Central Bedfordshire Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

This meeting may be filmed.*

please ask for Paula Everitt
direct line 0300 300 4196
date 04 May 2017

NOTICE OF MEETING

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

Date & Time
Monday, 15 May 2017 10.00 a.m.

Venue at
Committee Room 2, Watling House, High Street North, Dunstable

Richard Carr
Chief Executive

To: The Chairman and Members of the SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE:

Cllrs P Hollick (Chairman), P Downing (Vice-Chairman), Mrs A Barker, N B Costin, P A Duckett, Mrs S A Goodchild, Mrs D B Gurney, G Perham and B Walker

[Named Substitutes:

R D Berry, Mrs C F Chapman MBE, J Chatterley, Ms A M W Graham and M A G Versallion]

All other Members of the Council - on request

MEMBERS OF THE PRESS AND PUBLIC ARE WELCOME TO ATTEND THIS MEETING

***This meeting may be filmed by the Council for live and/or subsequent broadcast online at http://www.centralbedfordshire.gov.uk/modgov/ieListMeetings.aspx?CommitteeId=576.**

At the start of the meeting the Chairman will confirm if all or part of the meeting will be filmed by the Council. The footage will be on the Council's website for six months. A copy of it will also be retained in accordance with the Council's data retention policy. The images and sound recording may be used for training purposes within the Council.

By entering the Chamber you are deemed to have consented to being filmed by the Council, including during any representation you might make, and to the possible use of the images and sound recordings made by the Council for webcasting and/or training purposes.

Phones and other equipment may also be used to film, audio record, tweet or blog from this meeting by an individual Council member or a member of the public. No part of the meeting room is exempt from public filming unless the meeting resolves to go into exempt session. The use of images or recordings arising from this is not under the Council's control.

AGENDA

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members

2. **Minutes**

   To approve as a correct record the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 20 March 2017 and to note actions taken since that meeting.

3. **Members' Interests**

   To receive from Members any declarations of interest and of any political whip in relation to any agenda item.

4. **Chairman's Announcements and Communications**

   To receive any announcements from the Chairman and any matters of communication.

5. **Petitions**

   To receive petitions from members of the public in accordance with the Public Participation Procedure as set out in Annex 2 of Part A4 of the Constitution.

6. **Questions, Statements or Deputations**

   To receive any questions, statements or deputations from members of the public in accordance with the Public Participation Procedure as set out in Annex 1 of part A4 of the Constitution.

7. **Call-In**

   To consider any decision of the Executive referred to this Committee for review in accordance with Procedure Rule 10.10 of Part D2.

8. **Requested Items**

   To consider any items referred to the Committee at the request of a Member under Procedure Rule 3.1 of Part D2 of the Constitution.

9. **Executive Members Update**

   To receive a brief verbal update from the Executive Members for:-

   - Social Care and Housing.
   - Health

Part A: External & NHS matters

To review and scrutinise any matters relating to the planning, provision and operation of health services in Central Bedfordshire commissioned by the NHS or external organisations (such as the Clinical Commissioning Group).

Reports

Item	Subject		Page Nos.
10	**Hospital and Care Providers' Quality Accounts 2016/17**	*	11 - 526

Comments on the Quality Account are voluntary, the Committee is not obliged to comment if it does not feel it necessary. Any statements agreed by the Committee will be sent to each Hospital and Care Provider in order to include the statement in their final document.

The Committee is asked to consider the Quality Accounts provided by:-

Appendix A	Milton Keynes University Hospital NHS Trust
Appendix B	Bedford Hospital NHS Trust
Appendix C	South Essex Partnership Trust (SEPT)
Appendix D	East and North Herts Hospital NHS Trust
Appendix E and Appendix F	The Luton and Dunstable University Hospital NHS Trust East London Foundation Trust (ELFT)

At the request of Members, a list of comparable NHS indicators used by Bedford, East and North Herts, SEPT and the Luton and Dunstable has been produced for consideration and comment and is available at Appendix 1.

Part B: Public Health, Social Care & Housing matters

To review and scrutinise any matters that fall within the remit of the Council's Social Care, Health and Housing or Public Health Directorates.

Reports

Item	Subject		Page Nos.
11	**The Integration of Health and Social Care in Central Bedfordshire**	*	527 - 562

To receive the Enquiry team report on the Integration of Health and Social Care in Central Bedfordshire and agree recommendations for the consideration of Executive.

CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE** held in Council Chamber, Priory House, Monks Walk, Shefford on Monday, 20 March 2017.

PRESENT

Cllr P Hollick (Chairman)
Cllr P Downing (Vice-Chairman)

Cllrs	Mrs A Barker	Cllrs	Mrs S A Goodchild
	P A Duckett		G Perham

Apologies for Absence:	Cllrs	N B Costin Mrs D B Gurney Cllr Mrs C Hegley B Walker
Substitutes:	Cllrs	M A G Versallion

Members in Attendance:	Cllrs	E Ghent	Deputy Executive Member for Adult Social Care
		C C Gomm	
		B J Spurr	Executive Member for Health
		Mrs T Stock	Deputy Executive Member for Health

Officers in Attendance:	Mrs P Everitt	Scrutiny Policy Adviser
	Mrs J Ogley	Director of Social Care, Health and Housing
	Mrs R Preen	Scrutiny Policy Advisor
	Mrs C Shohet	Assistant Director of Public Health

Others in Attendance	Mrs S Boulton	Chairman
	Ms M Brooks	Assistant Director Commissioning
	Mr C Goodson	Senior Locality Manager
	Mr C Hartley	East of England Ambulance Service
	Dr Z Kittler	Clinical Director, East London Foundation Trust
	Mr P Rix	Associate Locality Director for Mental Health Central Bedfordshire
	Mr D Simpson	Interim Chairman Central Bedfordshire Healthwatch
	Mr M Tait	Accountable Officer

SCHH/16/80 **Minutes**

RESOLVED that the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 23 January 2017 be confirmed and signed by the Chairman as a correct record.

SCHH/16/81 **Members' Interests**

Cllr A Barker declared an interest as she had been an employee of the East of England Ambulance Trust Service and was supporting a friend who was a current user of East London Foundation Trust (ELFT) services.
Cllr S Goodchild also declared she was supporting a friend who was a current user of ELFT Services.
Cllr M Versallion declared an interest as a non Executive Director of the Luton and Dunstable Hospital.

SCHH/16/82 **Chairman's Announcements and Communications**

The Chairman wished to extend his thanks both personally and on behalf of the Committee to Maurice Jones, who had retired from the Council, for his contribution to the establishment of Central Bedfordshire and for his work more recently as Executive Member for Health.

A visit to the Bromley-by-Bow Community Hub would take place on Tuesday 11 May 2017. Members of the Committee had been invited to attend.

The Chairman would attend a Scrutiny Health Master Class event, also in May.

SCHH/16/83 **Petitions**

None.

SCHH/16/84 **Questions, Statements or Deputations**

None.

SCHH/16/85 **Call-In**

None.

SCHH/16/86 **Requested Items**

None.

SCHH/16/87 **Executive Members Update**

The Deputy Executive Member for Adult Social Care advised:-

- The Council had received the top Pinder Design Award for Best Independent Living Scheme at Priory View, Dunstable and an award for the Greenfields scheme in Leighton Buzzard.
- The additional money allocated to the social care budget. A report outlining how this money would be apportioned would be provided.

- Attendance at the Grove Theatre for a Dementia event. Members requested a dementia workshop be arranged later in the year to include a shortened version of the film 'Inside Out of Mind".
- Attendance at the Saville Seminar on how to set up a Housing Development Company. Members welcomed the initiative and expected to receive more details at a future meeting.

SCHH/16/88 **East of England Ambulance Service Trust (EEAST) - Performance Update**

Sarah Boulton, Chair, EEAST advised Members of the regional picture for the Ambulance Service and advised of improvements that had been made. The improvements had come at a cost and the EEAST had incurred a deficit in funding and had a capacity shortage. The CQC had praised the service for its outstanding care of patients and would continue its focus on clinical triage and the new practice that involved professional advice to paramedics on treatment of patients that avoided a trip to A&E.

Chris Hartley, Director of Communications and Clive Goodson, Senior Locality Manager outlined performance improvements and new innovations implemented by the Ambulance Trust. Of particular note was the success of the Mental Health Street Triage service that had prevented ambulance attendance. The implementation of a Service Plan Review would help inform more efficient and effective operations and identify the resources required to deliver the required service.

Members welcomed the direction of travel and the innovations made by the East of England Ambulance Service Trust in joint working initiatives with other emergency services.

