presenting to the Trust with these three acute presentations. Practices were audited and case studies shared to embed and sustain practices which were already well understood.

How did we perform?

The Trust performed exceptionally well in the delivery of same day care to patients presenting with pulmonary embolism, tachycardia with atrial fibrillation and pneumonia with only small numbers of patients having been admitted when admission could potentially have been avoided.

Chart showing percentage compliance with SDEC for each quarter

	Q1	Q2	Q3	Q4
Same Day Emergency Care - PE	100%	95%	98%	100%
Same Day Emergency Care - Tachycardia with AF	86%	90%	96%	94%
Same Day Emergency Care - Community Acquired Pneumonia	97%	87%	97%	94%

Priority 4: Prevention of Ill Health

4.1 To ensure that at least 80% of our frontline clinical staff is provided with the flu vaccination by February 2020

Why was this a priority?

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

What did we do?

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

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

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

How did we perform?

We were delighted to have had a successful campaign with 81% of frontline clinical staff receiving the flu vaccine which surpassed the required target (80%).

4.2 Alcohol and Tobacco – Screening and Brief advice

Why was this priority?

This Screening and brief advice is part of an on-going programme to deliver the Long Term Plan for the NHS and is expected to result in 170k tobacco users and 60k at risk alcohol users receiving brief advice which is seen as a key component of their path to cessation.

What did we do?

A revised patient assessment proforma developed in the past year was used to assess and record patients tobacco and alcohol risk status. Of those patients identified as current smokers we aim to provide brief advice on the best ways to stop smoking in accordance with best practice. We also offer Nicotine Replacement Therapy (NRT) to patients during their inpatient stay plus a referral to the 'Stop Smoking Service' (if required) upon discharge. In addition, we provide brief advice to those patients identified as drinking above low risk levels of alcohol and / or offer a referral to ResoLUTiONS for specialist on-going support.

The public health teams providing support for smokers and those with high alcohol intakes worked in partnership with the Trust to deliver more frontline services on the wards, providing both support to patients and teaching input to staff. Wards and departments have been provided with resources to support staff in delivering smoking cessation advice and to deliver brief verbal advice around alcohol consumption. Visual aids are being used by staff to determine alcohol units and to assist patients to identify and understand their alcohol risk status. Specific guidance around NRT has been incorporated onto the assessment proforma to guide staff to prescribe this in accordance to patients' level of dependency based on their Fagerstrom score.

A review of the referral process to our local support services led to a quality improvement initiative to introduce an 'electronic referral process' (with a view to boosting the number of referrals). We worked in collaboration with our partners to design an electronic referral form to be incorporated into the Trust's ICE electronic referral system. This 'e-referral' to the stop smoking services and ResoLUTiONS was launched Trust-wide in January 2020 and since then we have seen a rise in the number of referrals being made. We continue to audit to monitor our progress.

How did we perform?

The results of audits of 100 patients each quarter have shown the following performance against this quality priority:

	End of year target	Q1	Q2	Q3	Q4
Inpatients (age 18+) admitted for at least 1 night who were screened for BOTH alcohol and tobacco	80% (minimum 40%)	63%	83%	73%	76%
Smokers who were given brief advice including an offer of NRT (number of smokers shown in brackets)	90% (minimum 50%)	33% (5/15)	43% (6/14)	42% (8/19)	44% (7/16)
Patients identified as drinking above low risk levels who were given brief advice or specialist referral	90% (minimum 50%)	36% (4/11)	75% (3/4)	100% (4/4)	18% (2/11)

The results are not as we would wish particularly in respect to the brief advice and support provided to people who smoke and those who drink above low risk drinking levels. The Trust has included a quality priority for 2020-2021 to make the site smoke-free and as a result, there will be ongoing work to provide enhance support to smokers. Ongoing audit to demonstrate further embedding and sustainability of these ambitions is planned and quarterly data will be submitted to NHS England and monitored by the Trust to help drive further improvement.

4.2 Antimicrobial resistance – Lower urinary tract infections and antibiotic prophylaxis in colorectal surgery

Why was this a priority?

The Long Term Plan includes antimicrobial resistance and stewardship as a major priority and use of the four steps outlined for urinary tract infection (UTI) was planned to reduce inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improved treatment and management of patients with UTI.

The Implementation of NICE guidance for Surgical Prophylaxis was planned to reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines.

With these improvements aimed at delivering safer patient care, increase effective antibiotic use, thus leading to improvement in both patient mortality and length of stay.

What did we do?

UTI Campaign

- We ran a campaign called "don't be a dipstick" to engage widely with all clinical staff in a fun and easily remembered format
- We reviewed the UTI guideline
- The antimicrobial pharmacist hosted various teaching sessions with medical teams, ward managers and specific departments about the appropriate use of urine dipsticks and how to interpret this.
- Appropriate use of dipsticks and prescribing for UTI's for elderly patients has been incorporated into regular junior doctors and trust induction presentations delivered by the antimicrobial pharmacist
- We worked with clinical biochemistry and the point of care testing team to source and implement urine dipsticks without nitrates and leukocytes

The **"Don't Be a Dipstick"** campaign was high profile and interactive. Staff completed a quiz to win prizes and were very positive about the impact on their clinical practice.

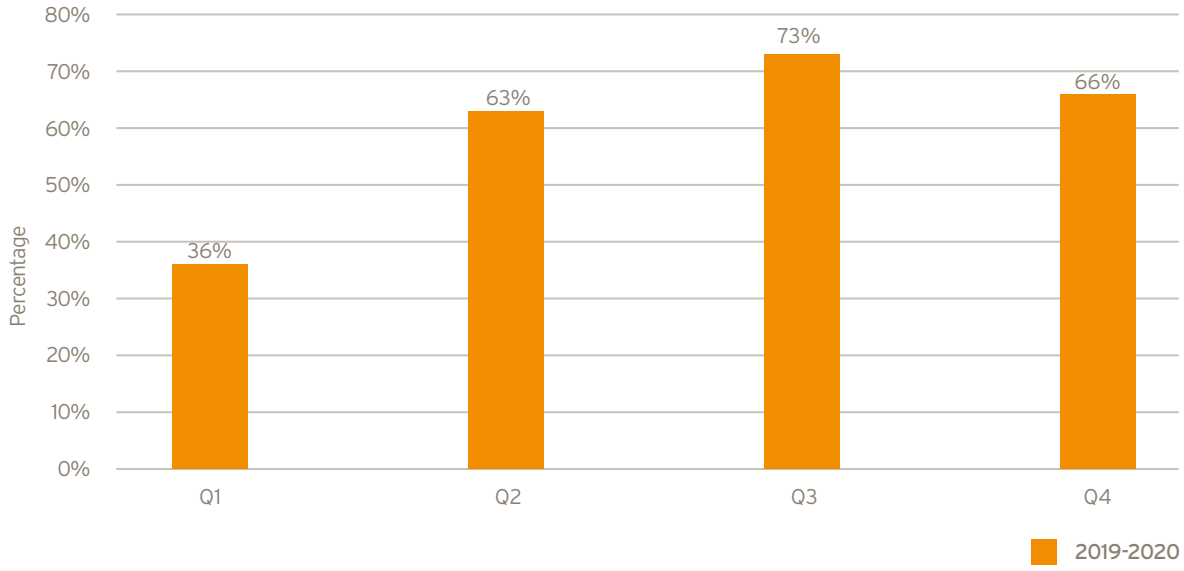
Colorectal surgical prophylaxis

- The antimicrobial pharmacist updated the colorectal prescribing guideline to include penicillin allergies
- The changes in practice were communicated directly to the anaesthetists and colorectal surgeons
- Results of audits of clinical practice were fed back to surgeons and anaesthetists with individual conversations where practice was not in accordance with best practice

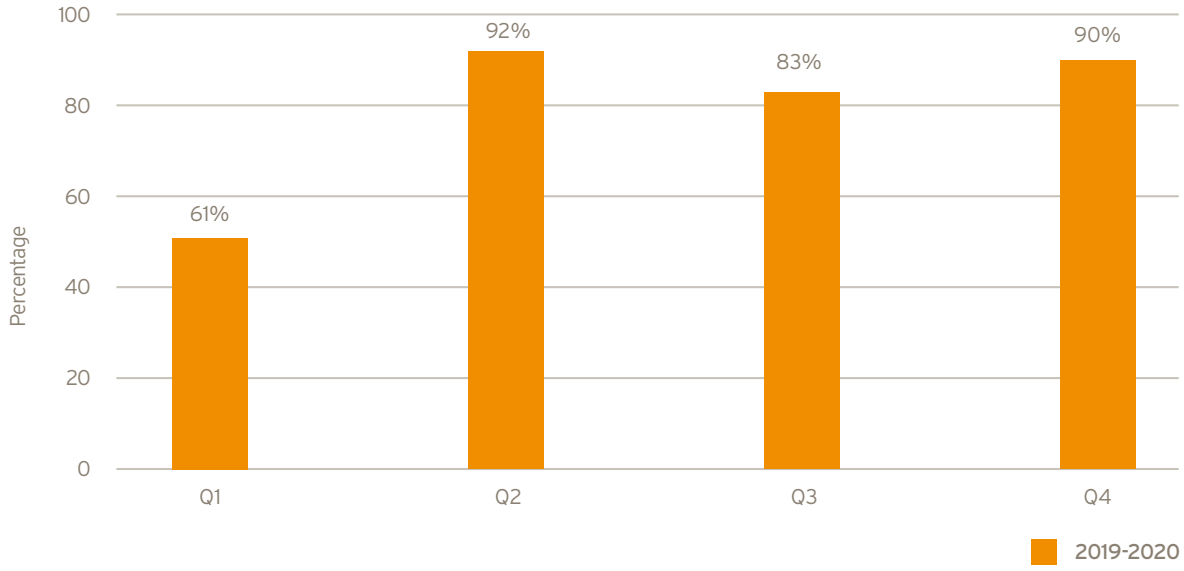
How did we perform?

Public Health England excluded Q1 data for all Trusts from inclusion in the calculation of the yearly target because there had been insufficient time for Trusts to adequately prepare for the implementation of the changes required for optimal performance. The Q4 performance, before COVID-19 affected services in March 2020, was slightly higher at 68%. The aim was to achieve at least 60% with a stretch target of 90%. This element of the quality priority forms part of the quality priorities for 2020/21 and so further targeted work of diagnosis and treatment of UTI will continue.

Percentage of patients aged 65+ who had lower urinary tract infection and whose diagnosis and treatment were in accordance with the best prtactice



Percentage of patients undergoing elective colerectal surgery who received Prophylatic Antloblotics in accordance with best practice



Quality Improvement Priorities 2020/21

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

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

A scoping exercise was undertaken, providing the opportunity for clinical and managerial engagement in determining the next year's priorities. A number of proposals were received from a range of staff including consultants, senior nurses, staff from Trust corporate functions; managers from both Luton and Bedford sites. In defining these priorities, we also considered the feedback received from external stakeholders and patient groups related to last year's quality account as well as progress made with quality priorities during 2019/20.

With the impending Trust merger and the additional work required to integrate clinical and corporate services, it has been established that quality priorities need to be focused on improvements in a considered way in order to manage demands on the time and resources available.

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

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

The diagram below describes each of the priorities under these headings together with a rationale for their inclusion, how we will measure success and how we will oversee the progress we make throughout the year. Whilst we have identified priorities for 2020/21, the future is currently uncertain so we may seek to review and reprioritise as the year progresses and as we continue to respond to the global COVID-19 pandemic.

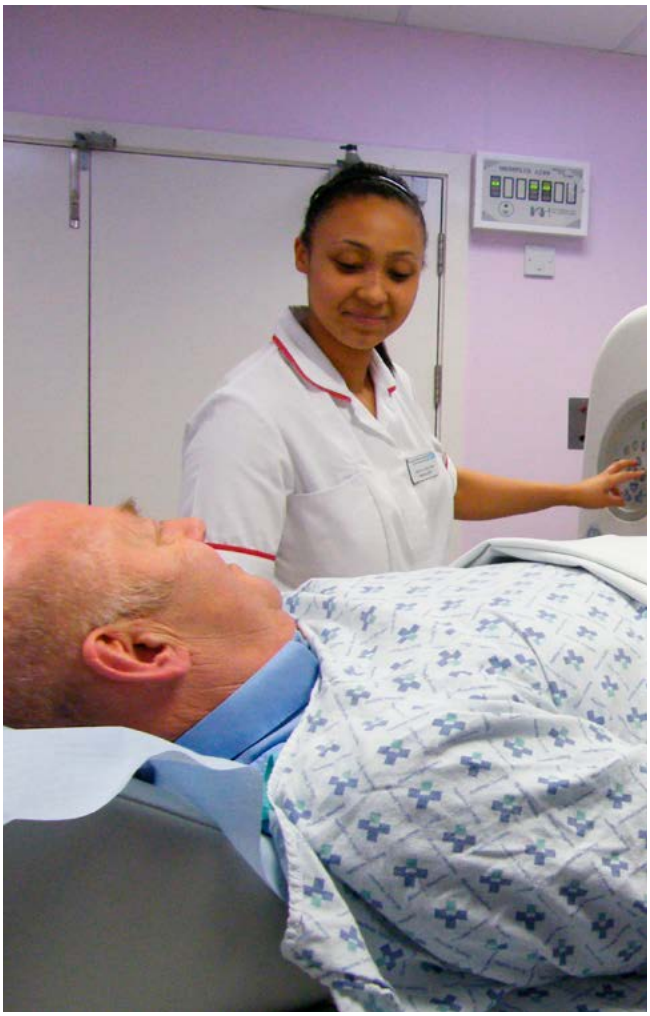
Quality Priorities for Improvement 2020 – 2021

Corporate Objectives	Deliver Excellent Clinical Outcomes
Quality Priorities	• Treatment of community acquired pneumonia in line with BTS care bundle • Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI) • Adherence to evidence based interventions clinical criteria
Rationale	Management of community acquired pneumonia has been a priority across the NHS for many years, particularly as part of the strategy for same day emergency care and also as part of winter planning. The care bundle, which is aligned with NICE guidance, sets out discreet steps that the Trust needs to follow with the aim to reduce mortality, length of stay and patient experience. Nationally, it is estimated that £765m spend per year and 29,000 deaths are associated with pneumonia. High sensitivity troponin tests are recommended as part of a rule out protocol for certain people attending as an emergency with chest pain. Improved compliance with the rapid rule out protocol will lead to improvements in the delivery of same day discharge, reducing length of stay and enhancing patient experience. The implementation of the evidence based interventions clinical criteria seeks to reduce the number of inappropriate interventions that patients receive by drawing on best practice guidance. There are 13 conditions where interventions should only be provided when certain clinical criteria are met. Compliance with the clinical criteria will reduce avoidable harm to patients and address unwarranted variation nationally. Robust implementation will ensure the most appropriate use of resources.

Corporate Objectives	Deliver Excellent Clinical Outcomes
Measures of Success	At least 70% of patients with confirmed community acquired pneumonia will: • Have a chest x-ray within 4 hours of arrival in hospital; • Have their pneumonia severity score calculated and documented in the medical notes • Receive antibiotics within 4 hours of arrival in hospital; • Receive antibiotics that are in accordance with the severity score and in line with NICE clinical guidance. At least 60% of patients attending ED with suspected acute myocardial infarction, who receive two high-sensitivity troponin tests, receive the second test within 3.5 hours of the first. At least 80% of patients undergoing any of the procedures defined in the national guidance (there are 13 category 2 procedures), meet the specific requirements set out in the Evidence Based Interventions clinical criteria specifications.
Monitoring Committee	Trust Quality Committee
Corporate Objectives	Improve Patient Safety
Quality Priorities	• Recording of NEWS2 score, escalation time and response time for critical care admissions • Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery • Programme to support patient safety and experience including – improve learning from incidents, claims and complaints, – support Just Culture
Rationale	Considerable work has been carried out nationally to improve the identification and treatment of acute illness in order to prevent deterioration and cardiac arrest. This has drawn attention to the importance of timely escalation and the changes planned within this programme of work uses evidence based best practice to improve consistency in the recording and response to deterioration. There is detailed NICE guidance setting out the requirements to offer iron before surgery to patients with iron-deficiency anaemia. Improved compliance with this guidance would reduce blood transfusion rate for patients undergoing major blood loss surgeries, reducing the occurrence of patient safety risks associated with blood transfusion. The Trust have recognised new requirements following recent publications from NHS Improvement; Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy. These documents reflect considerable changes in previous approaches to governance and the Trust will need to consider new methodologies and processes in response to this.