RECOMMENDED the Committee

1. **Appreciated the work undertaken by the EEAST.**
2. **Noted that there is a current financial deficit but were reassured that paying it back will not impinge upon performance.**
3. **Recognised the need to reset the targets by which time an ambulance is expected to reach the patient to take account of the nature of the emergency call.**
4. **Welcomed evidence of how the triage system was saving a number of patients from a hospital admission.**

SCHH/16/89 **Townsend Court Houghton Regis**

Matthew Tait, Chief Accountable Officer, Bedfordshire Clinical Commissioning Group (BCCG) apologised for the lack of consultation on the relocation of Mental Health patients on behalf of the BCCG and ELFT. Patients had been moved from Keats Ward, Weller Wing, Bedford to more appropriate accommodation at Townsend Court, Houghton Regis. Service provision for older patients had been provided at Fountains Court in Bedford for the short to medium term, until a longer term strategy had been developed by the BCCG and ELFT.

Members noted the changes in delivery of mental health care services had been carried out in the patients' best interests. ELFT had increased the

number of clinical staff on wards in the past two years and assurances were given that patients with transport difficulties would be helped on a case by case basis by support staff with transport issues. ELFT are looking at ways of funding appointed drivers to assist both staff and service users and carers with transport issues in the future.

Arrangements would be made for Ward Members and Members of the Committee who wished to visit the Townsend Court Houghton Regis and Fountains Court in Bedford. The Deputy Executive Member also requested a meeting for Ward Members with ELFT officers to discuss the changes to mental health services.

RECOMMENDED the Committee

1. **Expressed its concern about the very late communication on the intention to change the use of Townsend Court. Central Bedfordshire looks to be informed about any such changes at an early date in the future.**
2. **Appreciates ELFT is seeking to improve its mental health services and make good use of its estate but reiterates the fact that Central Bedfordshire has a particular concern for our residents.**
3. **Seeks reassurance that when considering a change of venue for people with certain conditions e.g. Alzheimers, such is taken into consideration.**
4. **Seeks assurance that transport issues are considered when making changes to its service provision.**
5. **Appreciates the offer for members to visit Townsend Court and Fountain Court and would like such visits to be arranged in the near future.**

SCHH/16/90 **Enquiry into Integration of Health and Social Care in Central Bedfordshire - update**

The Chairman updated the Committee on the work of the Enquiry Team in their investigation into the Integration of Health and Social Care in Central Bedfordshire. A report would be submitted on Monday 15 May, 2017.

Noted the update.

SCHH/16/91 **Work Programme 2016/17 and Executive Forward Plan**

The Chairman advised of changes to the work programme that included the addition of the Homelessness Reduction report scheduled for June and the rescheduled date for the Enquiry Report. The Assistant Director Public Health advised a pharmaceutical needs assessment would be undertaken and the findings of this and the Judicial Review would be submitted to the Committee later this year.

Noted the changes to the work programme outlined above.

SCHH/16/92 **Joint Health Overview and Scrutiny Proposal**

The Scrutiny Policy Adviser introduced a report that set out proposals for a Joint Health Overview and Scrutiny Committee to scrutinise the Sustainability and Transformation Plan (STP) for Bedford, Luton and Milton Keynes.

The Committee were in favour of option 3 and supported the proposal that Central Bedfordshire Council undertake the duties of Chairman as it was the only Council without a hospital within its boundary. Members also supported the proposal for Bedford Borough to administer the JHOSC and for the venue to be rotated for each meeting.

Members supported the proposal that the following definitions of a substantive change in NHS provision be included in the Terms of Reference:

- a change in the way the service is delivered;
- a change in the place the service is delivered;
- a change of partners and/or the way in which partners co-operate;
- a change in budgetary arrangements.

RECOMMENDED:

1. **To adopt option 3 and have a JHOSC with statutory scrutiny powers**
2. **To promote the appointment of a Central Bedfordshire Chairman on the basis that Central Bedfordshire does not have a General Hospital within its boundary, would bring some independence to the table and has the larger population in Bedfordshire.**
3. **That the Chair initially be held for two years until the result of the next elections in 2019**
4. **That Central Bedfordshire is supportive that Bedford Borough Council is to administer arrangements.**
5. **That the meeting venue be rotated between the participating authorities;**
6. **That the definition of 'substantial change' be circulated and include the provision outlined at item 4.**

(Note: The meeting commenced at 10.00 a.m. and concluded at 1.43 p.m.)

Chairman……..

Dated……..

This page is intentionally left blank

Central Bedfordshire Council

Social Care Health and Housing Overview and Scrutiny Committee

Monday 15 May 2017

Quality Accounts

Advising Officers:
Tracey Brigstock, Director of Nursing and Patient Services, Bedford Hospital NHS Trust
Jacqui Evans, East and North Herts Hospital NHS Trust (Lister)
Michelle Bradley, Director for Bedfordshire Mental Health & Wellbeing Service, East London Foundation Trust (ELFT)
Sarah Browne, Deputy Director of Nursing for Essex Partnership University NHS Trust
Victoria Parsons, Company Secretary, Luton and Dunstable University Hospital Trust
Kate Burke, Corporate Affairs Director, Milton Keynes University Hospital Trust.

Purpose of this report

The Committee is asked to consider the Quality Accounts from the local hospitals and NHS Care providers in Central Bedfordshire and provide any comments as they feel appropriate. Comment on the Quality Accounts are voluntary, the Committee is not obliged to comment if it does not feel it necessary.

RECOMMENDATIONS

The Committee is asked to comment and agree a statement, if so minded, on the Quality Accounts submitted by Bedford Hospital NHS Trust, SEPT, The East and North Herts NHS Trust, The Luton and Dunstable University Hospital Trust, The East London Foundation Trust and Milton Keynes University Hospital Trust.

Issues

1. All providers of NHS healthcare services in England are required to publish a quality account that represents the quality of the healthcare services delivery over the previous year. Trusts are required to share their quality accounts with Healthwatch and appropriate Overview and Scrutiny Committees with responsibility for health matters who are offered the opportunity to comment on the draft document on a voluntary basis. The quality accounts are produced annually and made available to the public.

2. The Department of Heath (DoH) have produced guidance on Quality Accounts titled “Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)”. The DoH guidance states that “Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.”

3. The Department of Health Guidance “Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)” suggests that OSCs might consider the following:-
   - Do the priorities identified by the provider contained in the Quality Account match those of the public?
   - Has the provider omitted any major issues from the Quality Account?
   - Has the provider demonstrated they have involved patients and the public in the production of the Quality Account?

Corporate Implications

4. The review of services contained in the draft Quality Accounts are for NHS agencies and not the Council itself. The services referred in the Quality Accounts will however support the Council Priorities by protecting the vulnerable; improving wellbeing.

Conclusion and next Steps

5. Any statements agreed by the Committee will be sent to the provider to allow them time to prepare their final Quality Account, which will include the statement, for publication

Appendices

Appendix 1 – Comparable indictors

Appendix A:	Milton Keynes Hospital Trust Quality Account 2016/17
Appendix B:	Bedford Hospital Trust Quality Account 2016/17
Appendix C:	SEPT Quality Account 2016/17
Appendix D	East and North Herts Hospital Trust Quality Account 2016/17
Appendix E	Luton and Dunstable Hospital Trust Quality Account 2016/17
Appendix F	East London Foundation Trust Quality Account 2016/17

Background Papers

Quality Accounts: a guide for Overview and Scrutiny Committees

Appendix 1

Social Care Health and Housing OSC
15th May 2017

QUALITY ACCOUNT

Situation

This paper summarises the approach taken for the development of a set of indicators, common to participating Trusts, for discussion at the annual meeting on 15th May 2017.

The participating Trusts are:

- Bedford Hospital NHS Trust
- East & North Hertfordshire NHS Trust
- East London NHS Foundation Trust
- Essex Partnership University NHS Foundation Trust
- Luton & Dunstable University Hospital NHS Foundation Trust

The set of indicators is attached at Appendix 1.

Background

At the Social Care, Health and Housing OSC meeting in May 2016 the participating Trusts agreed to identify a priority list of 20 performance indicators, common to all, so that Central Bedfordshire residents can compare hospital services in their area.

Assessment

The approach took account of the following:

- There are a number of indicators that are already supplied within the QAs (nationally mandated as core indicators) which therefore should not be re-supplied in a different format where possible
- NHS Digital Indicator Portal lists approx. 1900 indicators. The Quality Account, quality improvement and outcomes framework indicators were reviewed. There was commonality with the mandated lists already included within the QA; or a range of indicators that are too specific to make reasonable comparisons across all organisations
- The indicators need to be comparable in terms of methodology
- The indicators should ideally reflect what is within each organisations ability to control
- The context for each Trust is different so variation is likely

A draft set of indicators was produced taking into account the above points and circulated to the Trust representatives for comment. Each representative was asked to review the indicators and identify those that were collected/ not collected/ not applicable or to add extras they felt would be useful and comparable.

Feedback indicated there is very little common across all Trusts; and where the indicators are not mandated the collection methods are not always comparable. However, eight common indicators were found and the outcomes for these are shown in Appendix 1.

Recommendation

The OSC is asked to consider the indicators supplied.

Appendix 1 – Common indicators

Indicator	Measure	Bedford	Date		Luton	Date		E&N H	Date		ELFT	Date		SEPT	Date
Incidence of MRSA	Number	**1**	2016/17		**1**	2016/17		**2**	2016/17					**1**	2016/17
Incidence of C Diff	Number (& rate per 100,000 bed days)	**8 (9.0)**	2016/17		**8 (3.5)**	2016/17		**22 (10.27)**	2016/17					**0**	2016/17
Staff recommend Trust (Staff survey 2016)	Percentage	**72%**	2016/17		**77%**	2016		**69%**	2016					**71%**	2016
Friends & Family - in-patient	Percentage	**92%**	2016/17		**95%**	2016/2017		**97%**	Feb-17					***96%**	2016/17
Rate of patient safety incidents (NRLS)	Per 1000 bed days	**38.2**	2016/17		**32.2**	Apr-Sept 16		**31.76**	Apr-Sept 16					**43.9**	Apr-Sept 16
KF26 - harassment/ bullying by staff (Staff survey 2016)	Percentage	**22%**	2016/17		**28%**	2016		**29%**	2016					**20%**	2016
KF21 - equal opportunities (Staff survey 2016)	Percentage	**86%**	2016/17		**85%**	2016		**87%**	2016					**91%**	2016
Overall staff engagement (Staff survey 2016)	Score	**3.82**	2016/17		**3.9**	2016		**3.86**	2016					**3.88**	2016

* Note: FFT score applies to community and in-patient services

Appendix A

Milton Keynes University Hospital NHS
NHS Foundation Trust

QUALITY ACCOUNTS 2016-2017

Ref	Contents	Page
1	**Part 1 The Quality Accounts**	
1.1	Statement on quality from the chief executive	4-5
1.2	Statement of Assurance	5-6
1.3	Introduction	6-7
2	**Part 2 Our Priorities**	
2.1	**Priorities for improvement**	7
2.2	Trust Objective 1 – **Patient Safety**	8
2.3	Quality indicator 1: Improving the management of patients with sepsis via delivery of the national CQUIN	8-9
2.4	Quality indicator 2: Delivering the Saving Babies Lives Care bundle in maternity	9-10
2.5	Quality indicator 3: Improving the patient experience through staff engagement	10-11
2.6	Quality indicator 4: Reducing the length of stay	11-13
2.7	Additional indicators	13
2.7.1	Clinical Effectiveness	13
2.7.2	Patient Experience	13-14
3	**Part 3 How we did last year 2016/17**	
3.1	Priority 1 – Improve systems to reduce the frequency and severity of medication errors	14-15
3.2	Priority 2 – Embed the new processes for the identification and management of the deteriorating patient	15-16
3.3	Priority 3 – Improve the management of patients with sepsis	16
3.4	Statement of Assurance from the Board of Directors	16-17
3.5	Obstetrics and Maternity Services	17
3.6	Referral to Treat (RTT) 18 week pathway	17
3.7	Review of Clinical Audits	17-26
3.8	Participation in clinical research	26-27
3.9	Raising the profile of Research and Development	27-28
3.10	Goals agreed with Commissioners CQUIN	28-31
3.11	Care Quality Commission (CQC) Registration and Compliance	31-33
3.12	Data Quality	33-34
3.13	Reporting against core Indicators	34
3.14	Indicator 1: Summary Hospital –Level Mortality Indicator (SHMI) value and banding	35
3.15	Indicator 4-7: PROM scores for groin hernia surgery, varicose veins surgery, hip replacement surgery, knee replacement surgery	35-37
3.16	Indicator 8: Emergency readmission to hospital within 28 days	37
3.17	Indicator 9: Responsiveness to inpatient personal needs	37-38
3.18	Indicator 10: % of staff who would recommend the provider to friends or family needing care	38
3.19	Indicator 11: % of admitted patients risk assessed for VTE	38-39
3.20	Indicator 12: Rate of C difficile	39
3.21	Indicator 13: Rate of patient safety incidents and % resulting in	

	severe harm or death	
4	**Part 4 Other information**	
4.1	Review of Quality 2016/2017	40
4.2	Hand hygiene compliance	41
4.3	Hospital acquired pressure ulcers (grade 3 and 4)	41
4.4	Patient falls	41-42
4.5	Medication incidents	42
4.6	Never Events	42-43
4.7	Duty of Candour	43-44
4.8	Sign up to Safety Campaign	44
4.9	Clinical Effectiveness	44
4.10	Patient Experience	45
Annex 1	**Statements from NHS: Milton Keynes, Milton Keynes Healthwatch MK and Milton Keynes Council's Health and Community Select Committee, Central Bedfordshire Council**	48-50
Annex 2	**Statement of directors' responsibilities in respect of the quality**	**53**
	report	
Annex 3	**Independent Auditor's Report**	**54**
	Scope and subject matter	
	Respective responsibilities of the directors and auditors	
	Assurance work performed	
	Limitations	
	Conclusion	
	Glossary	58-70

Part 1: The Quality Account

1.1 Statement on quality from the Chief Executive

It is my privilege to introduce this year's Quality Account for Milton Keynes University Hospital NHS Foundation Trust.

This important document gives us the opportunity to reflect on all we have achieved in improving the quality of care we provide to our patients during 2016/17; as well as to identify where we will focus our efforts next year to make the care and experience we provide as safe, positive and effective as it can be.

Each year we set our objectives as a hospital and each year our top three objectives are improving patient safety, improving patient experience and improving clinical effectiveness. Those three aims remain at the heart of everything we do and everything we are here to deliver every day, for every one of the hundreds of thousands of people we care for every year.

It has been an exciting year of developments at the hospital, with the Trust investing in the development of staff, our services and the estate itself to improve both the quality and capacity of care we offer the people of Milton Keynes and surrounding areas.

We opened a new 20-bed surgical ward in February 2017 to help us address the ever-increasing demand for our services and began construction on a new main entrance – due to open in June 2017 – which will enable us to accommodate the greater number of visitors who will be coming to the hospital this year.

As well as these improvements to the site, building has also started on a new Academic Centre at the start of the year. The construction is a result of our partnership with the University of Buckingham Medical School, who are funding its development, and will provide an outstanding education resource with facilities to train medical students, doctors, nurses and health professionals working across the hospital.

More good news came in the form of a 'Good' rating following an inspection by the Care Quality Commission (CQC) in June 2016. It marked a significant improvement to our last CQC rating of 'Requires Improvement' two years prior and recognised the Trust as being effective, caring, responsive and well-led.

Demand on the hospital's services continued to increase during 2016/17. We received 11% more GP referrals than had been planned for, and demand on Accident & Emergency was also 3% higher than in 2015/16. The impact of the increase in demand has been that the Trust has accommodated a growing number of emergency admissions, and treated over 1,500 more elective admissions than planned at the start of the year.

Despite the increase in demand on its services, the Trust has successfully reduced waiting times for planned patients during 2016/17, and the national standard for

consultant-led Referral to Treatment Waiting Times was successfully delivered for five consecutive months. The national standard for diagnostic waiting times also achieved for the whole of the second half of the year. Performance against cancer treatment standards has proved a challenge but significant improvements were made in the final quarter of 2016/17.

I look forward to another year of developing and continuing to improve our hospital and the care we provide for the people of Milton Keynes.

1.2 Statement of Assurance

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to the best of my knowledge, the information in the document is accurate.

During the year, we have continued to be actively engaged with the Milton Keynes Council Health and Adult Care Select Committee and the Health and Wellbeing Board on subjects of importance to the community.

This report also outlines our measures for assuring and sustaining performance for the future, recognising that there are areas requiring improvement

This report also outlines our measures for assuring and sustaining performance for the future, recognising that there are areas requiring improvement.

Joe Harrison

Chief Executive

May 2017

1.3 Introduction

This report provides an overview of performance across our key priorities and illustrates our commitment to providing a quality service for patients.

It also outlines our planned measures for assuring and sustaining our performance for the future. This includes recognition that there are areas which require improvement.
Milton Keynes University Hospital NHS Foundation Trust (referred to as 'MKUH' or 'the Trust') is a district general hospital providing a broad range of general medical and surgical services, including A&E, maternity and paediatrics. We continue to develop our facilities to meet the needs of a fast-growing population. The hospital provides services for all medical, surgical, maternity and child health emergency admissions.