Corporate Objectives	Improve Patient Safety
Measures of Success	At least 60% of unplanned critical care admissions from non-critical care wards, of patients aged 18 and over will: • have a NEWS2 score recorded, • have time of escalation recorded and • have time of clinical response recorded. At least 60% of patients scheduled to undergo elective major blood loss surgery are screened, and appropriately treated for, iron deficiency anaemia in line with NICE guidance. They will have: • A test to determine haemoglobin level • A follow on test to determine whether any low Hb is caused by iron deficiency (serum ferritin) • Where there is iron deficiency anaemia, the patient will receive oral or intravenous iron therapy in line with clinical guidance. • Governance policies will have been adapted to reflect the new requirements of these documents and develop new processes accordingly. The Trust will develop a Patient Safety Incident Response Plan in accordance with Patient Safety Incident Response Framework (PSIRF) • New governance structures which have been developed and incorporated into the new clinical service lines so as to ensure compliance with governance requirements. • The Trust will monitor compliance with all new processes introduced via the newly established Clinical Quality Operations Board
Monitoring Committee	Trust Quality Committee
Corporate Objectives	Improve Patient experience
Quality Priorities	• Some areas of discharge process can be improved to provide a better patient experience • Programme to support patient safety and experience including – improve learning from incidents, claims and complaints, – support Just Culture • Implement requirements of Smoke Free Hospital
Rationale	This work will continue to build upon work started in 2019/20 to improve discharge planning and implementation for patients. Over 2019/20, there was a reduction in the number of complaints and concerns around discharge but a number of work streams had been identified and need further work to embed improvements. Furthermore, changes to the Trust structure, afforded by the merger, means that there is opportunity to expand upon the work cross-site. The Trust have recognised new requirements following recent publications from NHS Improvement; Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy. These documents reflect considerable changes in previous approaches to governance and the Trust will need to consider new methodologies and processes in response to this. Providing smoke free hospital grounds imparts a clear message to all in society that smoking is harmful to health and provides an environment conducive with quitting. Quitting is not easy and a full package of supportive measures is planned to ensure that patients, staff and visitors are supported to quit or abstain whilst on hospital premises. Cleaner air and a reduction in litter caused by smoking will lead to a more pleasant environment for all people who work in and visit our hospitals.

Corporate Objectives	Improve Patient experience
Measures of Success	• Increase the number of wards using the Reason to Reside categories at board rounds. • Devise and pilot audit criteria for essential discharge communication to patients, families and care providers • Measure and improve the time from decision to discharge until time the patients leave the wards • Reduction in issues related to discharge medication. • New governance structures will have been developed and incorporated into the new clinical service lines so as to ensure maximum learning from patient experience information. • Existing policies will have been adapted cross-site to reflect the new requirements of national documents and develop new processes accordingly. • After Action Review will have been implemented and used to support learning from incidents which impact on patient experience. • The hospital sites are clearly signposted as being smoke free sites. • People who are found to be smoking onsite are actively asked not to smoke onsite with information on how to quit being offered to them. • Referrals to stop smoking services for inpatients increase by 100%. • Nicotine replacement prescriptions increase by 50%. • Staff will not be seen smoking either onsite, or whilst wearing uniform or lanyard even whilst off-site.
Monitoring Committee	Trust Quality Committee
Corporate Objectives	Prevent ill health
Quality Priorities	• Appropriate antibiotic prescribing for UTI in adults aged 16+ • Cirrhosis and fibrosis tests for alcohol dependent patients • Staff flu vaccinations
Rationale	There is established NICE and PHE guidance for appropriate diagnosis and management of UTI. Improving diagnosis and treatment will reduce treatment failure, risk of healthcare associated bacteraemia and reduce associated length of stay. In 2016/17, more than 50,000 liver admissions nationally were unplanned and avoidable. Improved cirrhosis testing will increase the number of liver disease diagnoses, the aim of which is to change patient behaviour in time for more effective treatment and better prospects of recovering supporting a reduction in the burden that liver disease places on the NHS. Staff flu vaccines are crucial for reducing the spread of flu during winter months, with a significant impact on the health of patients, staff, their families and the overall safe running of NHS services.
Measures of Success	At least 60% of all antibiotic prescriptions for UTI in patients aged 16 and over, will meet NICE guidance for diagnosis and treatment. At least 35% of inpatients with a diagnosis of alcohol dependence will have a referral for a test to diagnose cirrhosis or advanced liver fibrosis. At least 90% of frontline staff with patient contact receive a flu vaccination.
Monitoring Committee	Trust Quality Committee



Statements of Assurance from the Board

3.1 Review of services

During 2019/20 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services.

We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes.

The Board of Directors considers performance reports quarterly including progress against national quality and performance targets. The Board also receives reports from its Clinical Outcomes, Safety and Quality subcommittee.

The income generated by the relevant health services reviewed during 2019/20 represents 100% of the total income generated from the provision of relevant health services by the Luton and Dunstable University Hospital NHS Foundation Trust.

3.2 Participation in Clinical Audits and National Confidential Enquiries

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

We are committed to participating in relevant national audits and national confidential enquiries to help assess quality of healthcare nationally and to make improvements in safety and effectiveness.

During 2019/20, we took part in 40 national clinical audits and three national confidential enquiries. By doing so we participated in 95% of national clinical audits and 100% of national confidential enquiries in which we were eligible to participate.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2019/20 are shown in the tables below. The information provided also includes the percentage of cases submitted as required by the terms of that audit or enquiry. In many cases, where a number of cases for submission is specified, the Trust has submitted more than the number required and so these audits are shown below as having submitted >100%. For some audits, the number is not confirmed until later in the year or the audit is still in progress.

No.	Audit (A-Z by project name)	LDH eligible	LDH participation	Percentage of cases submitted
1	Assessing Cognitive Impairment in Older People: Care in Emergency Departments	Yes	Yes	>100%
2	BAUS Urology Audits - Female Stress Urinary Incontinence Audit	Yes	Yes	Study in progress – figures not confirmed until audit report
3	BAUS Urology Audits - Radical Prostatectomy Audit	No	Not applicable (N/A)	Not applicable (N/A)
4	BAUS Urology Audits - Cystectomy	No	N/A	N/A
5	BAUS Urology Audits - Nephrectomy Audit	Yes	Yes	25 cases submitted - Study in progress – figures not confirmed until audit report
6	BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	Study in progress – figures not confirmed until audit report
7	Care of Children (Care in Emergency Departments)	Yes	Yes	>100%
8	Case Mix Programme (CMP)	Yes	Yes	>100%
9	Child Health Clinical Outcome Review Programme	No	N/A	N/A

No.	Audit (A-Z by project name)	LDH eligible	LDH participation	Percentage of cases submitted
10	Elective Surgery – National PROMs Programme	Yes	Yes	Continuous data collection
11	Endocrine and Thyroid National Audit	Yes	Yes	Continuous data collection
12	Falls and Fragility Fractures Audit programme - Fracture Liaison Service Database	No	N/A	N/A
13	Falls and Fragility Fractures Audit programme - National Audit Inpatient Falls	Yes	Yes	>100%
14	Falls and Fragility Fractures Audit programme - National Hip Fracture Database	Yes	Yes	100%
15	Falls and Fragility Fractures Audit programme – Fracture Liaison Service Database / Vertebral Fracture Sprint Audit	No	N/A	N/A
16	Inflammatory Bowel Disease (IBD) Audit	Yes	Yes	*40-50%
17	Major Trauma Audit & Research Network (TARN)	Yes	Yes	72%
18	Mandatory surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	100%
19	Maternal, New-born and Infant Clinical Outcome Review Programme (Perinatal Mortality Surveillance (reports annually)	Yes	Yes	100%
20	Medical and Surgical Clinical Outcome Review Programme	Yes	Yes	4
21	Mental Health (Care in Emergency Departments)	Yes	Yes	>100%
22	Mental health care pathway CYP urgent and emergency mental health care and intensive programme	No	N/A	N/A
23	Mental health clinical outcome review programme	No	N/A	N/A
24	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Yes	833 cases submitted: Study in progress – figures not confirmed until audit report
25	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary rehabilitation- organisational and clinical audit	Yes	Yes	100%
26	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Yes	Yes	*233 cases submitted
27	National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	100%
28	National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	100%
29	National audit of care at the end of life (NACEL)	Yes	Yes	100%
30	National Audit of Dementia (care in general hospitals) - Dementia care in general hospitals	Yes	Yes	>100%

No.	Audit (A-Z by project name)	LDH eligible	LDH participation	Percentage of cases submitted
31	National Audit of Pulmonary Hypertension (NAPH)	No	N/A	N/A
32	National Audit of Seizure management in Hospitals (NASH) - Emergency Departments	Yes	Yes	100%
33	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	**0%
34	National Bariatric Surgery Registry	Yes	Yes	100%
35	National Cardiac Arrest audit (NCAA)	Yes	Yes	100%
36	National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	Continuous data submission
37	National Cardiac Audit Programme (NCAP) - Myocardial Ischemia National Audit Project (MINAP)	Yes	Yes	572 cases submitted (no target)
38	National Cardiac Audit Programme (NCAP) – National Adult Cardiac Surgery Audit	No	N/A	N/A
39	National Cardiac Audit Programme (NCAP) – National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	336 cases submitted Continuous data submission
40	National Cardiac Audit Programme (NCAP) -National Heart Failure Audit	Yes	Yes	78%
41	National Cardiac Audit Programme (NCAP) – National congenital Heart Disease (CHD)	No	N/A	N/A
42	National Clinical Audit of Anxiety and Depression (NCAAD)	No	N/A	N/A
43	National audit of Psychosis	No	N/A	N/A
44	National Diabetes Audit - Adults National Foot Care Audit	No	N/A	N/A
45	National Diabetes Audit - Pregnancy	Yes	Yes	100%
46	National Diabetes Inpatient Audit (NaDIA) -reporting data on services in England and Wales	Yes	Yes	100%
47	National Diabetes Audit – Adults - NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	Yes	100%
48	National Diabetes Audit – Adults - National Core Diabetes Audit	Yes	Yes	100%
49	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	31%
50	National Emergency Laparotomy Audit (NELA)	Yes	Yes	92%
51	National Gastro-intestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)	Yes	Yes	Continuous data submission
52	National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit	Yes	Yes	Continuous data submission
53	National Joint Registry (NJR)	Yes	Yes	100%

No.	Audit (A-Z by project name)	LDH eligible	LDH participation	Percentage of cases submitted
54	National Lung Cancer Audit (NLCA)	Yes	Yes	100%
55	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
56	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
57	National Ophthalmology Audit (NOD) - Adult Cataract surgery	Yes	No	Our IT systems are incompatible with the audit supplier's requirements
58	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
59	National Prostate Cancer Audit	Yes	Yes	100%
60	National Smoking Cessation Audit 2019	Yes	No	Participation in national CQUIN instead
61	National Vascular registry	No	N/A	N/A
62	Neurosurgical National audit programme	No	N/A	N/A
63	Paediatric Intensive Care Audit Network (PICANet)	No	N/A	N/A
64	Perioperative Quality Improvement Programme (PQIP)	Yes	No	Some elements not in place so no information to audit
65	Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A
66	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	100%
67	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	99.9%
68	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	Yes	100%
69	Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	100%
70	Surgical Site Infection Surveillance	Yes	Yes	>100%
71	UK Cystic Fibrosis Registry	No	N/A	N/A
72	UK Parkinson's Audit – Neurology	Yes	Yes	>100%
73	UK Parkinson's Audit – Speech and language therapy	Yes	Yes	>100%
74	UK Parkinson's Audit – Elderly Medicine	Yes	Yes	>100%

*due to the complexity of the information to ascertain the full sample, it is not possible to determine the % case ascertainment without undue resource implications.
**partial data was submitted for all cases, but resource to complete the submission was unavailable due to the amount of data required.

Participation in national confidential enquiries 2019/20

Topic	Cases submitted
Acute bowel obstruction	4
Dysphagia	4 (this study is still open at the time of reporting)
Out of hospital cardiac arrest	7

National clinical audits

The reports of 23 national clinical audits published were reviewed during 2019/20 and the following provides an overview of the actions that have been, or are being, put in place to improve the quality of the healthcare we provide.

Specialty	Project Title	Quality Improvements
Acute Stroke	Sentinel Stroke National Audit programme	The Trust achieved an overall 'A' grading for the first time. Improvements included the addition to the MDT of a stroke pathway coordinator and achieving Thrombolysis within 1 hour.
Breast surgery	Impact of geriatric liaison service for breast cancer patients	Holistic evaluation of older breast cancer patients identifies high risk, frail patients, provides valuable input with regard to treatment decisions and results in additional targeted input from other specialities. Longer follow up is required to assess the impact of the co-ordinated care on patient outcomes.
Cardiology	National Heart Failure Audit	Improvements identified include introducing a specific blood test to rule out heart failure for patients presenting with heart failure symptoms with no previous diagnosis. This blood test would help identify patients needing review by specialist team and improve the quality of diagnosis and treatment.
Obstetrics	National Diabetes audit (Adults) - National Pregnancy in Diabetes Audit	Raising awareness of referral for preconception care and counselling to the joint antenatal clinic in primary care through CCG diabetes implementation groups, networks and practice nurses. Have the pump team receive additional training in pregnancy management and to increase contact with pregnant patients in order to maintain tighter glycaemic control. Change practice to weekly face to face reviews and increase joint diabetes clinic follow up for mothers with type 2 diabetes mellitus in the second trimester for women with a high blood sugar. Improve pre-conception awareness for Folic acid preconception care in liaison with primary care teams and General Practitioners. The diabetes antenatal team will focus on type 1 diabetes mellitus pregnant women in their 3rd trimester, use flash glucose monitoring and continuous glucose monitoring to improve blood glucose management.
Neonates	National Neonatal Audit Programme - Neonatal Intensive and Special Care	Introduction of probiotics, early breast milk expression and earlier introduction of breast milk to the baby; reduce transfusions by introducing delayed cord clamping.
Neurology	UK Parkinson's Audit	Plans are underway to employ a Parkinsons Disease nurse working across acute and community servicesww

Specialty	Project Title	Quality Improvements
Paediatrics	National Audit of Seizures and Epilepsies in Children and Young People - Epilepsy12	Epilepsy medication and basic life support workshops are held twice a year for the families and carers of children prescribed rescue medication for prolonged seizures. During the workshops current information is provided about rescue medication, refresher training is given along with basic life support training.
	British Thoracic Society Paediatric Pneumonia Audit	The development of a local guideline for community acquired pneumonia guideline which embeds the British Thoracic Society care bundle.
	National Paediatric Diabetes Audit	Improvements required Addressing the low percentage (LDH 25.7% vs. national 49.8%) of children over 12yrs completing all 7 care processes. From July 2019 we began checking and documenting the completion of care processes at each clinic visit To improve blood glucose control (31.7% children with high blood sugars) from July 2019 we strategically began offering to this cohort and their families additional educational sessions and intensive input with 2 weekly PDSN led clinics.
Respiratory	Improving the diagnostic accuracy of COPD	Main issue identified was a lack of spirometry evidence in patient records to support a diagnosis of COPD. The accuracy of COPD diagnosis can be improved by regular focused teaching sessions and creation of a ward proforma.
	COPD - pulmonary rehabilitation	We are in talks with our commissioners with a view to expanding the service in order to meet increased demands.
	National Lung Cancer Audit (NLCA)	The respiratory team have been engaging with local GPs and other primary care professionals to increase the numbers of early referrals. We have also been selected as one of the pilot sites for the national Lung Health Check programme, which will offer CT scanning to selected individuals within the population at high risk of lung cancer. The aim is to increase the proportion of cases detected at an earlier, more treatable, stage. We have continued to optimise our Lung Pathway in line with the National Optimal Lung Cancer Pathway by switching to twice-weekly Lung cancer clinics and will shortly be introducing diagnostic MDTs as part of the clinics. We are also reviewing the accuracy of performance score data collection. We are also continuing to take steps to speed up the diagnostic pathway, and remain up to date with introduction of new molecular treatments via Oncology.
T&O	Surgical Site infection Audit Trauma & Orthopaedics	Surgical Site Infections reduced from 6.3% (2015) to 0% (2019). An Urgent Review Pathway was established including access for urgent consultant review. Education of Junior Doctors seek senior review when they suspect infection rather than starting antibiotics.. Protocol for urgent outpatient reviews days a week with lower limb surgeons covering for each other's patients. Patient education and designated phone number to call 24/7 rather than calling their GP if they suspect wound infection. Monthly meeting of the lower Limb Arthroplasty group to discuss and deal with any issues.

Local Clinical Audits

Specialty	Project Title	Quality Improvements and actions required to improve quality of care
Accident and Emergency	An alternative, safe and efficacious inhalational analgesia for an overcrowded Emergency Department	Penthrox analgesia was introduced for immediate pain relief in moderate to severe trauma pain and has been hugely beneficial to patients and staff. Fewer patients require procedural sedation and can continue analgesia during transfers to imaging or while waiting for doctors to decide a plan. It has made reduction of joints relatively pain free as an ancillary benefit and has surpassed the expectations of many clinicians who were initially sceptical about using this drug.
Anaesthetics	Lanyard Cards to Improve Access to Anaesthetic Information in Emergencies	Lanyard cards provide reassurance at times of stress and fatigue to ensure the correct and safe management of an acutely unwell patient with surprisingly a reluctance to have the data in a digital format. Furthermore, operating department practitioners, who were not the primary recipients of the cards, have found them extremely helpful in their practice.
Anaesthetics	Pre-Operative Screening for and Monitoring of Diabetes – a snapshot audit of a new process	Improvement of adherence to guidelines in all areas by feedback and education of staff. Dissemination of detailed information in letters, leaflets and posters available from Pre-assessment.
Breast Surgery	Evaluation of a New Mainstreaming BRCA testing service for Breast Patients at Luton & Dunstable Hospital	Time scales from referral to test and test to result were improved with the new service. All results were available in time to allow individualised patient treatment.
Cardiology	Temporary Trans venous Pacemakers (TTP)	A review of the complication rates for TTP led to recommendations including prioritising primary permanent pacemaker and use of Isoprenaline and Atropine where appropriate – instead of a temporary pacemaker. A new proforma for post TTP care has been introduced as well as changing the size of TTP wires.
Colorectal	Role of pus microscopy, culture and sensitivity testing (MC+ S) in management of abscesses	A more selective approach to obtaining pus samples for patients, only when it is believed that it would aid clinical management, has led to a reduction in costs associated with blanket testing. Standardization of Prescription of post-operative antibiotics.

Specialty	Project Title	Quality Improvements and actions required to improve quality of care
Dermatology	A prospective comparison of store and forward (SAF) tele dermatology, using an innovative digital web based platform, with traditional face to face (FTF) assessment for two week wait (2WW) referrals	Tele dermatology (TD) platform developed to manage in-patient ward referrals. Increased efficiency of seeing 2WW referrals whilst maintaining comparable (and superior) performance compared to traditional clinic workflow, i.e. face to face. Adhering to national skin cancer targets. Tele dermatology has comparable diagnostic accuracy with face to face assessment for 2 week wait referrals – 66% concordance (face to face 62.5% concordance). Cost savings in locum staffing (~£120k/pa) by substituting TD clinic with locum consultant 2WW. Dermatology team have demonstrated that a high quality digital tele-dermoscopy system saves Consultant time and reduces costs.
Diabetes	Diabetes In reaching Project	Diabetes in-reach has been extended to cover weekends, emergency assessment unit and acute wards. This had contributed to reduced length of stay for diabetic patients. Self-administration of insulin allows patients to manage their insulin on the ward. Further improvements included Mandatory 'Safe Use of Insulin' e-learning on ESR (May 2019).
ENT	Prospective Audit of Balloon Eustachian Tuboplasty (ENT Department)	We were able to offer a safe operative procedure to a group of adult patients with long standing Eustachian dysfunction. This has resulted in significant improvement in their symptoms that otherwise had no hope of improvement with conventional treatment strategies e.g. decongestants, Valsalva maneuver and repeated grommet insertions.
Neonates	New-born and Infant Physical examination (NIPE)	A web based system was introduced in July 2016to ensure no babies were missed. Our performance is above that expected which is 95%. NICU babies are sometimes too sick or preterm to complete the examination and consequently some being discharged home without a complete NIPE. It is compulsory to have the NIPE form printed prior to discharge and the NIPE lead chases up any misses so that the person discharging the baby is fed back personally. We review the data on a monthly basis.
Neurology	Audit of Botox clinic for headache	New service set up, initially there were issues with equipment, and solution was an equipment trolley which was implemented. This is a growing service with patients returning every 3 months. Additional nurse is being trained to provide enough capacity for the service.

Specialty	Project Title	Quality Improvements and actions required to improve quality of care
Obstetrics	Accelerating the recognition and initiation of interventions to mothers with Post-Partum Haemorrhage (PPH) at LDH	A Quality Improvement group for PPH commenced August 2019 since when there has been a reduction in PPH rates from 3.9% (May 2019) to 2.9% (Dec 2019). Introduction of a PPH risk assessment during antenatal care and on admission to labour. PPH packs have been introduced which are taken into rooms of mothers assessed to be high risk for PPH. A PPH medication box has been introduced to reduce time between recognition of PPH and intervention. Weighing scales purchased to assess blood loss on absorbent pads. Pouch drapes to capture blood loss and enable accurate visual assessment of blood volume losses. A blood warmer and blankets have been purchased to aid patient recovery during/after PPH. Evaluation of PPH patients logged onto Datix, to identify particular characteristics amongst local population predictive of PPH. Raising awareness about PPH and keeping patient warm through her labour and postnatal period. To reduce induction of labour and our operative vaginal delivery rates, advocate that more women give birth by spontaneous vaginal delivery
OMFS	Evaluation into the effectiveness of diagnostic and therapeutic Sialoendoscopy within an OMFS Department	Sialoendoscopy procedure is effective at providing the relief of obstructive sialadenitis whilst maintaining salivary function. The overall success rate as measured by relief symptoms was 94.4%.As a result patient quality questionnaire is used routinely.
Rheumatology	Nurse led osteoporosis service	An innovative osteoporosis service with patients consulting a metabolic bone Clinical Nurse Specialist (CNS) with remote oversight by a Consultant. Eliminating consultant appointments and reducing hospital visits by using telephone triage and consultation. A dedicated proforma was developed for triage and history taking. Patient review in virtual MDT meeting between Consultant and CNS. Treatment plan is reaffirmed using safety checklist. 60 patients triaged resulting in improved median referral-to-treatment by 12 weeks and brought forward treatment starts from 84 to 38 days.
Sexual health	Audit of testing for hepatitis B and C in Luton Sexual Health	Since the previous audit in 2017 improvements have been identified as follows: • Testing according to standards for hepatitis B has increased from 62% to 90% • Testing according to standards for hepatitis C has increased from 50% to 100% Improvements: Clinic proformas and displaying testing criteria around the clinic acted as an aide memoire. Clients who are diagnosed with hepatitis B and/or C are referred directly to the hepatology team, when they can access monitoring and treatment to reduce their risk of potentially life threatening complications.

Specialty	Project Title	Quality Improvements and actions required to improve quality of care
Urology	Assessing quality of TURBT service(Audit & Re-audit)	The introduction of an in-theatre Mitomicin policy drastically improved both the rates of single post-op Mitomicin and the time to instillation. Improvement was seen in the 14 day referral to review time, with the introduction of a dedicated Urology One-stop for outpatient, improving from 60% to 79%.
Urology	Validity of Precision Point Biopsy Technique	Good cancer detection rate 65% with no complications. Cost efficient as it can be performed under local anaesthetic in Outpatients. Cancer detection rate in precision point biopsy are comparable to TTPB and TRUS biopsy and complications are minimized

3.3 Participation in Research

Participation in clinical research demonstrates the Luton and Dunstable University Hospital's commitment to improve the quality of care we offer and to make a contribution to wider health improvement. Our clinical staff keep up-to-date with the latest treatment possibilities and active participation in research leads to improved patient outcomes

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2019/20 and who were recruited during that period to participate in research approved by a Research Ethics Committee was 728.
This research can be broken down into 161 research studies (144 Portfolio and 17 Non-Portfolio).

3.4 Commissioning for Quality and Innovation payment framework (CQuIN)

Commissioning for Quality and Innovation (CQuIN) is a framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. The CQuIN schemes for 2019/20 highlighted evidence based practice that was already being rolled out across the country, allowing the benefits to be spread more rapidly. This was a new approach to CQuINs, prioritising simplicity and deliverability.

For 2019/20 our CQuIN targets were worth £3.6million, and for our main commissioners we achieved 95% of this. The chart below shows which CQuIN schemes we participated in, which included all the relevant national schemes and the two specialised services schemes which were relevant.

No	Scheme sub-part title	Key outcomes
1a	AMR - Lower Urinary Tract infection in older people	90% of antibiotic prescriptions for lower UTI in older people, meets NICE guidance NG109 and PHE diagnosis guidance (60-90%)
1b	AMR - antibiotic prophylaxis in colorectal surgery	90% antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose prescribed in accordance to local antibiotic guidelines - using NICE CG74 (60-90%)
2	Staff Flu Vaccinations	80% uptake of flu vaccine by frontline clinical staff between 1st Sept-28th Feb 2020 (60-80-%)
3a	Alcohol and Tobacco Screening	80% of inpatients (age 18+) admitted for at least 1 night who are screened for BOTH alcohol and tobacco (40-80%)
3b	Tobacco Brief Advice	90% smokers given brief advice including offer of NRT (50-90%)
3c	Alcohol Brief Advice	90% pts identified as drinking above low risk levels, given brief advice or specialist referral (50-90%)

4	Three high impact actions to prevent Hospital Falls (25%-80%)	80% of inpatients (age 65+, admitted for 48hrs+) receiving key falls prevention actions: Lying and standing BP at least once; no hypnotics/antipsychotics/ anxiolytics OR documented rationale; mobility assessment within 24hrs of admission to inpatient unit which states aid not required or the walking aid is provided within 24hrs of admission
5a	Same Day Emergency Care - PE	75% patients with confirmed PE are managed in same day setting where clinically appropriate - NICE CG144 (50-75%)
5b	Same Day Emergency Care - Tachycardia with AF	75% patients with confirmed AF are managed in same day setting where clinically appropriate - NICE CG180 (50-75%)
5c	Same Day Emergency Care - Community Acquired Pneumonia	75% patients with confirmed CAP are managed in same day setting where clinically appropriate - NICE CG191 (50-75%)
	Specialised Services Scheme	TARN data submissions
	Specialised Services Scheme	Participation in specialist services networks

Whilst NHS England has suspended the CQuIN schemes for 2020/21 due to the COVID-19 pandemic, it is the intention of the Trust to continue with those quality improvement projects. As such, they have been included in our Trust's Quality Priorities for 2020/21.

3.5 Care Quality Commission Registration (CQC)

The Luton and Dunstable University Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is **'Registered without conditions or restrictions'**.

The CQC has not taken enforcement action against Luton and Dunstable NHS Foundation Trust during 2019/20.

The Trust's services were assessed by the CQC in December 2018, and we were pleased to achieve an overall rating of **'Good'**.

During the year, we have implemented the action plan developed following our last CQC inspection and this has been signed off at our Quality Committee.

3.6 Data Quality

The accuracy and completeness of the data we use to support the delivery of high quality care is of the utmost importance to the Trust. The Trust has been making progress with data quality during the year 2019/20 and there are many processes carried out by the Information Team, which identify data quality issues.

Listed below are a few of the processes that are either carried out on a routine or ad hoc basis by the Department:

- Data accuracy checks: (Assertion 1.7.2) - Data Quality metrics and reports are used to assess and improve data quality.
- Completeness and Validity checks: (Previously IG Standard 507) – The IG Toolkit changed 2018 and we therefore no longer require this check, however we are monitoring Data dictionary items for Outpatient, Inpatient and ED on a monthly basis as part of our Data Quality Improvement Plan (DQIP)
- CCG challenges: Investigation, resolution\rejection and monitoring of issues highlighted to us by the CCGs
- Monthly and weekly data quality reports for key Departments i.e. Emergency, Outpatients, Wards, Theatres
- Benchmarking analysis: SUS+ dashboards, Data Quality Improvement Plan

During 2019/20 we have taken the following actions to improve data quality:

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

visibility of any data quality problems and expanded our contacts within the departments.
- Continued to work with Commissioners to monitor and improve data quality pro-actively in key areas.

Action Plan for 2020/21Data Quality Improvement as a result of Benchmarking and Trend Analysis

1) Information Governance
- **Data Quality Accuracy Checks –** ensure sufficient checks take place to assure compliance.

2) CCGs Challenges
- Continue to work with Outpatients, IT & Divisions to improve other areas of known data issues (Admission Method vs A&E Attendance)
- Continue to communicate with users the importance of recording the current GP at time of activity
- Continue to improve the NHS Number coverage
- Continue to monitor Multiple Firsts and highlight areas that are consistently creating first appointments
- Monitor the additional 19/20 DQIP metrics and ensure improvements made are reflected in reporting
  - Non pre-booked outpatient attendances
  - Non pre-booked day cases
  - Incorrect emergency admission method

3) Outpatients
- Continue to produce weekly and monthly reports identifying patients with an attendance status of 'not specified'. Also work with Outpatients, IT and Divisions to reiterate the importance and financial impact of not recording information accurately. Areas to be included:
  - Outcome of Appointments – DNA's to be included
- Resume regular Outpatient Data Quality meetings to highlight main Data Quality issues in this area
- Present Data Quality awareness seminars within the main areas registering patients and referrals
- Jan 2020 Finance received possible loss of 800K for Circle patients – missing URN. Run regular reports to highlight patients where we believe a URN should be entered

4) Inpatients
- Continue to work with General Managers, Ward Managers and Ward Clerks to improve the data that is entered and identify good working processes for the following areas
  - SAU – Admissions and Ward outpatient/Attenders
  - Hospital at Home/Nerve Centre: No transfers in or out of Virtual wards
  - Base wards to EAU: No transfers from base to assessment wards ex.ACC
  - Postnatal Admissions with single live birth coding
  - NICU overlapping dates and times
  - Non Consultant Admissions extension of the On-Call

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

6) Theatres
- This is an area which has been particularly difficult to engage. Historically, when DQ reports have been circulated, there is lack of ownership and interest from the department.
- We need to identify the best route to ensure senior management are supporting DQ in this area.

7) Referrals
- Continue to send referrals reports to users to rectify the referral source
- Report on referrals created more than 2 weeks after the date received for specific areas: Cardiology Tests: this issue was picked up via the SQPR process when refreshing previous months.
- Present Data Quality awareness seminars within the main areas registering patients and referrals

8) Patient Demographics
- Continue to monitor and update Invalid Postcodes, GP Details and missing NHS numbers
- Highlight the importance of patient registrations, QAS, NHS number and GP details in DQ meetings
- Present Data Quality awareness seminars within the main areas registering patients and referrals

9) A&E
- Continue to improve the NHS Number coverage: This is challenging for out of area patients.
- Continue to attend ED system review meetings, to voice Data Quality issues with department and IT

10) SUS+ dashboards
- Continue to monitor our compliance again national averages and react accordingly
- Ensure regular reports are in place to support national requirements \ targets

3.7 NHS Number and General Medical Practice Code Validity

Luton and Dunstable submitted records during the reporting period 2019/20 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 99.6% for admitted patient care increase of 0.3%
  - 99.8% for outpatient care
  - 97.8% for accident and emergency care increase of 0.8%
- Which included the patients valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for accident and emergency care

3.8 Clinical Coding Error rate

Luton and Dunstable was not subject to a Payment by Results clinical coding audit during the reporting period April 2019 – March 2020 and the error rates reported in the latest published audit for that period for diagnosis and treatment coding were 92.50% and 95.1%.

3.9 Data Security and Protection Toolkit (DSPT) Attainment levels

Luton and Dunstable University Hospital NHS Foundation Trust will be publishing an assessment on the 31st March 2020

To achieve Standards met compliance The Trust must meet the requirements of all assertions.

Four extra requirements have been added to the DSPT and the Trust's current position is: Standards not met

- 108 of 116 mandatory evidence items provided
- 32 of 44 assertions confirmed

The figures above will rise significantly before the March 31st Deadline however this will not change The Trusts position.

As part of the Internal Audit plan, PWC is performing a review of the DSP Toolkit. The audit is focusing on a limited number of areas from the Toolkit to assess the adequacy of evidence of compliance.

IG Incident Reporting Tool

The DSP Toolkit also incorporates an IG Incident Reporting Tool which the Trust is required to use for reporting IG incidents. Under GDPR serious IG breaches (defined as incidents that are highly likely, to have an impact on the 'rights and freedoms' of the individuals concerned), MUST be reported to the ICO within 72 hours of the Trust becoming aware of the incident. Once information about an incident has been submitted through the tool the details are automatically fed to the ICO unless the tool decides from the information provided that it is not a reportable incident.

There have been 4 reported incidents (using this tool) for the last quarter. None of the incidents required further input from the ICO

3.10 Learning from Deaths 2019/20

During 2019/20 1,162 of Luton and Dunstable NHS Foundation Trust patients died (of which 37 were neonatal, stillbirths or maternal, 7 were children under 16 years old; 8 were patients with Learning Disabilities). The following number of deaths occurred in each quarter of 2019/20:

Table showing numbers of deaths by quarter of 2019/20

Quarter	Deaths
Q1	285
Q2	257
Q3	282
Q4	338
Total	**1,162**

Cases are selected for review according to the Trust Learning from Deaths policy which is based on national guidance.

By March 2020, 345 primary reviews and 38 structured judgement reviews (SJR) were carried out in relation to the deaths included above.

The number of deaths in each quarter for which a primary review or a structured judgement review (SJR) was carried out is shown in the table below. The primary review of notes of deceased patients has previously been undertaken by a small group of clinicians in their own time. As winter pressures developed in early 2019, and persisted in an unprecedented way throughout the summer of 2019, the amount of time individuals were able to commit to this fell, and consequently, the numbers of cases reviewed fell in comparison to the previous year.

Table: number of deaths in each quarter for which a primary review or SJR was completed

Quarter	Deaths	Primary review	SJR requested	SJR completed
1	285	94	33	25
2	257	68	14	10
3	282	29	10	2
4	338	154	9	1
Total	**1,162**	**345**	**66**	**38**

From January 2020, the Trust introduced a Medical Examiner system, in line with national guidance. Six of the ten posts have been recruited to, so we have been able to partially implement the scheme. There is already a significant increase in the numbers of cases being reviewed, and we are now much more confident of the accuracy of the cause of death, with difficult cases being discussed with the Medical Examiners before medical certificates of cause of death are issued. The new process is also helping to improve the turnaround of cases referred to the Coroner, by providing independent scrutiny of the medical notes, and the opportunity to educate junior medical staff on the correct way to complete the Medical Certificate of Cause of Death. A meeting with local community and faith leaders to introduce and explain the medical examiners system, and their role, was held in January 2020, with active participation from all groups. Our aim is to provide a service which meets the educational and improvement goals of the healthcare system, while at the same time, providing a responsive and accessible service for bereaved families.