In addition to delivering general acute services, Milton Keynes University Hospital increasingly provides more specialist services, including cancer treatment, cardiology and oral surgery. It also has responsibility for treating premature babies born locally and in the surrounding areas.

We aim to provide quality care and the right treatment, in the right place, at the right time. The Trust's strategic objectives are focused on delivering quality care, with the first three objectives being:

1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness

To support our framework for quality we have a rigorous set of standards for monitoring our performance against local and national targets, and this helps us to tackle issues as they arise.

As well as our staff, we are also proud of our strong relationships with our stakeholders. The involvement of patients, the public, governors, local information networks, and health system partners is integral to our development.

Our governors are involved throughout the year in monitoring and scrutinising our performance. The governors continue to demonstrate their enthusiasm and commitment to fulfilling their role as elected representatives of patients and the public, through their direct activity with the community as well as their participation in Milton Keynes Healthwatch meetings and other community forums. An elected governor also attends meetings of the Quality and Clinical Risk Committee which

monitors performance of the hospital against the quality priorities set in the Quality Account.

During the year, we have continued to be actively engaged with the Milton Keynes Council Health and Adult Care Select Committee and the Health and Wellbeing Board on subjects of importance to the community.

This report also outlines our measures for assuring and sustaining performance for the future, recognising that there are areas requiring improvement.

Part 2 Our priorities

2.1 Priorities for Improvement

Introduction

Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement.

The purpose of the Quality Accounts is to enable:

- Patients and their carers to make well informed choices about their providers of healthcare;
- The public to hold providers to account for the quality of the services they deliver; and
- Boards of NHS providers to report on the improvements to their services and to set out their priorities for the following year.

As part of our quality account for 2017/18 the Trust is required to choose at least three quality priorities for the year to be included within Part 2 of our Quality Accounts.
There are criteria for choosing these priorities, which are:

- They should be determined following a review of the quality of service provision
- They should reflect both national and local indicators
- They should be aligned with the three domains of quality: patient safety, clinical effectiveness and patient experience.

Once agreed the Quality Account must report upon how progress to achieve the priorities is identified, including how they will be monitored and measured and how they will be reported by the Trust.

Our Priorities for 2017/18

The following priorities identified have been shared with, and agreed by our governors.

2.2 Trust Objective 1 – Improving Patient Safety

1. Improving the management of patients with sepsis via delivery of the national CQUIN
2. Delivering the Saving Babies Lives Care Bundle in maternity
3. Improving the patient experience through staff engagement
4. Reducing length of stay

2.3 Quality Indicator 1: Improving the management of patients with sepsis via delivery of the national CQUIN

Sepsis is the leading cause of death in hospitals worldwide. The incidence of sepsis is increasing, likely in part to be due to an ageing population who are more at risk of infection. The UK Sepsis Trust estimates that over 12,500 lives per year could be saved if sepsis is recognised and treated in its early stages. Early identification and treatment is key to reduction in death from sepsis. There is evidence to show that we can make improvements in our recognition and treatment of sepsis. Administration of intravenous antibiotics within one hour of diagnosis of sepsis is the gold standard and the priority for treatment as part of the regime known as the 'Sepsis Six'.

The Trust has worked very hard in 2016/17 to improve sepsis care in line with best practice and this will continue in 2017/18.
During the year we were measured against these standards via the national CQUIN:

- Every patient who attends one of our emergency areas must have a sepsis assessment and, if they are identified as having sepsis, they must be given antibiotics within 1 hour. The national minimum target is 50%
- Every patient identified as having sepsis in an inpatient setting must be given antibiotics within 1 hour. The national minimum target is 50%

As part of NHS England's CQUIN indicators for Sepsis the Trust reported against the timely identification and treatment for sepsis in Emergency Departments and Acute Inpatient settings respectively. As a result of the sampling methods used to measure performance against CQUIN indicators, the Trust has not met the quarterly targets required for these CQUIN's We believe that this is due to a mixture of non-compliance with the protocol and continued difficulties collecting the data.
Our performance was 33%

Sepsis has received trust wide attention and has been the focus of a specific working group which is chaired by the Associate Medical Director Lead for Patient Safety, with MKUHFT also being represented at the Oxford Academic Health Network Sepsis Steering Group. The MKUHFT Sepsis working group is multidisciplinary including sepsis leads for each clinical division as well as representatives from Clinical Governance, Management, Nursing, Education, Transformation and Communications. During the year the MKUHFT working group has developed and supported the introduction a new proforma across the adult admission and inpatient areas and is in line with recent NICE guidance and the UK Sepsis Trust. Sepsis boxes have been introduced across the organisation including maternity areas.

These boxes contain all of the equipment and documentation to implement the Sepsis six.

There is an increasing level of training being rolled out across the organisation with training included in the Trust induction programme, and bespoke sessions, which have included maternity and the Emergency Department. Sepsis training has been identified by the Sepsis group to be extended across the organisation in 2017/18.

Work has been ongoing to increase awareness of sepsis to both staff and our patients. Patient and relative information and communications leaflets have been introduced with information reflecting the national guidance. Staff awareness has included sepsis scenarios used in Simulation Acute Medicine training which is multi professional and enables doctors and nurses understand the practical processes involved with identification and management of sepsis.

A new trust guideline is currently in development to ensure all staff have ready access to the in-house expectations for sepsis treatment and care pathways, and will link together all the improvements the Sepsis Working Group have established this year. In addition all deaths from sepsis are reviewed to ensure that all correct steps in the patients care had been taken.

2.4 Quality Indicator 2: Delivering the Saving Babies Lives Care Bundle in maternity
Measurement – a 90% completion of the 'fresh eyes' process on the Labour ward

Saving Babies' Lives Care Bundle is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

The care bundle approach is now a recognised and familiar way to bring about improvement in the NHS. Care bundles typically draw together a small number of focused interventions designed to effect improvement in a particular disease area, treatment or aspect of care. When implemented as a package, evidence shows that greater benefits are achieved at a faster pace than if those improvements had been implemented individually.

As a Trust we are undertaking all four elements of the saving lives bundle, one of the few Trusts in the country to do so. For our quality priorities we are focussing on the care bundle about effective fetal monitoring during labour as this has emerged as a theme when we have looked at some of the care we have delivered.
For high risk births we regularly check the babies' heart rate using an electronic trace called a CTG (Cardiotocography). This trace gives us an indication of fetal wellbeing.

Reading the trace is a complex process so we undertake a second check of every trace to reduce the risk of incorrect interpretation. This is undertaken by the midwife caring for the woman and a second midwife who acts as an independent review. This process is known as 'fresh eyes'. We measure how well our labour ward completes the 'fresh eyes' reviews every hour and we report on this every month. We believe that this is a key intervention to deliver the care bundle and it is also an area that we can make improvements and so we have chosen this as a priority.

2.5 Quality Indicator 3: Improving the patient experience through staff engagement

Measurement – Three marks improvement in the staff survey key finding of "Staff recommendation of the trust as a place to work or receive treatment"

The quality of patient experience, as measured by inpatient satisfaction in acute trusts, is strongly linked with engagement (as it is with other aspects of staff experience). Patient satisfaction is significantly higher in trusts with higher levels of employee engagement. Research conducted by Professor Michael West of Aston Business School, have been able to establish a connection between levels of staff engagement and patient experience through the results of the staff survey data and other performance data.

Each year NHS staff are invited to take part in the NHS Staff Survey, the largest survey of staff opinion in the UK. Staff are sent a questionnaire asking about many different aspects of working experience including appraisal and development; health and wellbeing; raising concerns and staff engagement and involvement.

The staff engagement element of the survey looks at the three dimensions of engagement: the levels of motivation and satisfaction; involvement and willingness to be an advocate of the service. The scores across all three dimensions are converted into an overall staff engagement score, which is an index of staff engagement in the Trust.
Michael West's research shows that where staff engagement scores are high, scores are also significantly higher for patient satisfaction.

"Staff recommendation of the trust as a place to work or receive treatment" finding forms part of the staff engagement score and is also seen as important indicator of staff confidence in the quality of care. There is evidence from analysis of the staff survey that links high scores on staff recommendation of the organisation as a place to work with patient satisfaction.

The trust's overall staff engagement score of 3.81 out of 5 (the higher the better) remained unchanged since 2015 and was average when compared with trusts of a similar type. However, the key finding of "staff recommendation of the trust as a place to work or receive treatment" decreased slightly from last year to 3.74 and is marginally below the national average of 3.77.

Given the importance of this key finding in improving patient experience, the trust seeks to increase its rating by three marks to 3.77.