Two death(s) representing 0.17% per cent of the patient deaths during the reporting period are judged more likely than not to have been due to problems in care. In relation to each quarter, this is as follows:

Table of deaths judged more likely than not to have been due to problems in the care provided to the patient

Number and percentage of patient deaths in each quarter that are judged to be more likely than not to have been due to problems in the care provided to the patient.

Quarter		
Q1	0	0%
Q2	0	0%
Q3	1	0.35%
Q4	1	0.29%

These numbers have been estimated using the Royal College of Physicians (RCP) structured judgement review (SJR) method, serious incident investigation process, the perinatal mortality review tool (PMRT), child death overview process (CDOP) or the LeDeR (Learning Disabilities Mortality Review) programme.

Complex Case Reviews for Potentially Avoidable Deaths 2019/20

Q1	One case reviewed by Medical Directors after SJR suggested a possible avoidable death. Subsequent review identified that care provided was appropriate, and death was not avoidable. Case discussed at Medical Governance meeting for education purposes to provide guidance to consultants on avoidability scoring in SJR's.
	A second case discussed where failure to follow dietician's advice on patient's fluid management and use of thickened fluids may have contributed to aspiration pneumonia. Review concluded that patient was continually aspirating, and non-observation of the thickened fluids recommendation had not substantially altered the outcome.
Q2	One case discussed at Post Event Action Review for Learning (PEARL) panel relating to possible delayed diagnosis of gallbladder empyema. Medically complex patient, with issues identified in transfer documentation received from another hospital (50 page discharge letter, concealing one important medical fact, which may have contributed to the patient's death) – this was fed back to the transferring hospital, who agreed to review their discharge documentation. We have also reviewed our discharge documentation to ensure that important aspects of the admission are appropriately highlighted. This case was classed as potentially avoidable by the Trust, even though the Coroner's Inquest returned a narrative verdict.
Q3	One case discussed at PEARL panel in January 2020. In this case, insertion of a chest drain, which was later deemed un-necessary, may have contributed to the death of a patient with Chronic Obstructive Pulmonary Disease. Following this case, it was agreed that where not clinically urgent, chest drain insertion should in future be deferred until the following day if CT is required to confirm a pneumothorax prior to drain insertion. If clinically urgent and time permits, the CT scan should be requested urgently and performed before drain insertion.

	A second case was identified by primary mortality review, and escalated to a PEARL panel, who felt this may have been a potentially avoidable death. The subsequent Serious Incident investigation concluded that despite areas identified for improvement, particularly around communication, the death was probably unavoidable.
Q4	One case reviewed at PEARL panel relating to multiple falls in a patient with learning difficulties and an intracranial tumour, who died as a result of haemorrhage from the tumour. It was declared as a Serious Incident and investigated. The investigation found it impossible to determine whether the bleed from the tumour had caused the falls, or the falls had caused the bleeding. Multiple opportunities for improvement and learning were identified in the report, which have been shared through appropriate channels, and monitored by the Medical Divisional governance team.
	A second case, where fluid management, inadequate monitoring of blood tests and their results, and venous thromboembolism (VTE) prophylaxis were found to have been sub-optimal, was agreed to have been a potentially avoidable death.

In summary, the Trust has reviewed seven potentially avoidable deaths, and has declared two of those deaths as likely to have been avoidable during 2019/20.

Learning Themes identified

Appropriate completion of Do Not Attempt Cardio-Pulmonary Resuscitation and Treatment Escalation Plan Orders remains an issue, with challenges from relatives (and in some cases from patients) becoming more numerous. It is far easier for clinicians to back down and not complete these important documents than to have the difficult conversations and do what they believe to be in the best interests of their patients. There needs to be additional training and senior support to enable staff to have these difficult conversations, and help patients and relatives to develop more realistic expectations related to healthcare, and to understand the concept of resuscitation and continuing medical treatment prolonging inevitable death, rather than prolonging meaningful life.

Services available to support the expedited discharge of patients who request to die at home are currently inadequate to enable timely fast track discharge to be achieved in many cases. Discharge instructions for patients nearing the end of their lives are not always followed and some patients approaching the natural end of their lives are inappropriately re-admitted to hospital. Improved support for these patients in the community is needed.

With continuing winter pressures affecting demand upon beds, we have seen an increase in the number of patients readmitted to hospital following failed discharges, some of whom go on to die in hospital. A specific review of these cases will be undertaken to objectively assess whether the decision to discharge was appropriate. And finally, it is recommended that a review of Venous Thrombo-Embolism (VTE) prophylaxis across primary and secondary care boundaries is undertaken in order to reduce VTE-related deaths in our communities.

Learning from deaths 2018/19

The final number of reviews for Quarter 4 of 2018/19 were: 68 primary reviews and 15 SJR's.

No deaths representing 0% of patient deaths during Q4 of 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the RCP SJR method, serious incident investigation process, PMRT, CDOP or the LeDeR programme.

Medical Examiner Service Update

The Medical Examiners have spent the majority of their time in April, May and June 2020 supporting the medical teams in managing the timely completion of Medical Certificates of Cause of Death and Cremation paperwork, which was mandated under the Coronavirus Act 2020 which became law on 1/4/2020. Their oversight role has therefore not been possible, and therefore has impacted on the reviews of patients who died in Quarter 4. From 13/7/20, ME oversight of deaths has recommenced. Like Bedford, we have not so far been able to recruit to capacity, but we plan to re-advertise in the next few weeks in an attempt to increase our numbers. While we remain short-handed, we are prioritising cases where early release of the body has been requested on religious grounds, cases which may or will require referral to the Coroner, deaths within 24 hours of admission, unexpected deaths, deaths where a cause cannot be offered by the clinical team, and cases where concerns about care have been raised by relatives or staff following a death.

We have continued our work with Datix on local configuration of the Datix Cloud IQ Mortality Review module, which is now in the final stages of development. We plan to test this on the Luton site before roll-out to Bedford Hospital. A final time line for this has not yet been agreed, as resources to complete the configurational changes internally from IT, and externally from Datix, are extremely stretched currently. In the meantime, we are working on a plan to integrate the mortality review process with the new service line structure which has been adopted as part of the merger, aiming to improve the governance oversight and clinical engagement in the Learning From Deaths agenda.

3.11 Seven Day Services Board Assurance Framework

NHS England committed in 2015 to providing a 7 day service across the NHS by 2020. The declared intention is that all in-patients admitted through Emergency and Urgent Care routes will have access to consistent and equal clinical services on each of the 7 days of the week, at the time of admission and throughout the stay in an acute hospital bed.

Ten standards have been set. Four of these are priority standards and are those most closely linked to the improvement in safety and efficiency and it is these four standards that the NHS expects to be in place for all Acute Trusts by 2020. These standards have been endorsed by the Academy of Royal Colleges

In Autumn 2019 our Trust repeated an assurance exercise, originally undertaken in early 2019, in respect to our compliance with the standards. This highlighted that improvements had been made but that further work was necessary to fully comply with the four high priority standards. The improvement work associated with meeting the standards was defined as one of our Quality Priorities for Improvement and we are presently undertaking a re-audit to evaluate our latest progress.

Standard 2	All emergency admissions must be seen by a Consultant within 14 hours of admission to hospital.	86% (target 90%)
Standard 5	Inpatients must have access to consultant-directed diagnostic services within specified timeframes 7 days a week	100%
Standard 6	Inpatients must have Consultant-directed interventions either on-site or through formally agreed networks, 24 hours a day, 7 days per week	100%
Standard 8	A) inpatients reviewed by Consultant once daily for 7 days per week (unless this would not affect the patent's pathway) B) Patients with high-dependency needs should be reviewed by a Consultant twice daily	A) 86% (target 90%) B) 100%

3.12 Freedom to Speak Up (FTSU) and Guardian

Being able to speak up at work is important for a number of reasons. It is inextricably linked with our Trust ethos and values and it is also vital because it can help us keep improving our services for all patients and the working environment of our staff.

We recognise that staff are often the first to identify problems within the hospital and we want to encourage hospital staff to come forward and raise their concerns. This will help make the Trust a more open and transparent place to work and make speaking up 'business as usual'.

The whole FTSU ethos is about helping the Trust to create a culture where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters relating to patient safety, the quality of care and cultures of bullying and harassment. To support this, managers need to feel comfortable having their decisions and authority challenged: speaking up should be embraced. Speaking up, and the matters that speaking up highlights, should be welcomed and seen as opportunities to learn.

The Trust has a well-established FTSP Guardian role. Our previous Guardian, Sarah Newby, left the L&D in August, 2019 and Clive Underwood, Lead Nurse in Theatres (previously a newly appointed Champion,) took over this role assisted by Phil Spencer and Melissa Damodaram as Champions. Melissa has left the trust and it is imperative for more champions to be recruited once the worst of COVID-19 pandemic has been resolved.

In regard to the importance of the Guardian role within our organisation:
The FTSU Guardians help:

- Protect patient safety and quality of care
- Improve the experience of staff
- Promote learning and improvement

By ensuring that:

- Staff are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

The values upheld by FTSP Guardians:

Courage- speaking truthfully and challenging appropriately

Impartiality- remaining objective and unbiased

Empathy- listening well and reacting with sensitivity

Learning- seeking and providing feedback and providing opportunities to improve.

FTSU Guardians operate independently, impartially and objectively, whilst working in partnership with groups and individuals throughout the organisation, including the senior leadership team.

They seek guidance and support from, and where appropriate escalate matters to, bodies outside the organisation. They support and contribute to the national FTSU network, comply with National Guardian Office Guidance and support each other by providing peer-to-peer support and sharing learning. They should also be supported (by the Trust) with the resources they need, including ring-fenced time, to ensure that they meet the needs of workers in their organisation.

There is also the responsibility of recording cases and reporting data quarterly to the national FTSU Guardian Office. The reporting provides a measure of the speaking up culture within the organisation and the use of the FTSU Guardian route. A quarterly report is also provided to the Trust Board.

Our staff are encouraged to raise any concerns they may have through their Line Manager in the first instance. If they feel uncomfortable about using this process, there is a 'Raising Concerns' page on the Trust's Intranet explaining the FTSU process, introducing the Guardian and Champion, contact details/links via email (dedicated email addresses) and Raising Concerns Policy. If staff want to raise a concern anonymously, there is a clearly defined process to be able to do this (download a form and post in confidence to the FTSU Guardian).

Once contact is made, the Guardian/Champion arranges a telephone or face-to-face conversation dependant on the wishes of the staff member, to sign-post where the concern should be escalated to.

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

There are other mechanisms of raising concerns such as through HR, with Occupational Health or with their trade union or professional association. L&D staff can also speak to a confidential advisor through the CiC Employee

Assistance programme. The National Staff Survey also has specific questions relating to raising concerns and being able to speak up.

To publicise the FTSU process and Guardian/Champion role, a series of staff engagement events took place in October 2019 to coincide with FTSU month. There was an information stand in the main staff cafeteria where staff were able to meet the Trust's Guardian and Champion and ask questions. Events (meeting with staff) were also held at the nearby Orthopaedic Hub and Arndale House in Luton. Separately to this, an 'Interview' with the FTSU Guardian was included in an issue of the Staff Involvement Group Newsletter to provide publicity for the FTSU process and Guardian role in the Trust.

The Trust's current policy is being updated in line with the recommendations from the National Guardian Office, NHS Improvement and NHS England. This will require joint agreement and partnership working with the JSMC and HR Departments. The new policy will reflect Trust values and make processes much more clear to staff. The Trust, through its Guardian and Champion(s), works very hard to ensure that staff feel safe to speak up so that they do not feel that they may lose their job or will suffer any form of reprisal. The Trust does not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to stop staff raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Staff also need the re-assurance that, providing they are acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns. This will be made clear in our new policy document.

Even though we want staff to feel that they can raise their concerns openly, the Guardian and Champion(s) appreciate that they may want to raise it confidentially. This means that while they may be willing for their identity to be known to the person they report their concern to, they may not want anyone else to know their identity. The trust has committed to keeping their identity confidential (should they wish), unless required to disclose it by law (for example to the police). This is often a concern when issues of bullying and harassment are being raised. Our process of staff downloading a FTSU form and sending this through to our Guardian allows staff to also do this. There must also be the recognition that it may make it difficult for the relevant person to investigate the concern thoroughly and give the person feedback on the outcome.

3.13 Guardian of Safer Working Hours Report Statement

In line with the Terms and Condition of Service (TCS) (2016) of the Junior Doctors

Contract the Trust Board has received an annual report from the Guardian of Safe Working (GoSW). This contained information relating to exception reports, rota gaps and the plan for improvement to reduce gaps to ensure the safe working of doctors within the Trust.

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

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

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

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

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

Within the Trust there have been no Guardian fines to date as our Guardian has been liaising directly with individual departments to improve their engagement and understanding of the terms and conditions to improve the trainee environment and rotas in place.


NHS
Sister

Review of Quality Performance

3.14 Review of clinical indicators of quality – progress 2019/20

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	2016* or 2016/17	2017* or 2017/18	2018* 2018/19	2019* 2019/20	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	1	1	1	2	N/A	The Trust has a zero tolerance for MRSA.
Hospital Standardised Mortality Ratio* (n)	Patient Safety CHKS*	108.7*	105.1*	102.3	97.94	100	The HSMR demonstrates an improving position.
Number of hospital acquired C.difficile cases (n)	Patient Safety Trust Board Reports	8	9	5	42^	N/A	National reporting changed in 2019/20
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	3	12	14	5	N/A	Maintaining a good performance
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	4	5	5	1	N/A	Maintaining a good performance
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.4	1.08	0.72	0.94	1.11 Apr-Oct 19 0.96 Oct 19-Mar 20	Maintaining good performance below the national average
Average Length of Stay (LOS) (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.2 days	3.2 days	3.0 days	3.1 days	N/A	Maintaining performance
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	4.06	3.97 4.73***	4.08 4.89***	4.0 4.78	 6.63	Maintaining good performance and below the national average.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (to November)	Clinical Effectiveness SSNAP data	78.3%	85.3%	79.9%	87.6%	Target of 80%	The Trust is above target for the annual average and performance is being maintained.

Performance Indicator	Type of Indicator and Source of data	2016* or 2016/17	2017* or 2017/18	2018* 2018/19	2019* 2019/20	National Average	What does this mean?
% of fractured neck of femur to theatre in 36hrs	Clinical Effectiveness CHKS****	62%	76%	71.3%	79.8%	67.6%	The Trust continued to improve and now exceeds the national average
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness CHKS****	70.79*	50.8*	63.16*	67.82	100	This is demonstrating the Trust as a positive outlier.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness CHKS****	89.56*	100.3*	76.5*	74.91	100	This is demonstrating the Trust as a positive outlier.
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness CHKS****	7.09%*	7.00%*	5.8%	6.6%	5.8%	This shows a slight deterioration and means we are slightly worse than the national average
% Caesarean Section rates	Patient Experience Obstetric dashboard	32.9%	31.2%	31.3%%	33.09%	25%	The Trust shows a higher rate than average and continues to monitor rates.
Patients who felt that they were treated with respect and dignity**	Patient Experience CQC National inpatient survey	8.8	9.0	8.9	8.9	Range 8.4 - 9.2	Stayed the same and within expected range
Complaints rate per 1000 discharges	Patient Experience Complaints data and coded discharges	6.64	5.50	4.70	4.31	N/A	The Trust continues to encourage patients to complain to enable learning but has seen a reduction in formal complaints.
Patients disturbed at night by staff (n)	Patient Experience CQC National Inpatient Survey	7.6	8.1	8.2	7.6	Range 7.3 - 9.2	Slight decrease but within expected range
Venous thromboembolism risk assessment	Patient Safety Audit reported on Board Quality Report	Achieved >95%	Achieved >95%	Achieved >95%	>95%	National target >95%	Maintaining a good performance consistently due to the introduction of an electronic solution

(n) Denotes that this is data governed by standard national definitions
* Denotes calendar year
** The Trust has maintained low rates of MRSA but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
*** The Royal College of Physicians requires the Trust to report this figure to be 16+ and non-maternity cases. This new result is now included. The national average is from the most recent RCP report, dated 2015.
**** The Trust used Dr Foster until May 2018
^ Three significant changes to the reporting algorithm for C. Difficile infections were made in 2019/20, impacting on Trust figures nationally. This included for example, reducing the number of days to identify healthcare associated cases from >3 days to >2 days following admission; cases occurring in the community (or within 2 days of admission) within 12 weeks of discharge from hospital. The ceiling set for Trust apportioned cases, which was adjusted for 2019/20 was 19.