With this renewed focus on staff engagement in the Trust, it has adopted a range of initiatives and interventions to support improved staff engagement and have a positive impact on patient experiences. This includes "You Said, We Did" campaign – which addresses the areas for improvement from the results of the survey; staff health and wellbeing initiatives, Schwartz rounds, value based appraisals and in May 2017 the first Event in the Tent.

The core concept of the Event in the Tent is to provide a forum where the trust can encourage and increase participation amongst staff and invite them to share their views on the Trust including improvements in patient experience and staff experience. With the recent CQC rating of Good, the Trust is now looking at ways in which it can achieve an 'Outstanding' rating and how we can support our staff in realising this ambition. This involves developing an open culture where staff feel confident to challenge our current ways of working and also looking at the health and wellbeing of staff to create a happier, healthier workforce.

It is envisaged that with this increased focus on staff engagement will result in an overall slight increase in the key finding. The key finding will be reported in the next staff survey. However, the scores will be monitored quarterly as part of the staff friends and family test reports.

2.6 Quality Indicator 4: Reducing the length of stay

Measurement: - A 5 percent increase in the number of patients discharge before midday.

Every hospital faces growing demand for services and all are looking for ways to improve patient experience and promote safe and timely discharge and reduce length of stay. Ensuring that patients don't stay in hospital for any longer than is clinically necessary improves quality of care, prevents patients becoming deconditioned and supports freeing up of capacity in the system.
Nationally there is a real drive to for hospitals to embed the Red: Green Bed days and the SAFER patient flow bundle and we are in the process of implementing these tools. All of these actions together should assist us in discharging patients more safely and more quickly.

Red: Green Bed days

Red: Green days is a visual system to assist hospitals in the identifying wasted time in a patient's journey and can be applied to in-patient wards in both acute hospital and community settings. At the centre of this concept are patients and their involvement in setting the expectation of what will be happening as part of their care in hospital. These 4 simple questions should be asked as soon as possible after their arrival at hospital.

1. **Do I know what is wrong with me or what is being excluded?**

2. **What is going to happen now, later today and tomorrow to get me sorted out?** (The diagnostic tests, therapy interventions etc with specified timelines as to when things ought to happen)
3. **What do I need to achieve to get home?** (The 'clinical criteria for discharge', which is a combination of 'physiological and 'functional' factors)
4. **If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?**

   Lack of clarity to the answers to any of these 4 questions often results in 'hidden waiting' which creates frustration and confusion for the patient.

A Red Bed Day is defined as a day when the patient is not in receipt of 'care' that is required to be delivered as an in-patient. With the key question – 'what is this patient waiting for to progress to the next phase of their care?' It is not simply that something is happening that makes it a Green Bed Day, it only becomes a Green Bed Day if that process/test/procedure could only happen as an in-patient for that particular patient's circumstances on that day. The day remains a Red Bed Day until the result of the investigation/ test is acted upon. Red days for patients often occur at weekends and Bank Holidays. Overall Red and Green days support in proactively identifying delays and resolving those to improve patient care and deliver improved flow.

SAFER Patient flow bundle

The SAFER patient flow bundle is a practical tool to help reduce delays for patients in adult inpatient wards (not maternity). When followed consistently, there are noticeable improvements in patient safety, patient flow and a reduction in length of stay.

The SAFER bundle consists of 5 elements of best practice. It's important that all 5 elements implement all five elements together to achieve cumulative benefits. The SAFER patient flow bundle works particularly well when it is used in conjunction with the 'red & green days' approach.

The SAFER patient flow bundle stands for:

S – **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – **All** patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set presuming ideal recovery and assuming no unnecessary waiting.

F – **Flow of patients** will commence at the earliest opportunity from assessment units /ED to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – **Early discharge. 33%** of patients will be discharged from base inpatient wards before midday.

R – **Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

2.7 Additional indicators

In addition to the 4 priorities given above the Board considers three indicators in Patient experience and Clinical Effectiveness which it monitors on a monthly basis to provide an overview of care delivered by the Trust. These indicators support the delivery of the Trust objectives which the Board has consulted the organisation and governors on.

2.7.1 Clinical Effectiveness

Patients Discharged at the weekend
The Trust has made significant investment in additional doctor's rounds at the weekend to facilitate discharge as this is when patient flow is at its most challenging. Our performance on this issue has been particularly good in the second half of the year since the investment was made

Numbers of delayed transfers of care
A delayed transfer of care occurs when a patient is medically fit for discharge but is waiting for a place to go home to – this may be their own home with a package of care, or a residential or nursing home. The Trust is working with our partners to improve discharge for our patients, and the Board continues to monitor this indicator, as it has not been met at any point this year.

Discharges from our Patient Discharge unit
The Trust has concentrated getting patients to our discharge lounge as soon as possible on the day of going home as it allows us to admit both emergency and planned patients much more quickly to the wards.

Patient Experience

Friends and Family Test recommend rates from patients. In 2016/17 the Trust's performance was 93%. The Friends and Family test is a national indicator which can be used to assess the Trust's performance against other organisations. In addition, the performance from different areas of the hospital is reviewed and action taken to address lower scores.

Response to Complaints within agreed timescales.
In 2016/17 the performance was 80**%** of complaints responded to within the agreed time against a target of 90%. The PALS and Complaints team is working with individual services to improve the timeliness of responses to complaints.

Over 75 year old patient ward moves at night
In 2016/17 over 1,800 patients over 75 years old were moved after 10pm at night. The Board recognise that wherever possible any such moves should be minimised, but that at times it is necessary to move patients to a bed in a more appropriate care location.

Part 3 How we did last year 2016/2017

3.1 Priority 1

Improve systems to reduce the frequency and severity of medication errors

There was an improvement in the reporting of medication errors in 2015/16 following a local CQUIN. The Trust subsequently chose to build on these improvements and further reduce the frequency and severity of medication errors. The approach taken focused on improving medication safety by reviewing and improving the systems used, principally the introduction of the national medication safety thermometer which provided a system for collecting data and a baseline to highlight areas for improvement.

MKUH has been collecting and uploading this data to the national tool, but since January 2017 the Trust has been unable to extract this data due to management and support arrangement changes at a national level. The ownership of the data has now changed to NHS South, Central and West Commissioning Support Unit and plans are in place to revise and relaunch.

Quarter 1 of the year was used to identify resource and agree processes for effective data collection. Test data was submitted in May and June, and monitoring started in July and ceased in quarter 4 for the reasons set out above.

The latest data MKUH holds is from November 2016 and shows:

a) The proportion of patients who had medication checked by a pharmacist within 24 hours of admission:
   - Average of 80% achieved. The possibility of raising this percentage depends on changes to weekend working and the introduction of additional pharmacy ward presence.

b) The proportion of patients who have had an omitted dose in the last 24 hours:
   - Medication Safety Thermometer - November data - 11% achieved. This proportion has reduced from a high of 13.5%. Work has been undertaken to improve medication storage on the wards, ensuring the medicines can be located by staff more easily.

c) The proportion of patients with medicine allergy status documented:
   - Medication Safety Thermometer - November data - 100%.

d) The proportion of patients with an omission of critical medicines:

- Medication Safety Thermometer - November data - 16%. There was a significant increase in October / November due to the unavailability of a key antibiotic as a result of a manufacturing problem - the average for the year was 6.8%. Antibiotic guidelines have now been reviewed to ensure that we have the necessary medicines available.

e) The proportion of patients receiving a high risk medication in the last 24 hours
   - Medication Safety Thermometer - November data - 39% against an average of 30%. This reflects the increase in antibiotic use in the winter months.

f) The proportion of patients on a high risk medication that trigger a multi-disciplinary team (MDT) referral:
   - Medication Safety Thermometer - November data - 1% which is higher than the 0.4% average due to the increase in use of critical medicines in the winter.

The focus this year was on setting up the process for recording as part of the medication safety thermometer, safe storage of medicines, ensuring they can be located, that medicines are available when and where they are needed and the appropriate use of antibiotics.

A service improvement project titled “The Safe and Secure Handling of Medication on Ward based Drug Trolleys” conducted by Anum Ahmed, a pre-registration pharmacist, won the regional Pre-Registration Project competition, and has been key to improving the safe use of medicines on our wards.

3.2 Priority 2
Embed the new processes for the identification and management of the deteriorating patient

Early identification of clinical deterioration is important in preventing subsequent cardiopulmonary arrest and reducing mortality. However, sometimes patients’ conditions deteriorate before staff are able to recognise and respond to the signs. This highlights the complexity in seeking to consistently and effectively detect and act on patient deterioration.

Following the investment in digital technology to assist in the collection of clinical observations (blood pressure, pulse, oxygen saturation levels) the Trust has embedded the use of the National Early Warning Score (NEWS) charts. Education and training was introduced in 2014/15 and has continued into 2016/17. This training is run in conjunction with the Rapid Response Team and embeds the Level 1 pathway (the pathway of care for acutely unwell patients). The Level 1 pathway was modelled on a successful initiative on the hospital’s paediatric wards, providing enhanced medical and nursing oversight of patients who might deteriorate, and promoting early decision-making and communication with the patient and family.