3.15 Quality Improvement

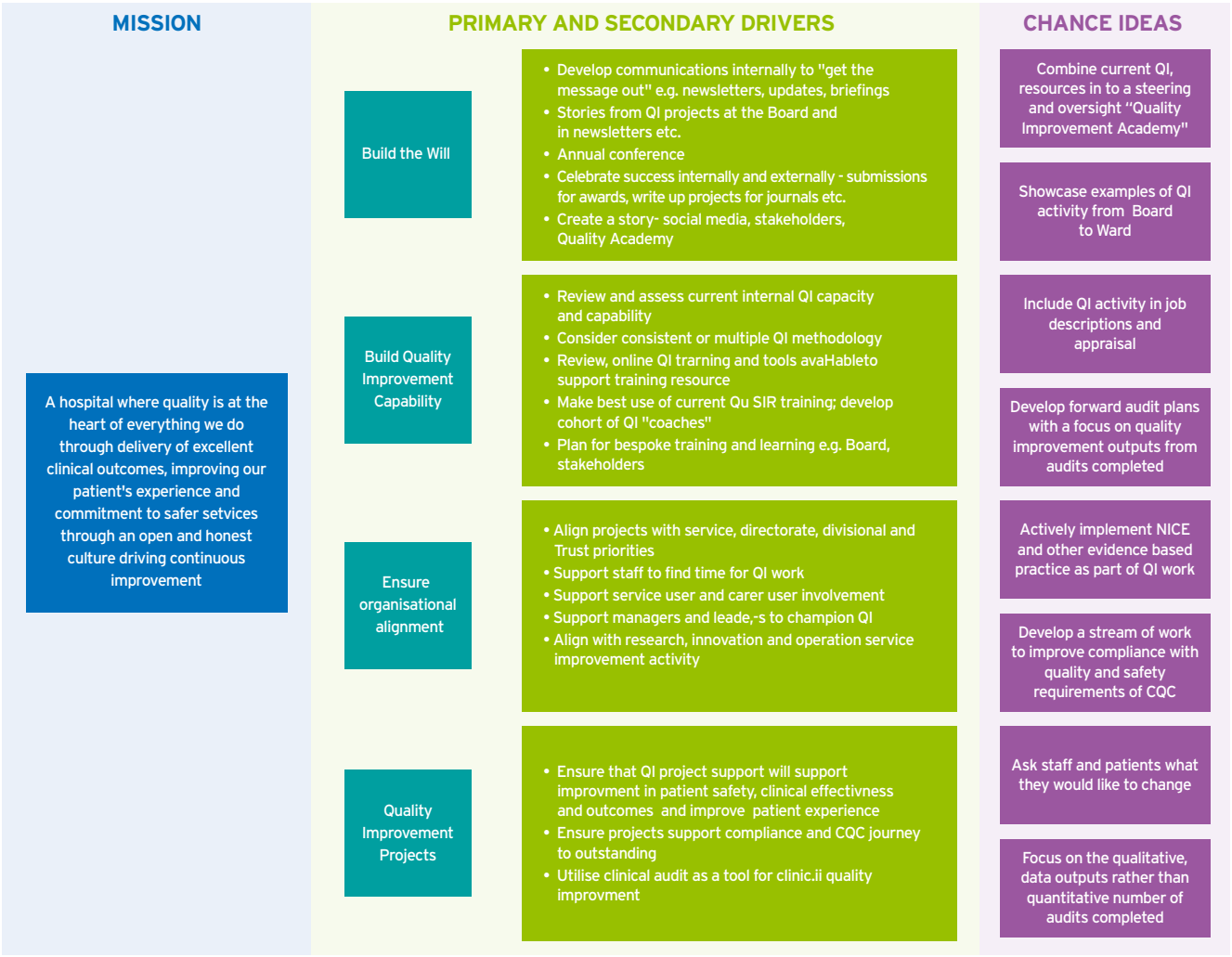
The Trust has always aimed to work in partnership with patients, staff and the communities we serve to improve the quality of services delivered and this will continue throughout the coming year. Furthermore, the Trust will seek to integrate the teams and the quality improvement endeavours across both sites of the newly merged organisation.

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

To support that delivery the Trust appointed an executive Director of Quality and Safety Governance to provide leadership to our quality improvement plans, with specific objectives around maintaining the Trust's Care Quality Commission's (CQC) rating of good together with developing a programme of work to support the organisation on its journey to outstanding. Over the past year, the work of the Quality and Safety Division has continued to evolve to bring sharper focus to learning and improving in a triangulated way. This work will continue to develop as we consult on the structures needed to deliver new ways of working in the newly merged organisation.

A delivery plan has been developed to provide a focus for the quality improvement agenda and a broad outline of key elements for that plan are summarised in the diagram below.

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



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

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

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

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

- key findings from national audit,
- use of gap analysis against NICE guidelines and standards
- findings from patient and staff surveys and FFT results
- Getting it Right First Time (GIRFT) reviews,
- contractual quality requirements within the Quality schedule,
- findings and learning from serious incidents, Never Events, complaints, inquests and litigation,
- outputs from the Freedom to Speak Up Guardian
- recommendations from external agency accreditation and inspection visits,
- benchmarking information from the recommendations of national reports and enquiries, for example the Paterson Report
- findings from mortality reviews and CHKS benchmarking data
- implementation of patient safety alerts
- risk registers
- CQC inspection outcomes and outlier alerts

"*The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*" was published in July 2019 by NHS England and NHS Improvement. The strategy sits alongside the NHS Long Term Plan. Progress on implementing the strategy within Bedfordshire Hospitals NHS Foundation Trust will be supported nationally through the implementation of the national patient safety syllabus. An early priority will be to identify the Patient Safety Specialist to lead this work across the Trust. Implementation of this strategy will form an important element of our own quality improvement once it starts to gain momentum nationally.

Capacity, Capability & Sustainability of Quality Improvement

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

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

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

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

The programme covers the following topics,
1. Leading improvement
2. Project management
3. Measurement for improvement
4. Sustainability of improvement
5. Engaging and understanding others
6. Creativity in improvement
7. Process mapping
8. Demand and capacity

The implementation of After Action Review (AAR) is one of our priority initiatives for implementation in 2020/21. AAR was identified as a key enabler within our quality strategy and the development of a cohort of AAR conductors along with a robust support mechanism for those people will enable wider and more structured learning and sharing when things go wrong as well as when things go well. AAR has been put forward in

the national strategy and as important mechanism to support staff and learn; thereby contributing to the culture that supports patient safety.

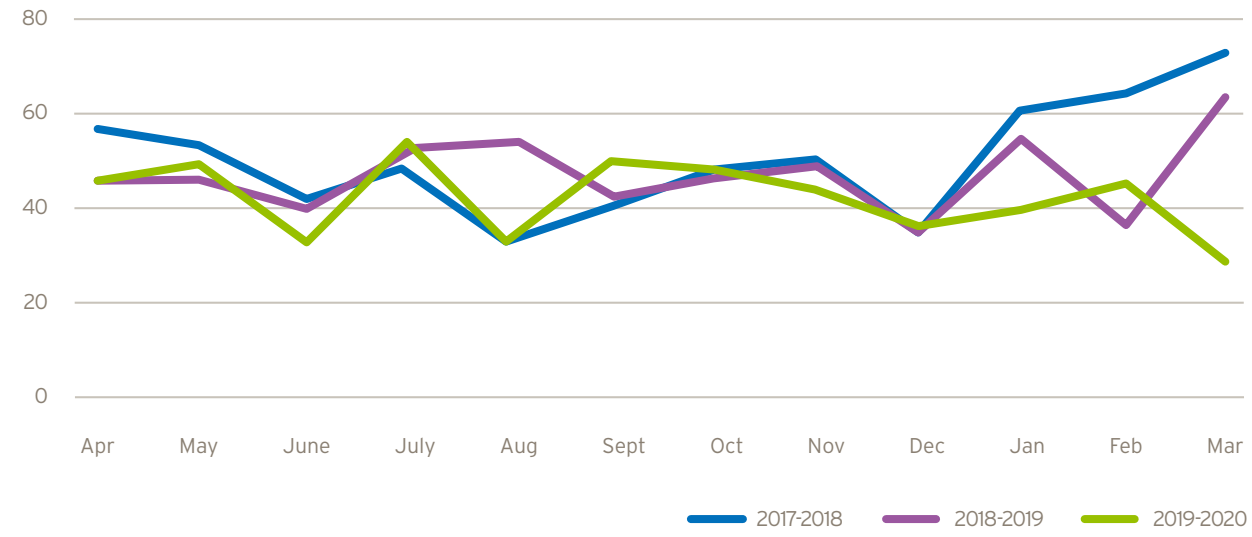
3.16 Complaints

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

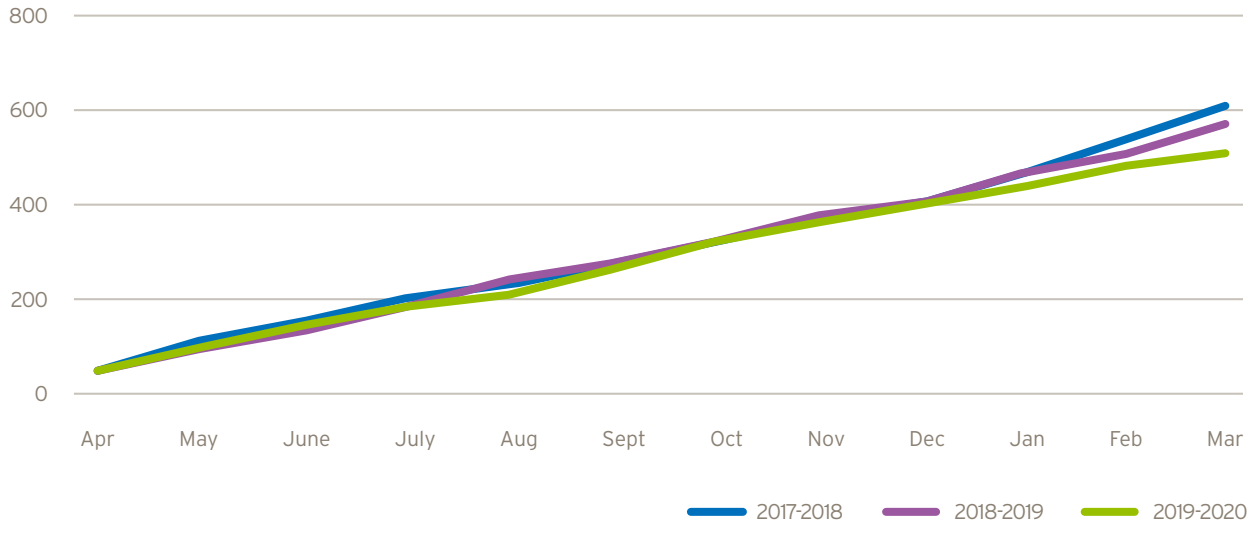
The Patient Advice and Liaison Team (PALS) have maintained a crucial front of house presence in the last year, in order to resolve issues raised with them to prevent escalation to formal complaints. Service Managers have been pro-active in contacting complainants to help resolve their complaints informally,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

During 2019/2020 we received 506 formal complaints compared to 563 in 2018/19 and 601 in 2017/18 respectively (see charts below). There has been a decrease in formal complaints due to early intervention by the PALS Team, resolving issues before they get to the formal stage, as well as work by Clinical, Service and General Managers to deal with them early. This is a reflection on the hard work and proactive efforts by all members of staff and positive outcomes compared to increased number of patients coming into the hospital. Also staff have attended complaints training which may also have influenced the number of formal complaints reported.

Formal Complaints - 2017/18 to 2019/20



Formal Complaints received in 2019/20 compared with 2018/19 and 2017/18



We endeavour to acknowledge all complaints within 3 working days and have achieved an average of 99.6 % compared to 98.3% in 2018/19. So far YTD 100% acknowledged within the 3 day lead time has been achieved in 9 out of 11 months.

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

Learning from Complaints

In 2019/20 we continue to share learning from complaints at divisional level through the governance process. Below are examples of some of the improvements made during 2019/20:

- One example of complaints where learning made a difference related to a lady whose drug allergy was not picked up on admission. Family members were unsure of what the medication was. Staff identified the issue and changed the patients' medication with no adverse effect to her or her treatment. The issue was shared at a Learning and Sharing Event and reminders to clinical staff about vigilance and accuracy when recorded patient medications requirements, as well as updating allergy information on a regular basis.
- Patient was admitted from a Care Home already receiving anticipatory medication and the staff commenced him on a syringe driver in order to keep him comfortable. However the family interpreted this as end of life care and were extremely upset. The staff apologised for the distress caused and put in place actions to undertake additional checks are made before syringe drivers are used, ensuring carers are consulted to gather the most accurate information possible for patients admitted from care homes.
- A patient who had a plaster cast applied for a patella fracture informed staff that when the cast was removed she was in great pain. Unfortunately because the lady had dementia the member of staff did not think her pain was as severe as it was. When the plaster as removed the lady had a gash to her leg. Staff apologised at the time and a full investigation was undertaken. The outcomes agreed were that staff were retrained and also given additional training about working with vulnerable patients, and a specific clinical guideline complementing this was developed.

Listening to Patient Concerns

The top five themes of complaints related to Clinical Treatment, Communication, Appointment Delays and Cancellations, Values and Behaviours (attitude of staff) and Admissions and Discharges.

The majority of complaints were resolved at local resolution level, with 4 complainants requesting that the Parliamentary and Health Service Ombudsman (PHSO) review their complaints. 2 complaints were not upheld, one was partly upheld there is one is still under investigation by the PHSO.

As a result of the external review commissioned by the Chief Nurse re management of the Complaints Process, this was shared with the Complaints Board and the proposals were shared for considerations and the following recommendations were approved:

- Rebranded the Patient Affairs Team this is now the Complaints Team, which is in line with most other Trusts.
- The Complaints and PALS Team have now been joined and working as one Team under the Patient Experience to provide a more seamless approach to managing concerns and thus preventing escalation to complaints which is evident in the reduced number of formal complaints received this year.
- The Complaints Policy and a Standard Operating Procedure were finalised and approved and currently on the intranet.
- Template letters were reviewed including all documents used in correspondence. All our complaint responses are now being signed off by the Chief Executive.
- Complaints are stored on improved electronic storage and we are in the process of destroying old paper files that have been uploaded on the electronic system.

Compliments

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

Extracts from Compliments:

Feedback to the breast cancer team:

I would like to leave you feedback on the outstanding care I have received since I first got my recall letter on 29th November, just 8 days after my mammogram. Thank you everyone. My husband and I feel very fortunate

Feedback for Maternity Unit

I recently gave birth in the maternity unit at your hospital and I have to say the care I received during my stay was excellent. The midwives in ward 31 were so efficient and caring; they made me feel as comfortable as they could. The staff were so friendly and they made me feel relaxed. I can't thank them enough for her professionalism and kindness that was shown to me.

Feedback for Accident and Emergency.

I suffered an allergic reaction to medication and I attended the A&E Dept. They were caring and efficient. I was seen after as short wait and given steroids by the triage nurse and then an hour later by an A & E doctor. The NHS at its best.

Feedback for the Surgical Division.

I will be writing to the doctors and staff on Ward 22 but I wished to let you know that I cannot thank them enough for caring for my mother, when she was admitted to your hospital. Although very poorly and unfortunately she passed away on Tuesday, the care they gave to her was first class. Not only were they looking after her but the care and support they gave to me during this very hard time was fantastic. From the bottom of my heart a very BIG thank you to your excellent doctors, nurses and everyone else on Ward

Feedback about catering

First stay at the L&D and I have to say all the staff are fantastic. Of course it's busy but what hospital isn't. I could not believe the menu it's better than a lot of restaurant I have been to. Plenty of it and piping hot. Keep up the good work well done to all.

3.17 Friends and Family Test

The Friends and Family Test (FFT) continues to be a mandated programme to gather patient feedback. The organisation submits monthly data to NHS England, which is benchmarked against other Trusts and also at regional level. Staff receive reports on a monthly basis, this has changed since last year, as weekly reports did not afford them enough time to rectify issues if highlighted. Throughout the year the response scores recorded for both Inpatient Services and the Emergency Department (ED) have remained higher than national benchmark scores.

Following the national review of the FFT process by NHS England we are in preparation of the change to the questions asked. Patients will be asked about their experience rather than recommending as services, which is far more appropriate for people using hospital services. The Patient Experience Team has planned for the switchover on 1st April 2020, which has included updating electronic and paper formats, as well as providing comprehensive publicity.

The new question will be;

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

Respondents will be asked to rate the experience from 'very good' to 'very poor'.

We continue to collect information from the following clinical areas;

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

Monthly reports relating to patient experience feedback is reviewed at the Clinical Outcomes, Safety and Quality Committee. Quarterly reports are shared at the Clinical Operations Board, Complaints Board and the Patient and Public Participation Group.