Data continues to be captured via the nursing metrics about the taking and recording of clinical observations and the appropriate escalation of observations outside normal parameters. This year the metrics had the additional requirement for staff to document the frequency of the observations needed as well as reporting the actual completion of observations undertaken. This additional indicator was added to improve the recognition of the changing needs of the deteriorating patient, including altering the frequency of observations needed, and ensuring this is communicated effectively between staff and teams involved in the care of a patient.

The Trust target for achievement of patient observations undertaken at the frequency indicated is 95% (Q1 in the table below) with current Trust wide performance (March 2017) being reported as 92%, an improvement from the 90% recorded in March 2016.

The Trust target for documenting the NEW score is 90% (Q2 in the table below), and current performance (March 2017) is at 93%, maintaining the levels achieved in 2015/16.

Trust wide nursing metrics for recognising the deteriorating patient:
Q1 Have patient observations been undertaken at frequency indicated?
Q2 Has the NEW score been documented?

	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Q1	95%	90%	90%	69%	85%	86%	91%	93%	92%	91%	92%	92%	92%
Q2	90%	93%	93%	95%	92%	94%	93%	93%	92%	94%	93%	93%	93%

The Rapid Response (RR) service captures data about patients on the daily caseload and provides regular reports to Clinical Quality Board. Since the introduction of the L1P the number of patients on the pathway has risen steadily. Baseline data from before the introduction shows that the number of deteriorating patients on the RR caseload in the hospital has more than doubled. The pathway has been adopted for maternity patients in February 2017, and the RR service will continue to capture activity data to track the use of the L1P in the hospital and present their findings to both the Nursing and Midwifery Board and the Clinical Board, to review recommendations and support the embedding of the new system.

3.3 Priority 3
Improve the management of patients with sepsis

We have reported against our management of patients with sepsis this year as this target has been rolled over.

3.4 Statement of Assurance from the Board of Directors

During 2016/17 Milton Keynes university Hospital NHS Foundation Trust provided and/or sub-contracted 37 relevant health services.

Milton Keynes University Hospital NHS Foundation Trust has reviewed all data available of care in those 37 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2016/17.

3.5 Obstetrics and Maternity Services

The Trust has continued its monitoring of improvements in obstetric and maternity services and was pleased by the 'good' rating from the CQC following inspection during the year. The maternity improvement board continues to meet and drive through quality changes for the benefit of the women and children in our care.

3.6 Referral to Treat (RTT) 18 week pathway

Despite treating significantly more patients than during the previous year, the Trust has successfully reduced waiting times for patients. Against the NHS Improvement recovery trajectory agreed at the beginning of 2016/17, consultant-led referral to treatment waiting times have consistently delivered in the second half of the year.

The national standard of 92% has also been achieved consistently since November 2016:

Month 2016/17	NHSI Trajectory	Trust Performance
April	88.0%	88.0%
May	88.5%	88.5%
June	88.2%	87.4%
July	89.2%	88.7%
August	89.5%	88.8%
September	90.3%	89.9%
October	90.6%	91.7%
November	91.5%	93.1%
December	92.2%	92.6%
January	92.3%	92.5%
February	92.4%	92.5%
March	92.5%	92.5%

3.7 Review of Clinical Audits

The Trust is committed to delivering effective clinical audit in all clinical services it provides. The Trust sees clinical audit as a cornerstone of its arrangements for developing and maintaining safe, high quality patient-centered services. The Trust

clinical governance and compliance assurance mechanisms provide opportunities to:

- Provide assurance of compliance with clinical guidelines and standards;
- Identify and minimise risk, waste and inefficiencies;
- Improves the quality of care and patient outcomes.

We are committed to participating in relevant National Confidential Enquiry to help assess the quality of healthcare nationally and to bring about improvements in safety and effectiveness.

During this period MKUH participated in 31 (79%) eligible National Clinical Audits which met the Quality Accounts inclusion criteria.

Participated eligible	31
Not participated	7
Not applicable	10

The Trust participated in 5 National Confidential Enquiry into Patient Outcome and Death studies.

National Confidential Enquiry into Patient Outcome and Death Study Eligible 2016-17	**Participated**	**Cases Submitted**
Mental Health	Yes	5
Acute Pancreatitis	Yes	5
Acute Non Invasive Ventilation	Yes	4
Chronic Neuro disability	Yes	2
Young People's Mental Health	Yes	2
Cancer in Children, Teens and Young Adults	No – no cases identified	

National Audit Participation 2016-17	**Number of cases submitted**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	111
Adult Asthma	Not available

Asthma (paediatric and adult) care in emergency departments	Not available
Bowel Cancer (NBOCAP)	426
Cardiac Rhythm Management (CRM)	Not available
Case Mix Programme (CMP)	453
Diabetes (Paediatric) (NPDA)	125
Elective Surgery (National PROMs Programme)	Not available
Falls and Fragility Fractures Audit programme (FFFAP)	549
Inflammatory Bowel Disease (IBD) programme	53
Learning Disability Mortality Review Programme (LeDeR Programme)	4
Major Trauma Audit	266
Maternal, Newborn and Infant Clinical Outcome Review Programme	Not available
National Audit of Dementia	55
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	41
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	17
National Diabetes Audit - Adults	44
National Emergency Laparotomy Audit (NELA)	105
National Heart Failure Audit	354
National Joint Registry (NJR)	
National Lung Cancer Audit (NLCA)	143
National Prostate Cancer Audit	392
Neonatal Intensive and Special Care (NNAP)	449
Nephrectomy audit	Not available
Oesophago-gastric Cancer (NAOGC)	44
Paediatric Pneumonia	20
Percutaneous Nephrolithotomy (PCNL)	Not available
Renal Replacement Therapy (Renal Registry)	8305
Sentinel Stroke National Audit programme (SSNAP)	207
Stress Urinary Incontinence Audit	Not available
UK Cystic Fibrosis Registry	21

The following audits which we were eligible but MKUHFT did not participate are:

National Cardiac Arrest Audit (NCAA)	Trust runs own audit using same tool as national audit
National Ophthalmology Audit	Software issues
National Vascular Registry	Vascular service is run from Bedford
Rheumatoid and Early Inflammatory Arthritis	Departmental pressures meant the team were unable to complete the second audit
Head and Neck Cancer Audit	Care is shared with Northampton hospital
Endocrine and Thyroid National Audit	Care is shared with Northampton hospital
Severe Sepsis and Septic Shock – care in emergency departments	Trust participating in local CQUIN

There were 11 national audit reports published and reviewed during this period

National Bowel Cancer Audit

Colorectal (large bowel) cancer is the most common cancer in non-smokers and second most

common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death in half of this number.	
Recommendation(s) Discussion points and actions points we intend to take	
1.	Continue current work on improving data collection and upload
2.	Audit data on circumferential resection margins for rectal cancer patients

Actions points carried forward onto forward audit plan for 2017-18.

National Clinical Audit of biologic therapy in Inflammatory Bowel Disease	
Recommendation(s)/Outcomes Discussion points and action points we intend to take	
1.	All patients will continue to be discussed in IBD Multidisciplinary Team to decide if Biologic therapy is appropriate.
2.	Continue screening patients before the biologic therapy
3.	Book a follow up clinic appointment at 3 months from 1st dosage for review of their disease activity
4.	Continue to use Biosimilars

Actions are being taken forward through the Medicine Clinical Improvement Group.

National Diabetes in Pregnancy	
The audit is a measurement system to support quality improvement in the care of women with diabetes who are pregnant or planning pregnancy, and seeks to address three key questions: • Were women adequately prepared for pregnancy? • Were adverse maternal outcomes minimised? • Were adverse fetal/infant outcomes minimised?	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Pre conception clinic
2.	Augmented care planning for pregnancy counselling
3.	Adequate dedicated Specialist Nurse support (currently only 2 days per week for pre conception, antenatal, post natal including pumps in pregnancy)
4.	Supported IT technologies – DIASEND, telehealth
5.	Audit current knowledge of pre pregnancy planning among patients
6.	Poster presentation in November local diabetes conference to highlight our performance

Actions are being taken forward collaboratively with Womens health and Medicine Governance groups.

National Heart Failure Audit
The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.
Recommendation(s)/Outcomes Discussion points and actions points we intend to take

1.	To improve coding, share with teams to use “diagnosis” rather than “?” or “impression”
2.	Partake in next annual audit
3.	Discuss with coding to come to audit afternoon in 2017 for education
4.	Business case for additional Advanced Nurse Practitioner; to preset at Management Board
5.	AHF pathway to improve referral to specialist for review
6.	Engage with community re overall pathway

Actions for the heart failure audit are tracked through the Cardiology Governance Meeting.

Stroke Sentinel National Audit Program (SSNAP)	
The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks.	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Need for improved adherence to agreed ring fenced bed policy
2.	Need to increase SALT provision for SRU.
3.	Need to review nurse numbers per shift.
4.	Need to involve patients and carers in evaluating care.

The Acute Stroke Audit actions are tracked at the quarterly quality meeting with Milton Keynes Clinical Commissioning Group and divisional dashboards.

Audit of Red Cells and Platelet Transfusion in Adult Haematology Patients	
The objective of this national audit was to examine the use of platelet transfusions against audit standards developed from national guidelines.	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Review local blood transfusion policy
2.	Review mandatory presentations
3.	Audit Blood Transfusion prescription requests
4.	Audit of platelet Transfusions
5.	Develop and publish local platelet guideline

Intensive Care National Audit and Research Centre Case Mix Programme

The Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland.

Learning identified from report and recommendations:

1. Our acute hospital standardized mortality rates for unit survivors is within 2SD of the national mean and our SMR for those with predicted mortality <20% is less than the national average.
2. Our bed days of care >8 hour delay (i.e. delayed discharges from DoCC to ward) is still very poor and we are a national outlier in this respect
    a. **Recommendations and actions we intend to take**:
        i. This is given a far greater priority within the Trust at all levels, including executive, operational, nursing and medical.
        ii. DoCC is moved up priority list when ward beds become available. This should be highlighted at morning "safety huddle" and is especially important when the DoCC is at capacity and unable to accept emergency admissions
        iii. Improved use of L1P to identify sick patients who need L2/3 care and proactive movement of patients from DoCC to improve patient flow and safety.
        iv. Consideration to CQUIN to meet improved time-to-discharge. These remain available for negotiation but we are still too much of an outlier for this to be a financially viable option.
    b. Note: I have already met Head of Operations lead, to discuss this issue. In addition, this must be flagged up to executive level if any progress is to be made

What did we do well at in the Trust? i.e. better than the England average

1. Unit acquired infections
2. Out-of-hours discharges
3. Non-clinical transfers
4. SMR for patients with predicted mortality <20%
5. Data collection

Actions for the ICNARC audit are being taken forward through the Clinical Improvement Group for Surgery.

National vascular registry 2016

The National Vascular Registry is measures the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals in England and Wales. It aims to provide comparative information on the performance of NHS vascular units and thereby support local quality improvement as well as inform patients about major vascular interventions delivered in the NHS. The measures used to describe the patterns and outcomes of care are drawn from various national guidelines including: the "Provision of Services for Patients with Vascular Disease" document and the Quality Improvement Frameworks published by the Vascular Society, and the National Institute for Health and Care Excellence (NICE) guidelines on stroke and peripheral arterial disease.

Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Difficult to extrapolate at MKUH – we don't do major arterial work here – it is all done in Bedford and with STP pathway will become centralised in Northampton shortly

No actions to be taken by Milton Keynes University Hospital Foundation Trust

National Neonatal Audit Programme	
Recommendation(s)/Outcomes Discussion points and actions points	
1.	To improve admission temperature by revising guidelines on usage of plastic bags for <34 weeks and education on resuscitation
2.	To improve administration of breast milk wihtin 24 hours of admission by allocating dedicated staff and resources- recruitment is in progress
3.	To improve number of babies on breast milk on discharge-

National Paediatric Asthma	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Education on assessment and management of asthma, wheeze and LRTI to doctors
2.	Education on the use of CXR and IV Abx
3.	Ensuring discharge advice provision and safety netting, usage of discharge stickers
4.	Review discharge criteria on the asthma guideline

National Paediatric Diabetes	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Continue to focus resources on patients with high HbA1c – nurse led high HbA1c clinics.
2.	To employ a psychologist as part of the diabetes team to support children and families with diabetes – business case accepted and discussion with CAMHS underway to employ additional team member.
3.	To work with IT to improve design and function of SPARKLE database so that activity and data is captured in national audit.
4.	Continue to offer pump therapy to families

There were **78** local clinical audits reviewed for this period. Below are examples of actions points we intend to take identified/taken to improve care.

Audit title	Key actions taken/we intend to take to improve patient care
Were all patients having had bowel surgery seen 1st day post op by a Physiotherapist?	Updated weekend patient sheet to include instructions to contact ward 20 either in person or by telephone to details of any new post-operative patients

Re-audit of fine needle aspirate	Local patient management guideline for fractured neck of femur updated to include standards for the transfer of patients from the Emergency Department to the Orthopaedic Ward within 2 hours of arrival.
Compliance of physiotherapy service in the stroke unit with NICE Guidelines	• Implementation of 7 day service for the physiotherapy team in the stroke unit. • Changed the prioritisation criteria for workload during the weekend
Tissue Retention Audit	100% of records were compliant with the standards set out in the MKHFT Records Management Policy and the Human Tissue Authority's Standards.
Competency of FY1 and FY2 doctors to interpret x-rays to confirm correct naso-gastric tube placement	• Registrar and above to interpret xrays within daytime hours • the on call radiologist will help interpret xrays which are difficult to interpret. • Ward poster for all ward areas. Naso gastric tube training on FY1 teaching programme.
Improving compliance with standards of record keeping in the in-patient physiotherapy services	• Written guidance produced for Physio staff re: expected standards for documentation • A common assessment proforma introduced for use in all ward areas excluding patients on ERP pathways
PSQ Pulmonary Rehab	• Meet with referrers to ensure that all making the referral explain to the patients why the referral has been made and that the ward patients are given the appropriate leaflet. Where this is not possible contact by email • To ensure at the time of the assessment that all patients are aware of the options that they are able to choose for their treatment and consent is gained.
Audit of histology reports of patients discussed and referred to the Cancer of Unknown Primary Multi disciplinary team	• Radiographer form re-emphasised. • Appropriateness of referrals feedback to Clinical Service Unit leads
Syphilis management at the Milton Keynes Sexual Health Centre	The development of a 'Reach –out' recall service for patients deemed particularly at high risk of acquiring a sexually transmitted infection.
Audit of Clostridium difficile clinical management	• Implementation of C diff management proforma as part of routine trust documentation • Availability of proforma on Intranet as part of C diff management pathway • Dissemination of information via local governance meeting, Trust audit awards, and presentation at National meeting (accepted for poster at Society of Acute Medicine conference in May) • Identification of juniors to continue data collection and re-audit for a 3rd loop

Heart Failure - a dangerous admission	• Documenting reasons for not initiating pharmacological treatment Heart failure MDT • Follow up with GP in immediate period • Improving discharge letters
Physiological monitoring & maintenance of homeostasis in acute stroke	• Stroke ward nurses trained in swallow assessment • Stroke pathway proforma includes a form to guide swallow assessment available in MAU and ED
Immune Thrombocytopenia (ITP) Management	• Raise awareness and education with team members • Review of the guideline for clarity with emphasis on documentation
Febrile Neutropenia Audit	• Availability of Nurses on unit who can access long lines in particular on PAU- to ensure that we have optimal number • Education for new and junior medical and nursing staff • Review of Oncology Pathway
Outcome of orthognathic cases using Patient At Risk scores	• All units met the Gold Standard for PAR outcomes for orthognathic cases • Average PAR reduction 83% • Treatment time / number of visits - no affect on PAR
Audit of the monitoring requirements of the Local Protocol for testing the hearing of parents and siblings of babies identified through the Newborn Hearing Screening Programme	• The 'Parent and sibling information request letter' has been updated • Protocol updated
Prescribing burden and paracetamol: can we stop to streamline discharge and save money?	To inform patients to ensure B&P are available at home when attending hospital for surgery
Emergency Thoracotomy: an update:	Series of teachings on emergency surgeries
Failed colonoscopy	Failure rate 6.3%.Main cause of failure is anatomy and looping. Patient with High BMI tend to fail more.
Antibiotic Prescribing in Appendicitis	• Update antibiotic protocol: include duration • .Increase awareness of hospital antibiotic guideline for appendicectomies: with more easily accessible guidelines, posters with antibiotic guideline in theatre, on surgical wards, in A&E • Encourage use of WHO Surgical Safety Checklist – to try ensure antibiotic prophylaxis given within the last 60 minutes prior to surgical procedure