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

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

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

Table One: Trust Comparisons to National Inpatient Recommend FFT Results

Comparison	Total Responses	Total Eligible	Response Rate	Percentage Recommend	Percentage Not Recommend
England excluding independent providers (Q1)	647,918	2,691,942	23.9%	96%	2%
Trust (Q1)	5,740	16,779	32.6%	96.3%	1.3%
England excluding independent providers (Q2)	430,971	2,693,709	24.8%	96%	2%
Trust (Q2)	5,016	15,998	31.3%	95.6%	1.3%
England excluding independent providers (Q3)	612,041	2,677,504	22.8%	96%	2%
Trust (Q3)	4,779	16,804	28.4%	96%	1.6%
England excluding independent providers (Q4)	**419,908**	**1,787,981**	**23.5%**	**96%**	**2%**
Trust (Q4)	**2,505**	**9,201**	**27.4%**	**95%**	**2%**

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

Comparison	Total Responses	Total Eligible	Response Rate	Percentage Recommend	Percentage Not Recommend
England excluding independent providers (Q1)	415,131	3,493,510	11.9%	85.6%	9%
Trust (Q1)	4,202	19,628	21.4%	98%	1%
England excluding independent providers (Q2)	443,703	3,520,982	12.6%	85.3%	8.6%
Trust (Q2)	4,410	13,321	28.6%	98.6%	0%
England excluding independent providers (Q3)	413,082	3,519,528	11.7%	84%	10%
Trust (Q3)	5,823	18,883	30.8%	98.6%	1%
England excluding independent providers (Q4)	**272,206**	**2,285,780**	**16.9%**	**85%**	**9%**
Trust (Q4)	**3,286**	**11,818**	**27.7%**	**98.5%**	**0%**

13/08/2020: Note NHS England has not published March data yet. Therefore only January and February data included in Q4

Table 3: Inpatients Percentage Recommend Scores 2019/20

% of Inpatients who would recommend 2019/20

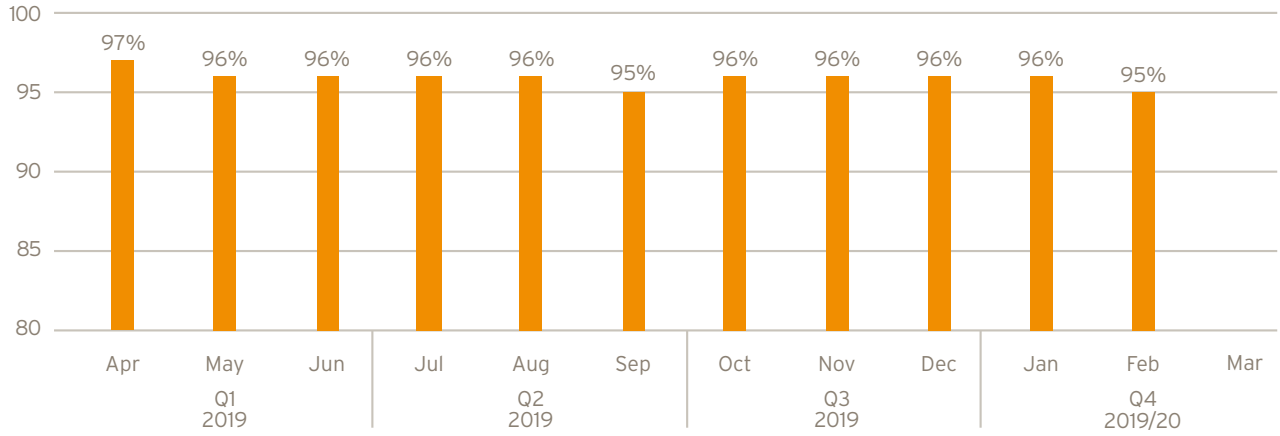


Table 4: Accident and Emergency Percentage Recommend Scores 2019/20

% of A&E patients who would recommend 2019/20

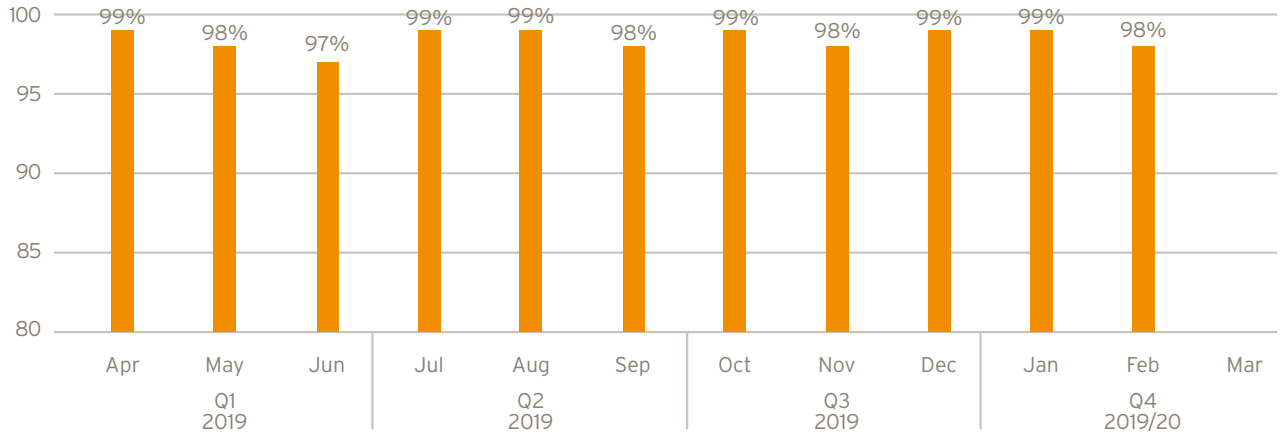


Table 5: Maternity Percentage Recommend Scores 2019/20

% of Maternity Patients who would recommend 2019/20

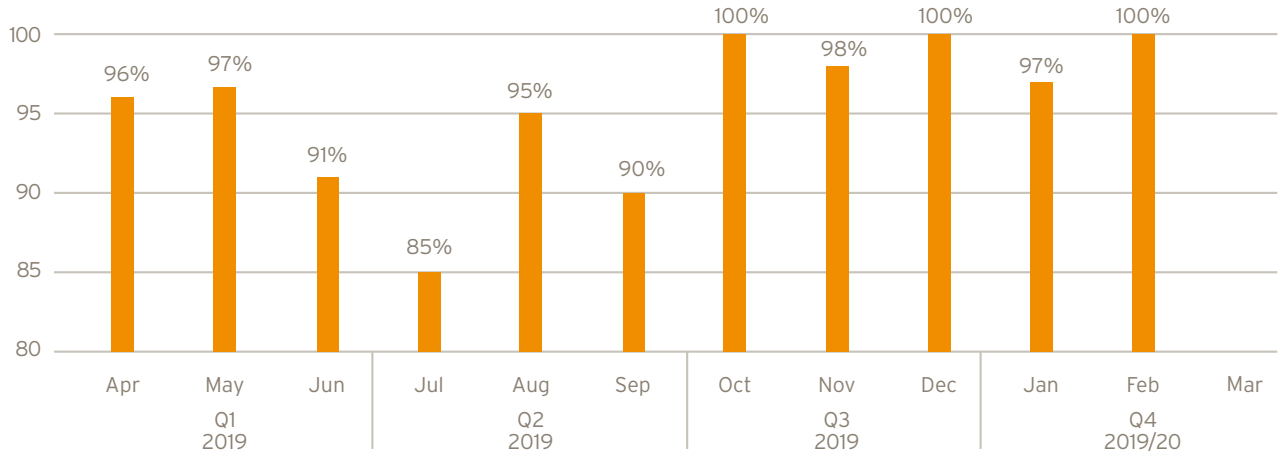
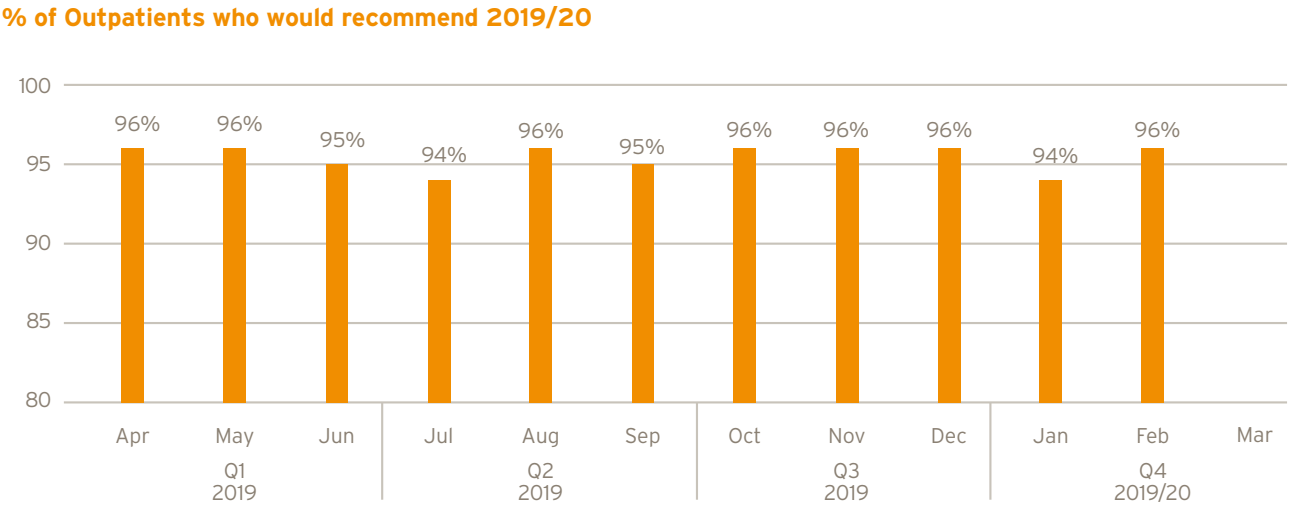


Table 6: Outpatients Percentage Recommend Scores 2019/20



3.18 National Surveys 2019

National inpatient survey

The national inpatient survey reports were published by the CQC on 2nd July 2020. Detailed management reports are shared internally and a programme of work will be developed and monitored at Trust Quality meetings. Of patients who were treated in July 2019, 37% of those sampled responded compared to 40% in 2018. The national response rate was 45% for both these years.

Results of the national in-patient survey 2019 compared to the previous 3 years

Category	2016	2017	2018	2019	Comparison with other NHS acute Trusts
The emergency / A&E department, answered by emergency patients only	8.5	8.7	8.5	8.2	About the same
Waiting lists and planned admission, answered by those referred to hospital	8.8	9.0	8.4	8.5	About the same
Waiting to get to a bed on a ward	6.7	7.1	6.9	6.7	About the same
The hospital and ward	7.6	6.3	7.7	7.6	About the same
Doctors	8.3	8.5	8.2	8.3	About the same
Nurses	7.7	8.0	7.8	7.8	About the same
Care and treatment	7.5	8.0	7.8	7.6	About the same
Operations and procedures, answered by patients who had an operation or procedure	8.5	8.1	8.2	8.1	About the same
Leaving hospital	6.8	*	6.6	6.4	About the same
Respect and Dignity	8.8	8.8	8.9	8.9	About the same
Overall views and experiences	5.2	4.4	5.6	7.9	About the same

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

Each section has a number of subsequent questions which allow us to identify in more detail areas for improvement.

National Maternity Survey

The national maternity survey was published in January 2020, providing feedback from women who gave birth in Luton and Dunstable Hospital in February 2019. The results are published on the CQC website and were based on the feedback from 119 women who responded.

Category	2019	Comparison with other NHS acute Trusts
Labour and Birth	8.9	About the same
Staff during labour and birth	8.3	About the same
Care in hospital after the birth	8.1	About the same

In each section, a number of questions are asked. For every question in every section with the exception of one question, we scored about the same as other Trusts. In one question - discharge from hospital being delayed - we scored better than other trusts.

Fieldwork for the survey of women giving birth in February 2020 was stopped due to the escalation of the COVID-19 pandemic.

Patient Stories and Improvements following patient feedback.

STORY ONE

Ward Manager 'Surgeries'

AB was an 84 year old gentleman with a number of health issues. He was being treated on a busy medical ward and it was agreed that as his condition was deteriorating his preferred place of care was at home. The Ward Manager had recently introduced 'Surgeries' 3 times a week making time available for patients, visitors, carers and family members to speak to her about any concerns they may have.

AB's daughter was very unhappy about the actions of the Social Worker, whom she felt was not listening to her requirements and that his attitude was not what she expected. The Ward Manager listened to the daughter's concerns and asked if she arranged a meeting with the Social Worker they could work through the concerns and avoid a formal complaint. AB's daughter agreed and the Ward Manager arranged a meeting with the Social Worker and themselves. The concerns about his discharge were raised and ongoing care. She felt that her father needed urgent care and this could be facilitated at home rather than in a care home, which had been previously suggested. A fast track referral was made and AB was discharged home with services in place where he passed away peacefully surrounded by his family.

AB's daughter was extremely grateful for the Ward Manager's input, as was the Social Worker, who was relieved to avoid a formal complaint being raised against him.

Lesson learned;

1. Listening to concerns at an early stage can often avoid a formal complaint.
2. Patient's family members are often experts in the needs of their loved one, therefore they have an important part to play in planning care.
3. Senior staff in the clinical areas should make themselves available to listen to concerns and put things right at an early stage

Overall Outcome: The number of formal complaints on the ward has decreased significantly since the introduction of the 'Surgeries'. The concept is being looked at by the Corporate Nursing Team, with view to rolling it out across all wards. The Patient Experience Team is designing posters to publicise the 'surgeries'.

STORY TWO

Catering Provision

BC informed the Housekeeping Staff that he did not fancy anything from the main menu but asked if he could have a double portion from the lighter menu. The Housekeeper reluctantly did so but when the meal arrived the plate appeared dirty and he had not been sent the correct quantity. The presentation of the food was not as he expected and did nothing the encourage recovering patients to eat. Also for breakfast he noted that all the toast was made in one go which meant by the time he received his it was cold and inedible.

Lessons Learned;

1. Housekeeping staff were made aware that they need to share the reasons why certain meals are served in various ways; sometimes it is due to calorific value and not just portion size.
2. Staff also need to ensure that food is presented in a way that is appetising to staff and take time to ensure correct presentation
3. The Catering Manager identified that batches of toast are provided throughout service and patients should be made aware that they can ask for fresh, hot toast.

Overall Outcome: The Contracting Monitoring Manager liaised with the third party provider to review the menus and presentation of the food. The Contracts Manager also rang the patient to discuss his feedback and assured him that the feedback had been shared with the third party provider. The Contracts Manager also gave the patient his contact details should he has issues in the future.

Improvement One

Treating patients with delirium is becoming more prevalent in hospitals, the Patient Safety Team and Dementia Specialist Team used World Delirium Day, not only to increase awareness and hold a tea party for patients, but to launch the Delirium Toolbox. The toolbox is kitted out with information to help them recognise and manage delirium patients. Information tells staff how to use SQiD (single question in delirium) and how to manage the possible causes.

Delirium tool boxes were distributed to 10 acute ward areas to help staff support patients with delirium. There is a building evidence base to suggest that simple interventions can help to support the person with delirium & dementia;

- Enabling communication: informing patients and carers about delirium, make sure hearing aids and glasses are worn.
- Orientation: reminder of date and environment, calendars, clocks.
- Activity Stimulation: access to activity, walking, encouraging family visiting.

These along with some good basic care interventions such as; hydration, mobility, sleep promotion, can all have a positive impact on recovery and wellbeing.

The toolboxes contained spare reading glasses, magnifiers, hearing amplifier, orientation board (date and place), simple activities/games to stimulate, carer passes and information for patients and carers. All of these are thought to help improve the recovery and wellbeing for someone experiencing delirium.

Improvement Two

As the Friends and Family Test is changing in April 2020, we have worked towards making it easier for patients to complete the feedback at any time. Figures from previous years show that using electronic devices continues to increase and in order to reduce the number of paper forms, which requires a resource to input the data, we have increased the number of iPads available in public areas, especially Outpatients.

To compliment this we have been developing QR codes on cards and leaflets which will enable patients to respond using smart phones. This will allow them to respond at a time that is convenient to them without having to wait for a tablet to become available. This will also improve the 'live-time' reporting which will allow staff to receive feedback in a more timely manner.

3.19 NATIONAL STAFF SURVEY 2019

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in eleven indicators. The indicator scores are based on a score out of 10 for certain questions with the score being the average of those.

The response rate to the 2019 survey among Trust staff was 47% (2018: 52%). Scores for each indicator together with that of the survey benchmarking Group 'Acute Trusts' are presented below.

	2019 Trust	Benchmarking Group	2018 Trust	Benchmarking Group	2017 Trust	Benchmarking Group
Equality, diversity and inclusion	8.8	9.0	9.0	9.1	8.9	9.1
Health and Wellbeing	6.1	5.9	6.0	5.9	6.1	6.0
Immediate Managers	7.0	6.8	6.9	6.7	6.9	6.7
Morale	6.3	6.1	6.1	6.1	Not measured	Not measured
Quality of Appraisals	6.2	5.6	6.0	5.4	5.8	5.3

	2019 Trust	Benchmarking Group	2018 Trust	Benchmarking Group	2017 Trust	Benchmarking Group
Quality of care	7.8	7.5	7.6	7.4	7.6	7.5
Safe environment – bullying and Harassment	7.9	7.9	7.9	7.9	7.9	8.0
Safe environment – violence	9.4	9.4	9.5	9.4	9.3	9.4
Safety culture	6.8	6.7	6.8	6.6	6.7	6.6
Staff engagement	7.3	7.0	7.2	7.0	7.2	7.0
Team working	6.8	6.6	Not measured	Not measured	Not measured	Not measured

Commentary
A sample survey was conducted in 2019 and this sought the opinion of 1250 of our staff. The response rate was 47% and although lower than the 2018 response rate it was average compared to all Acute Trusts. The results are mostly average or above average in comparison to the benchmarking group with a slight reduction in relation to equality, diversity and inclusion since last year. There is a significant increase in relation to discrimination at work from patient/service users and members of the public, in particular, which is concerning.

In the section entitled 'Your Job', there were some very good results such as:

- I am enthusiastic about my job: 82% (up 5%)
- I am able to make suggestions to improve the work of my team/department: 78% (up 3%)
- I am able to do my job to a standard I am personally pleased with: 86% (up 2%)
- I feel that my role makes a difference to patients/ service users: 92% (up 3%)
- I am trusted to do my job: 94% (up 2%)
- I am able to deliver the care I aspire to: 76% (up 5%)

The high priority given to quality improvement with a substantial number trained in Quality, Service Improvement and Redesign is having a positive impact as staff become engaged in developing new ideas for service delivery across the organisation.

Immediate line managers continue to support their teams, give clear feedback on work, take a positive interest in their staff's health and wellbeing, value their work and support training, learning and development. Line managers are able to make a distinct impact on how staff feel about their roles and the quality of the relationship is key to retaining staff.

There continues to be a positive safety culture where action takes place to deal with errors, near misses or incidents and there is feedback about changes and improvements. Staff confidence in relation to feeling secure raising concerns has dipped slightly this year so we will continue to promote the Freedom to Speak up Guardian role to reassure colleagues that we are keen to hear their views.

Areas for improvement
We recognised that there is still more work to do in relation to harassment, bullying and abuse from some patients and service users and we will continue to support staff in dealing with these difficult situations. In addition, discrimination is an issue, particularly for BAME and disabled staff and we will be working towards improving this over the next year.

Stress in the workplace continues to remain higher than we would like, however, it is lower than the average which is 5% higher. As an organisation, we cannot be complacent and our health and wellbeing activities are designed to support staff and mitigate the impact of stress in a highly pressurised, busy hospital. In response to a question about the organisation taking positive action on health and wellbeing, we have had a positive response which is 9% above the average.

Finally, we remain concerned about the feedback from the survey that suggests that staff have experienced musculoskeletal (MSK) problems as a result of work activities. The trend is upward since 2014 with a slight reduction this year but the Trust remains above average. We continue to provide direct access to physiotherapy for staff through the occupational health department.

Future priorities
We will be developing a publicity campaign to promote our organisational values and encourage the general public to work with us to ensure positive behaviours in all our interactions with them.

The policy and campaign to reduce acts of violence from the public has had some impact and we will continue to promote and enforce this across the Trust.
Staff can access fast-track physiotherapy and we offer comprehensive manual handling training for both

clinical and non-clinical colleagues. We will consider if it would be appropriate to launch a series of 'reminders' about safe moving and handling as part of our internal communications.

We will reinforce the positive messages around speaking up if a member of staff has concerns through the Freedom to Speak Up Guardian.

3.20 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 2019/20 the Trust has continued with initiatives, to promote opportunities for staff to adopt a healthier lifestyle either on site or by promoting external facilities that are conducive to good health.

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

The Occupational Health team completed their annual renewal assessment, and successfully retained their reaccreditation under the Safe Effective Quality Occupational Health Service (SEQOHS). The full accreditation inspection takes place every five years, the most recent was in 2018. The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the Faculty of Occupational Medicine. SEQOHS accreditation is the formal recognition that an Occupational Health Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

Annual health and wellbeing event
In June 2019, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place. Attendance levels have increased year on year, and we had over 300 members of staff attend, with many participating in the activities. Awareness raising stands and activities included: Chair exercises, laughter yoga, Zumba, Pilates, Yoga, physiotherapy advice and Healthy food prep demo and taster sessions, Pluck a duck competitive steady hand game, smoothie bikes, mini health checks and a company promoting ergonomically friendly office equipment. All attendees received a free goodie bag containing 5 pieces of fruit.

This year, 81% of our frontline staff were vaccinated against flu, compared to 76.5% in 2018/19 and amongst the highest uptakes when compared to other NHS Acute Trusts.

Employee Assistance Programme
The Trust continues to employ the services of an Employee Assistance Programme, which is available to all staff. This provides access to an independent, free and confidential telephone advice service, staffed by highly experienced counsellors who can provide practical and emotional support with work or personal issues. Advice is available 24 hours a day, 365 days of the year. The provision of this support during the past five 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 630 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary onward referrals made.

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

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

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

Weight loss programme
In February 2019 all NHS Trusts were approached by NHS Improvement inviting them to demonstrate an interest in obtaining a small amount of funding, in order to implement a Weight Management support service for staff.

Our vision was that the funds could be used to purchase vouchers which would then be given to staff to enable them to access a local, reputable Weight Management support service

As a result we secured 1.5K, and we worked closely with the Total Wellbeing service here in Luton. The funds enabled us to offer 60 members of staff support. To be eligible for the programme individuals had to have a BMI between 25 and 45

There were ten workshop sessions available for individuals to attend with the aim of 5% body weight reduction.

Each workshop session lasted 1½ hrs and covers various topics such as:-

- Reading food labels for healthier food choices
- Portion distortion
- Healthier snacking
- Food and mood
- Hidden sugars
- Takeaways to fakeaways and eating out
- Fats
- Physical activity

Smoking cessation
In June 2019, Total Wellbeing Luton commenced smoking cessation support specifically for staff. Sessions are held every Monday in the Occupational Health Department. From the 53 members of staff who have signed up to the programme thus far 29 have been recorded as successfully quitting.

3.21 National core set of quality indicators

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

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

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

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

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. It includes deaths which occurred outside of hospital within 30 days (inclusive) of discharge.

The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge was 'higher than expected' (SHMI banding = 1), 'as expected' (SHMI banding = 2) or 'lower than expected' (SHMI banding = 3) when compared to the national baseline.

The Trust is a provider of level 3 neonatal care that cares for the most premature babies and it is acknowledged that SHMI does not adequately risk adjust for a level 3 NICU provided in a District General Hospital.

	Reporting period	L&D Score	National Average	Best performing Trust	Worst performing Trust	Banding
Value and banding of the SHMI indicator	Published Feb 19 (Oct 17 -Sep 18)	As expected	As expected			2
	Published April 20 (Dec 18 - Nov 19)	As expected	As expected			2
% Deaths with palliative care coding	Published Feb 19 (Oct 17 -Sep 18)	36.1	33.6	59.5	14.3	N/A
	Published April 20 (Dec 18 - Nov 19)	41	37	1	59	N/A

The Luton and Dunstable University Hospital considers that this data is as described for the following reason:

- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived;
- Data is collated internally and then submitted on a monthly basis to NHS Digital via the Secondary Users Service (SUS). The SHMI is then calculated by NHS Digital, with results reported monthly on a rolling year basis.
- Clinical coding of patient records is subject to an annual audit.

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

- On-going Use of "Structured Judgement Reviews" led by our team of newly appointed Medical Examiners, as a methodology for mortality reviews. The learning from these feeds through to the regular morbidity and mortality learning meetings held within each of the clinical services
- We have appointed a Board-level Executive lead for the Mortality Review Process, and we have a non-Executive lead charged with oversight and challenge.
- The outcomes from Mortality Reviews are shared quarterly through a Board level quality report as from September 2017.

- Membership of our Mortality Board has been broadened to include representation from external stakeholders; including our lead Clinical Commissioning Group this allows oversight to ensure that any deaths that require a community review are subject to a consistent process.

Indicator: Readmission within 28 days of discharge

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of Trust during reporting period.

	Reporting period	L&D Score	National Average	Best performing Trust	Worst performing Trust
Patients aged 0 – 15 years	2018/19	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2019/20	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2018/19	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2019/20	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 Trust does not routinely gather data on 28 day readmission rates
- The Trust gathers data on 30 day readmission rates
- The most recent available data on NHS Digital relates to 2011/12 uploaded in December 2013.

Indicator: Patient Reported Outcome Measures (PROMs)

PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery. Final annual confirmed PROMs data are planned for release approximately 18 months after the end of each financial year by NHS Digital, therefore there is a significant time lag in being able to publish data within the Quality Account.

	Reporting period	L&D Score	National Average	Best performing Trust	Worst performing Trust
Collection of PROMs for Groin Hernia and Varicose Vein surgery ceased in 2017.					
Primary hip replacement	2017/18	0.43	0.46	0.55	0.36
	2018/19	0.448	0.465	0.52	0.41
Primary knee replacement	2017/18	0.31	0.34	0.41	0.25
	2018/19	0.32	0.34	0.39	0.28

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:
- The Trust has a process in place for collating data on patient reported outcomes
- Data is sent to NHS Digital who calculate PROMS scores and then publish them on NHS Digital
- Data is compared to peers, highest and lowest performers, and our own previous performance as set out above

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:
- Ensuring results are reviewed through the organisational governance structure in addition to local clinical governance forum
- Use of information to support improved data submission and quality and use of outcome scores at multidisciplinary staff meetings to promote ideas for further quality improvement.

Indicator: Responsiveness to the personal needs of patients

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

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

	Reporting period	L&D Score	National Average	Best performing Trust	Worst performing Trust
Responsiveness to the personal needs of patients	2017/18	66.2	68.6	86.2	54.4
	2018/19	62.9	67.2	85	58.9
	2019/20	*	*	*	*

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. 2018/19 data relates to the survey of people who were inpatients in July 2018, who responded to a survey between August 2018-January 2019, which was published in August 2019.

*The data for this indicator for patients responding to the 2019 inpatient survey has not yet been published on NHS Digital (as at 9th September)

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

- Improved access to interpreters.
- Reviewed the complaints process and have initiated recommendations to streamline the responses.
- Themes from complaints identified discharge from hospital as a concern. Therefore this was included as a Quality Account Priority for 2019/20 and will continue for 2020/21.

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	Best performing Trust	Worst performing Trust
% staff who would recommend the Trust as a provider of care to family and friends	2017/18	72%	70%	87%	60%
	2018/19	71%	71%	87%	40%
	2019/20	76%	71%	87%	40%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The source of the data is the National Staff Survey.

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

- Engaged with staff about the vision, values and behaviours and have embedded them within the appraisal process.
- Provided information and training at the Staff Engagement Event in July and December 2019 to over 2500 staff, keeping them updated about services and in particular the benefits of the planned merger with Bedford Hospital.
- Engaged staff in quality improvement across the Trust and shared learning from QI using a wider range of communication methods.

Indicator: Risk assessment for venous thromboembolism (VTE)

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

	Reporting period	L&D Score	National Average	Best performing Trust	Worst performing Trust
% patients who were admitted to hospital and who were risk assessed for VTE. *(Prior to April 2019, the standard related to adult inpatients aged 18 and over. Since this time, the standard relates to inpatients aged 16 and over.)*	2017/18 – Q4	97.5	95.2	100	67.0
	2018/19 – Q1	99.3	95.6	100	52.7
	2018/19 – Q2	98.2	95.7	100	74.8
	2018/19 – Q3	99.0	95.7	100	54.9
	2018/19 – Q4	99.5	95.7	100	74.0
	2019/20 – Q1	99.2	95.6	100	69.8
	2019/20 – Q2	99.0	95.5	100	71.7
	2019/20 – Q3	98.3	95.3	100	71.6

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 through monthly audit

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

- Introduction of an electronic VTE risk assessment tool, this mandates risk assessments on admission and prompts our clinicians to consider prescribing thromboprophylaxis at the same time.

Indicator: Clostridium difficile infection rate

The rate of cases of C. difficile infection per 100,000 bed days reported within the Trust amongst patients aged 2 years or over during the reporting period.

	Reporting period	L&D Score	National Average	Best performing Trust	Worst performing Trust
Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over	2015/16	5.3	14.9	0	66
	2016/17	3.6	13.2	0	82.7
	2017/18	3.9	13.6	0	91.0
	2018/19	1.7	12.2	0	79.7
	2019/20	17.91	Data unavailable (Sept 2020)		

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:

- The Trust has a process in place for collating data on C.difficile cases
- Data is collated internally and submitted to Public Health England
- Data is compared to peers, highest and lowest performers, and our own performance as set out in the table above

The reporting criteria for diarrhoeal disease due to *Clostridium difficile* have changed from this financial year.
For 2019/20 cases reported to the healthcare associated infection data capture system will be assigned as follows:

1. *Hospital onset healthcare associated* (HOHA): cases that are detected in the hospital two or more days after admission.
2. *Community onset healthcare associated* (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
3. Community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.
4. *Community onset community associated:* cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

In 2019-20 the Health care associated or hospital acquired cases (HA) i.e. Trust apportioned cases included the first 2 categories (HOHA & COHA).

All cases of *Clostridium difficile* diarrhoea were subject to a root cause analysis. A practice compliance assessment is also undertaken to establish any "lapses of care or testing". This then forms the basis of future learning for our organisation. The Trust follows the agreed appeals process with the CCG in cases where it is established that there were "No lapses of care". All C.difficile isolates are typed to enable early warning of clusters or point source outbreaks. In 2019/20 we identified an increase in cases due to one serotype 015. Epidemiological investigations failed to identify a link between these cases.

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	Worst performing Trust	Best performing Trust
Total number (n) and rate (r) of patient safety incidents (per 1000 bed days)	Oct 17 – Mar 18	n=3742 r= 32.18	42.5	24.2	124
	April 18 – Sept 18	n=3512 r=30.92	44.5	13.1	107.4
	Oct 18 - Mar 19	n= 3841 r= 33.17	46.1	16.9	95.9
	April 19 - Sept 19	n=5019 r=43.24	49.8	26.3	103.8
Total number (n) and percentage (%) patient safety incidents resulting in severe harm or death	Oct 17 – Mar 18	n=16 0.42 %	0.3	1.5	0
	April 18 – Sept 18	n=15 0.42 %	0.3	1.3	0
	Oct 18 - Mar 19	n=12 0.31 %	0.3	1.7	0
	April 19 - Sept 19	n=17 0.34 %	0.3	1.6	0

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The Trust has a process in place for collating data on patient safety incidents;
- Data is collated internally and then submitted to the National Reporting and Learning System
- Data is taken directly from NRLS reports

The number of patient safety incidents reported continues to reflect a positive culture for reporting all patient safety incidents and near misses. The number and percentage of incidents resulting in severe harm or death has reduced following the introduction of a more consistent approach to aligning the level of harm reported to NRLS with the outcomes of investigations. All serious incidents are investigated using root cause analysis methodology. We work closely with commissioners and the National Reporting and Learning System (NRLS) to ensure that any changes made to incident classifications following a root cause investigation are reported to NRLS and that data provided to NRLS is reviewed and validated against Trust data to ensure it is consistent.

We continue to use the outcomes of investigations into patient safety incidents to drive improvements to the quality and safety of our services.

3.22 Performance Against National Priorities

		2016/17	2017/18	2018/19	2019/20	Target 19/20
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	8	9	5	42	19
MRSA	To achieve contracted level of 0 cases per annum	1	1	1	2	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	99.9%	100%	100%	100%	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	88.6%	89.2%	87.6%	88.7%	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	96.4	96.3%	95.8%	93.9%	93%
Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	100%	100%	100%	100%	94%
	Anti-cancer Drugs	100%	100%	100%	100%	98%
Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	93.2%	91.9%	91.1%	89.8%	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.8%	98.4%	98.1%	**	95%
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	0.7	3.4	0.8	1.04*** 0.6 (M1-11)	<1

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

** Data not provided as Trust part of pilot for new Emergency Access Monitoring data

*** March performance adversely impacted by the COVID-19 crisis resulting in cancellation of all but the most urgent diagnostic testing. Performance for months 1-11 was well within the target.

Glossary

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

Term	Description
Fagerstrom score	This score is calculated by using the Fagerstrom Test of nicotine dependence. It helps to ensure that the prescribing of nicotine replacement therapy is appropriate for the needs of the patient
Frailty	**Frailty** is a common **geriatric** syndrome that embodies an elevated risk of catastrophic declines in health and function among older **adults**
GDPR	The General Data Protection Regulation is a regulation in law on data protection and privacy which came into effect in May 2018.
GIRFT	The **Getting It Right First Time (GIRFT)** programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements
HAI	Hospital Acquired Infection
HealthWRAP	This is the name of the training which forms part of the national PREVENT strategy, the aim of which is to stop people becoming terrorists or supporting terrorism. The NHS is a key partner in the national counter terrorism strategy.
Heart Failure	The inability of the heart to provide sufficient blood flow
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
ICNARC	Intensive Care National Audit and Research Centre
ICO	The Information Commissioner's Office (ICO) is the independent regulatory office in charge of upholding information rights in the interest of the public.
ICS	Integrated Care System – partnerships across areas form to work collectively to provide better, more joined up care for patients. Our ICS is across the areas of Bedford, Luton and Milton Keynes (BLMK)
ILS	Immediate Life Support
Just Culture	Just culture is about creating a culture of fairness, openness and learning in the NHS by making colleagues feel confident to speak up when things go wrong, rather than fearing blame.
Laparoscopic	Key hole surgery
Learning Disability	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
LIG	Local Implementation Group
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
MDT	Multidisciplinary Team – includes the various disciplines who are involved in the delivery of care. This includes doctors, nurses, midwives, therapists, pharmacists and clinical support staff.
MRSA (Meticillin-Resistant Staphylococcus areus)	MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means that infections with MRSA can be harder to treat than other bacterial infections.
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Needs Based Care	Inpatient adult wards are organised by patient need rather than age for example a cardiac ward, respiratory ward
NELA	National Emergency Laparotomy Audit
Neonatal	New-born – includes the first six weeks after birth

Term	Description
NEWS2	NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012, which advocates a system to standardise the assessment and response to acute illness.
NICE	The National Institute for Health and Care Excellence (NICE) publish clinical guidelines which recommend how healthcare professionals should care for people with certain conditions. The recommendations are based on the best available evidence.
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
NRT	Nicotine Replacement Therapy is treatment that can be prescribed and administered to help people who smoke or vape avoid the withdrawal effects if they stop smoking or vaping
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	Degenerative disorder of the central nervous system
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
PEARL	Post Event Action and Review for Learning (PEARL) – this is the name that we use at the Trust for our panels which are used to review incidents to determine if they meet the criteria of a Serious Incident. They were renamed as part of our move towards a just culture to try and eliminate some of the worry that staff feel about a 'serious incident' by focusing on the learning.
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
PPE	Personal Protective Equipment – consists of masks, gloves, aprons, visors which are worn by clinical staff to protect themselves from the risk of infection
PPH	Post-partum haemorrhage – a term used to describe blood loss after childbirth
Prevalence	The proportion of patients who have a specific characteristic in a given time period
QSIR	Quality, Service Improvement and Redesign The QSIR programmes are delivered in a variety of formats to suit different levels of improvement experience and are supported by publications that guide participants in the use of tried and tested improvement tools, and featured approaches, as well as encouraging reflective learning
RAG rating	Red, Amber and Green ratings are used in the display of some metrics to show whether they meet the standards or not
Red and Green	The Red: Green Bed day is a visual management system to assist in the identification of wasted time in a patient's journey. If it is red, the patient has not progressed, green they have.
Safety Thermometer/Harm Free Care	Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
SHMI	Summary Hospital-level Mortality Indicator **(SHMI)** is an indicator which reports on mortality at trust level across the NHS in England using a standard
Sialadenitis	Inflammation in the salivary glands, usually cause by a virus or bacteria.

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

Research – Glossary of terms

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

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

Statement of Directors responsibilities for Quality Account

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

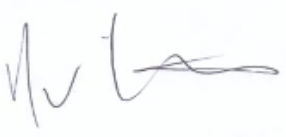
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- 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 2019 to May 2020;
  - papers relating to quality reported to the Board over the period April 2019 to May 2020;
  - feedback from commissioners dated 22nd October 2020;
  - feedback from governors dated (suspended requirement due to COVID pandemic);
  - feedback from local Health watch organisations dated 10th September 2020;
  - feedback from Overview and Scrutiny Committee has not been provided this year;
  - the trust's complaints report (Q1-Q3) published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5th March 2020 (NHS England suspended data collection and reporting for Q4 to create capacity for the COVID-19 response);
  - the 2019 national patient survey;
  - the latest national staff survey dated March 2020;
  - the Head of Internal Audit's annual opinion of the trust's control environment (suspended requirement due to COVID pandemic);
  - CQC inspection report dated 7 December 2018.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- 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

Simon Linnett
Chairman



David Carter
Chief Executive Officer

Stakeholder Feedback

healthwatch Central Bedfordshire

Comments from Healthwatch Central Bedfordshire (HWCB) – Luton & Dunstable Hospital Quality Account

Overview

This report is very informative and well written, it is logically laid out, easy to read and sets the scene. It explains the Trusts objectives as well as its performance. It is also easy to understand why priorities were chosen, what quality improvements the trust has made and how they measure against local and national benchmarks.

The Trust clearly has quality improvement for staff and patients, and their families, at the heart of what they deliver, and the document reflects an overarching approach to quality improvement.

The culture of making things better for patients and staff comes across clearly and is supported by measurable outcomes of success and the Trust is open and transparent about where the Trust has made improvement and where further effort is required.

HWCB notes that there were four Quality Improvement Areas that cover the years 2018- 2021, and these remain:

a. Improve Patient Experience
b. Improve Patient Safety
c. Deliver Excellent Clinical Outcomes
d. Prevention of Ill Health

Within the Report, the Trust has laid out what it has done and continues to do to meet the standards it has set itself. There is evidence supplied of learning and a desire for continual improvement. The Trust is also open in agreeing that it is still falling short in a couple of areas, for example, Discharge Process, Resus Training, and Safeguarding Children Training.

The use of statistical monitoring does in the most part, provide robust evidence of the impact of the quality improvement projects on the delivery, experience and outcomes for individuals, and the Trust is proactive in identifying what further action needs to happen to gain further improvements. It is also refreshing to see that the Trust learns not only from its own data but uses national benchmarks and actively seeks to learn from other organisations and best practice.

2019/20 Quality Priorities

In relation to the quality goals for 2019/20, it is pleasing to see the improvements made in complaints responses and the focus driven from the Chief nurse on this improvement plan.

With regard to the discharge planning priority the Trust acknowledges that it has made some improvements, but there is further effort needed to ensure the process is robust and HWCB are pleased to see this remains a priority for next year as it is vitally important for both the individual patient and their family.

In relation to the progress on falls prevention it is clear that although the Trust has not achieved what it set out to achieve, partly due to the Covid challenges, it is noted and commended that significant progress and improvement has been made. Equally, the improvement in statutory and mandatory training following the CQC inspection last year - the comprehensive plan and achievements are significant. The Trust should be commended on the percentage of staff trained in prevention of radicalisation.

Improvement in the fractured neck of femur pathway represent a significant outcome measure for patients and the overall reduction in mortality over the past three years is very impressive as is performance against the standards for seven-day services.

It is noted that further work is required on alcohol and tobacco screening and brief advice, and this is particularly important given the population demographics. However, HWCB are pleased to see that this has been included as an ongoing priority for the next year.

Other examples of improved performance across the Trust's work are highlighted in the report, for example, the tracking and dealing with complaints, dealing with UTI's, Neck Fractures and Improving Data Quality. In addition, page 30 reviews the steps taken by the Trust in relation to clinical audits and sets out how the Trust has responded.

Other examples of improvements instigated by the Trust include:

- Page 39 outlines the benefits of employing Medical Examiners to deal with cases relating to the deceased and working with those patient's families.
- Page 42 indicates how the 'Freedom to Speak Up Guardian' process works for staff and the benefits of having that person challenge on behalf of staff, and additionally the Trust supports 'Safer Working Hours' for Junior Doctors with a robust process of recording working times.

In addition, the Quality Performance Data Table (P49) gives evidence of internal Governance via for example Patient Safety Trust and Clinical Effectiveness Boards, and the appointment of a Director of Quality responsible for quality improvement is seen by Healthwatch Central Bedfordshire as a positive move.

Patient and Staff Surveys / Engagement / Data

The report highlights a decrease of complaints received and evidence of listening to and learning from incidents where things could have been managed better, and internally the feedback from staff and the Friends and Family Test show great confidence in the organisation. The Trust comments on how effective its internal staff flu vaccination programme was and there is evidence that the Trust performed exceptionally well in the uptake of flu vaccination amongst staff and continual staff engagement.

It is clear that the Trust performs well in the Friends and Family data set with very high scores of patients recommending the service. However, the Trust shows that the measurement is largely static over the last three years and has set out some improvement goals as a result.

In the national staff survey, it is encouraging to see that the scores remain largely positive and there is a strong safety culture reported. The Trust also acknowledges that there is further work to do in relation to equality and diversity, and discrimination, and given the diversity of the staff and population this is welcomed.

The staff undertook a consultation exercise on determining the priorities for 2020/2021. The priorities for 2020/21 are welcomed, and they also set some stretch target, such as the staff flu vaccination rate, but most have some clear measurable goals for improvement and align to the expectations set out nationally and locally, and areas of improvement that one would wish to see for the local population.

There is a clear improvement plan set out for the accuracy and completeness of data quality.

General Comments

P68 onwards (Section 3.21) tables the performance of the Trust in relation to National Averages against the National Core Set of Quality Indicators. The Trust appears to perform very competitively across a range of metrics and again supplies a commentary/explanation behind each target, being self-critical where necessary but giving confidence that it is prepared to take necessary action where relevant.
The report paints a positive picture of the Trust pre Covid. The merger of the Luton & Dunstable and Bedford Hospitals is complete and will set new challenges alongside the pandemic being dealt with, however from this Report it appears that Luton & Dunstable Hospital (as a unit) are in a good place to face those challenges. The trust should be commended for setting high aims on targets, defining why they are important, for being open and honest with areas that need further improvements, and for setting deliberate aims about improving patient experience.

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Luton Council comment on the Luton and Dunstable University Hospital NHS Foundation Trust Quality Account 2019/20

"Thank you for sharing your Quality Account report 2019-20.

Following consultation with the Chair, please note that the Luton Scrutiny Health & Social Care Review Group will not send comments this year."

Democracy and Scrutiny Officer
Luton Council
7th September 2020

Central Bedfordshire Council comment on the Luton and Dunstable University Hospital NHS Foundation Trust Quality Account 2019/20

"SCHH OSC has been reviewing quality accounts from the various hospitals used by Central Bedfordshire Council residents and intends to continue to do so.

This year the accounts have been delayed due to the COVID-19 pandemic and fall at the time when it has not been possible to consider the accounts at a meeting. On this occasion Central Bedfordshire Council does not have a comment to add on the Account. The Committee will look to comment on the next round of Quality Accounts, subject to the deadlines imposed by the Government."

Scrutiny Policy Adviser
Central Bedfordshire Council
11th September 2020

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October 2020

Re: Luton and Dunstable Hospital Quality Accounts 2019/2020

Healthwatch Luton: Board Director Response

The Luton and Dunstable Hospital's Quality Accounts for 2019/20 have been provided for Healthwatch Luton to formally reply as a stakeholder.
Healthwatch Luton are the independent champion for health and social care services, and we gather feedback on a range of providers in Luton from Luton residents, and ensure their experiences are fed to the providers and commissioners to help improve service delivery.

Healthwatch Luton have worked well with Luton and Dunstable Hospital for many years, and in particular, meet often with the Trust's Patient Experience Manager, to discuss a range of comments and feedback from those who have used the Trust's services.

We would like to acknowledge in this response the difficult times to which the Trust has been through over the last half year with the COVID 19 Pandemic, and how, for the feedback Healthwatch Luton collate – the hospital has, through this somewhat uncertain time, provided Luton residents (and beyond) an exceptional level of care and support. There have been many affected services, and it has been with doubt one of the hardest times for most health and care settings but Healthwatch think the Luton and Dunstable Hospital should be commended for their ability to provide a continued high level of care for people even during this time.

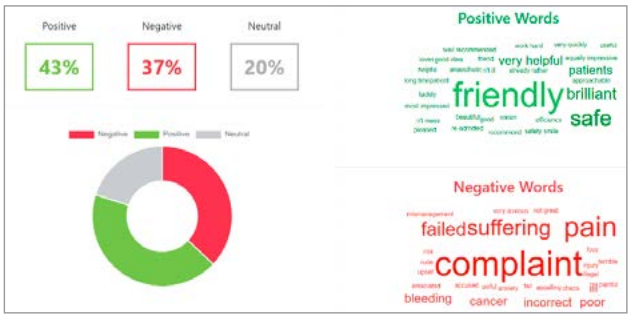
This Quality Account focuses on areas of patient safety, effectiveness of treatment and patient experiences, and this section of our feedback for this account focuses particularly on patient experiences. Under the Hospital's Quality Priority areas – Healthwatch will also highlight our response in relation to Patient Experience.

Healthwatch Luton 2019 Feedback

Each year we collect feedback from Luton residents on a range of health and care services in Luton. We gather both positive and negative feedback on services, and anonymously report these experiences to the providers to help shape delivery of care. We signpost individuals and provide information and support to their health and care decisions, informing them of options and choices available to them.

In 2019, we received nearly 100 feedbacks from Luton residents on the Luton and Dunstable Hospital on a range of areas. Healthwatch Luton also ran three Enter and View visits, speaking to nearly 30 patients whilst in hospital on particular wards, nearly 15 staff and 5 relatives.

The top five areas people feedback to us on were treatment and care, staffing, access to services, communications, facilities and surroundings, administration, and discharge.



Overall in the year, the feedback we received about the hospital was mainly positive, although the thematic review of people's responses highlighted some areas were more significantly negatively fed back on, such as

continuity or integration of care or referrals. The main positive feedback from people was on staffing, facilities and treatment and care.

People reported to Healthwatch that the main positive elements of the hospital experience as a patient was the friendly and attentive staff, the 'safeness' of the wards and the hospital itself, as well as staff being 'helpful' and 'kind'.

The areas that were highlighted most to Healthwatch on patient experience which were negative were around 'not understanding' or 'communications' but all these individuals were picked up and supported by the PALS or Patient Experience Manager individually.

Each feedback was dealt with Healthwatch and the hospital individually. This report highlights the thematic overview of the responses we gathered throughout the year and below highlight the main themes from the entire hospital.

The Themes above do not provide this report much detail in context around people's experiences, for example – the referrals which are mainly negative are mainly around the waiting times in which to get referred into the hospital from other areas such as primary care.

In further detail – people experienced more difficulty in communication and administration (mainly around medication and discharge). However it should be noted some of the referral negative feedback was around the process of referrals. When someone with a long term condition is being reviewed by a consultant, and further symptoms arise – the process of returning to the GP to make a further referral with the same consultant for many patients is time consuming and almost limiting in care and treatment. However, this is a process concern, and not in particular associated with the Luton and Dunstable Hospital.

This year the hospital has accomplished a huge amount during the pandemic – including implementing the pandemic protocols, implementing Rapid Discharge and the merger of the hospitals to make Bedfordshire Hospitals NHS Foundation Trust. They have also focused on the rearrangement of services during the pandemic, continued the development plan of the buildings and secured a good financial plan – all of which should be commended.

The report would like to note the decline in complaints around February / March 2020 in this Quality Account which mirrored Healthwatch's negative feedback of NHS services in full- at the time the COVID-19 Pandemic took hold in England. We continued to receive less negative feedback on the hospital until around June 2020.

Healthwatch Luton feel the Luton and Dunstable and highly responsive to patient experience, in ensuring patient voices are heard and work well and hard with Healthwatch Luton in highlighting patient needs. Our Enter and View reports and reviews evidence how the hospital respond and act on patient recommendations and we feel the Quality Teams and Patient Teams are particularly responsive to any issues raised by Healthwatch Luton, and we thank them for working in partnership with us.

Lucy Nicholson
On behalf of the Healthwatch Luton Board of Directors
Chief Executive
Healthwatch Luton

NHS
Bedfordshire, Luton and Milton Keynes
Commissioning Collaborative

Statement from Bedfordshire, Luton & Milton Keynes Clinical Commissioning Collaborative (BLMK CCG) to Luton & Dunstable University Hospital NHS Trust Quality Account 2019 - 2020

BLMK Clinical commissioning group (BLMK CCG) acknowledges receipt of the 2019/2020 Quality Account from Luton & Dunstable University Hospital NHS Trust (L&D). The Quality Account was shared with BLMK CCGs Non-Executive director (lead for patient safety), Executive Directors, Performance and Quality Teams and systematically reviewed by key members of the CCG's Quality Committee & performance, as part of developing our assurance statement.

The CCG have been working closely with the Trust during the year, gaining assurance on the delivery of safe and effective services. In line with the NHS (Quality Accounts) Regulations, BLMK CCG have reviewed the information contained within the L&D 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.

We would like to commend L&D on their efforts to manage and support patients and staff through the unparalleled challenges faced through the COVID19 Pandemic of 2020. We welcome the joint work with other local providers to reduce system pressure, and are appreciative of the continued efforts undertaken to remodel wider services to meet patient demand and endeavour to provide a positive patient experience. BLMK CCG will continue to work collaboratively with the L&D to support these endeavours.

BLMK CCG welcomes the Trusts continued commitment to safe effective and well led health care and recognises the Trusts alignment of their Quality Improvement & Quality strategy for 2018-2021. In recognition of the diverse population served the Trust have outlined their key priority areas which reflect the Integrated Care System priorities, of improved patient experience, patient safety, improved outcomes and prevention of ill health. BLMK CCG will work alongside the Trust and ICS in support of these priorities over 20/21 and beyond.

Reviewing the Trusts quality accounts from 2019/20 and the associated priorities, BLMK CCG is aware of how these priorities were formed to align with areas requiring improvement and additional assurance on quality delivery.

Areas of quality improvement and performance over 2019/20 that BLMK CCG identified are; positive progress in reduction of inpatient falls and harm to patients as a consequence and been impressive and a positive move in reduction of Trusts complaints as a total. We will work with the Trust to continue to assure that patents are clear on how to complain recognising this reduction.

Priorities on mandatory training in the current climate and in recognition of geographical area served is reflected by improvements in Infection control mandatory training and also significant sustained improvements in Safeguarding and Prevent training.BLMK CCG recognises the improvements for patients and achievements in quality priorities in delivery of "Same Day Emergency Care" targets. We also acknowledge the Trust efforts in supporting staff welfare in delivering 81% of staff flu vaccine in 2019/20.

Moving forward into 20/21 the CCG will work alongside the Trust and our collective ICS partners in the ambition to deliver against the identified key priorities of , outstanding care providers , improved patient experience, patient safety better outcomes a clear focus on health promotion and ill health prevention.We acknowledge the Trusts key advances in developing sustained quality improvements with new formation of Quality Improvement board. In additional role of Medical examiner in reviewing deaths and leading and proposals for improving end of life care across the system in Bedfordshire.

We look forward to working with the newly formed Bedfordshire Hospitals NHS Foundation Trust (Bedford Hospital & Luton & Dunstable University Hospital) across our Integrated Care system in 20/21 and beyond

Patricia Davies
Accountable Officer
BLMK Commissioning collaborative

Anne Murray
Chief Nurse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