Time to senior review for acute surgical referrals from the point of referral.	Clerking process more streamlined to ensure that patients are seen in a timely yet practical manner.
An audit on the quality/accuracy of emergency referrals from A&E	Outcome: We need collect our own data and then compare with college guidelines and see if we can adhere to them or should we be adhering to our MKUH targets of time taken to see patients
An audit of Urological readmissions Urology readmissions detailed assessment within a six mont period 1st September 2015 to 1st March 2016	Adjustment and refinement of post discharge protocol to avoid lack of advice on analgesia, where to get pain killers and advice to contact if problem rather hospital attendance.
Maternity VTE risk assessments	• Completion of postnatal VTE assessment form • Documented advice in handheld notes when to stop Low Molecular Weight Heparin • Prescription of TEDS on drugs chart • Correct advice regarding TEDS postnatally • Correct calculation of LMWH Dose
VTE risk assessment audit-Are we meeting RCOG standards?	• Booking form amendments to include multiple pregnancies. • .All high risk women should be seen in maternal medicine clinic. • Start LMWH from 1st trimester when indicated. • Improve documentation in handheld notes. • Documentation in handheld notes when to stop LMWH.
Audit of Percutaneous Breast Biopsies	• Standard by RCR (not specifically for breast biopsy – but for all image guided procedures): An adequate specimen from the biopsy site should be provided for histological/cytological assessment. Target: 95% • Audit shows 99% accuracy in current practice (100 consecutive cases audited dating backwards from 1.12.16)

3.8 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by MKUH in 2016/17, who were recruited to participate in National Institute of Health Research (NIHR) studies approved by a research ethics committee, was 3,187, with more data still to be included for this years' recruitment.

For 2015/16 we were the top recruiting small acute trust in the country, topping the league table for division1 (cancer), division 3 (Children, genetics, haematology, reproductive health and childbirth and division 6 (which includes: anaesthesia/peri-operative medicine and pain management, critical care, injuries and emergencies, surgery, ENT, infectious diseases/microbiology, ophthalmology, respiratory disorders, gastroenterology, hepatology). Our next closest rival was Harrogate and District NHS Foundation Trust with 2187 recruits and our league also included two

other University Hospitals. This was a major achievement for our research and development department and the Trust. This year 53 studies have contributed to the recruitment figures and we are currently in second position behind Homerton University Hospital NHS Foundation Trust.

The Research and Development department had a budget of £655,000 for 2016/17, which has been used to provide support for portfolio studies across the Trust. This includes research nurses and the support services that are an integral part of the research process, namely pathology, pharmacy and radiology. This year the team has continued to grow to support the increasing number of studies taking place across the Trust and we have secured an increase in budget to £700,000 for 2017/18.

Our aim is to provide patients with the latest medical treatments and devices and offer them additional treatment choices.

3.9 Raising the Profile of Research and Development (R&D)

This year we have continued to work towards raising the profile of research and development within the Trust. We have taken opportunities to inform the people of Milton Keynes of the research that is taking place at their local hospital. For example, the research and development team ran a stand at the MK play day to raise awareness of research taking place in paediatrics, and this was well attended by the local community. We also held a stand for Healthwatch to tell people about the variety of studies on offer for the local population, and in outpatients and the education centre for both patients and staff as part of International Clinical Trials Day. This was supported by the 'OK to ask' campaign, which aimed to increase awareness of trials in the general public.

A second grant submission has been made in relation to the Trust's collaboration with the Open University, this time to the Medical Research Council. We have applied for a grant for a clinical trial using fluorescence to detect the spread of cancer during surgery, therefore potentially reducing the number of patients recalled for further surgery. This is one of the collaborations between a researcher from Open University and Mr Chin, a Consultant General Surgeon, as chief investigator. MKUH would act as a sponsor for this clinical trial.

The research and development team supported the SNAP 2 study **(**The Sprint National Anaesthesia Projects: SNAPs) a 'snapshot' evaluation study of clinical activity and patient-centred outcomes that are important and relevant to both patients and anaesthetists.

The 'Canine olfactory detection of urological cancer from human urine' (MDD) study has continued to receive media attention and the team have delivered some successful healthy volunteer recruitment events in and around Milton Keynes as well as continuing to recruit eligible patients attending MKUH.

The team have submitted expressions of interest for several commercial studies during this financial year, and have been awarded commercial studies in cancer, cardiology, diabetes and stroke. This will contribute to increases in the quality and

quantity of research opportunities offered to the Trust's patients and the public, and ultimately lead to better clinical outcomes.

3.10 Goals agreed with Commissioners CQUIN

A proportion of Milton Keynes University Hospital NHS Foundation Trust income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between Milton Keynes University Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2016/17 are listed below.

National Goals

2016/17 CQUINs for Milton Keynes University Hospital NHS Foundation Trust			
Goal	**Goal Name**	**High level detail**	**Performance 2016/17**
1	Introduction of health and wellbeing initiatives-	The introduction of health and wellbeing initiatives for staff covering physical activity, mental health and improving access to physiotherapy for people with MSK issues.	This CQUIN has been achieved in full. **TBC.**
2	Healthy food for NHS staff, visitors and patients	Implementation of healthy food initiatives, including; the banning of price promotions and advertisements on sugary drinks and food high in fat, sugar and salt, the removal of these products from checkouts and ensuring healthy options are available to staff during night shifts.	This CQUIN has been achieved in full. **TBC.**
3	Improving the uptake of flu vaccinations for frontline clinical staff	Achieving an uptake of flu vaccinations by frontline clinical staff of 75%.	This CQUIN has been achieved in full. The Trust achieved a total frontline flu vaccination uptake of 78.6%.

4	Timely identification and treatment for sepsis in emergency departments	Improving the identification of patients with sepsis in emergency departments, and the timely initiation of treatment (IV antibiotics) within 1 hour alongside antibiotic review within 72 hours.	The Trust delivered 38% of the CQUIN screening element and 33% of the Treatment element. **TBC.**
5	Timely identification and treatment for sepsis in acute inpatient settings	Improving the identification of patients with sepsis in acute inpatient areas, and the timely initiation of treatment (IV antibiotics) within 1 hour alongside antibiotic review within 72 hours.	The Trust delivered 28% of the CQUIN screening element and 25% of the Treatment element. **TBC.**
6	Reduction in antibiotic consumption per 1,000 admissions	To reduce total antibiotic consumption, per 1000 admissions as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic prescription.	The Trust delivered 25% of this CQUIN. **TBC.**
7	Empiric review of antibiotic prescriptions	To improve the number of antibiotic prescriptions reviewed within 72 hours.	This CQUIN has been achieved in full. **TBC.**
8	Root-cause analysis on all long waiters and a clinical harm review for a positive diagnosis	To demonstrate appropriate management and review of long wait cases on the 62-day urgent GP referral to first treatment pathway, in line with the NHS England backstop policy.	This CQUIN has been achieved in full. **TBC.**
9	Therapy assessment within 24 hours of DTA	To perform comprehensive physiotherapy or occupational therapy assessment on patients over the age of 75, within 24 hours of admission with an EDD of greater than 3 days.	The Trust delivered 90% of this CQUIN.

Local Goals

Goal	Goal Name	High level detail	Performance 2016/17
1	Increased rates of breastfeeding	To educate and provide support to new mothers wishing to breastfeed their babies. The number of mothers having initiated breastfeeding within the first 48 hours of birth, to exceed 76% per month.	The Trust achieved 89% of this CQUIN.
2	Increased rates of breastfeeding (Community Midwife)	To educate and provide support to new mothers wishing to breastfeed their babies at discharge from Community Midwife. The number of mother's breastfeeding at discharge from Community Midwife to exceed 55% by March 2017.	The Trust did not deliver this CQUIN.
3	Discharges Before Midday	To support safe and effective discharge of medical patients admitted as emergencies: patients to be discharged safely before 12 (excluding patients with a zero length of stay)	The Trust achieved 18% of this CQUIN. **TBC.**
4	Prescription Chart to Pharmacy by 10am	All Medical patients to have their 'To Take Out' medication (TTO's) transcribed and sent to Pharmacy for checking and dispensing by 10am on the day of discharge.	The Trust achieved 68% of this CQUIN. **TBC.**
5	Improving Knowledge, culture and understanding of Mental health conditions in acute care	To improve knowledge of mental health conditions in acute care services, through providing support learning via quarterly learning events across a range of staff groups.	This CQUIN has been achieved in full. **TBC**.

Specialised Goals

Goal	Goal Name	High level detail	Performance 2016/17
1	Two year	To establish a robust system to recall,	This CQUIN has been

	follow up assessment for very preterm babies	evaluate and record outcome for babies born more than 10 weeks early and to ensure data is entered to the national BadgerNet system.	achieved in full. **TBC.**
2	Activation system for patients with long term conditions	To develop a system to measure skills, knowledge and confidence needed to self-manage long term conditions (i.e. HIV) and use that information to support adherence to medication and treatment as well as improving patient outcomes and experience.	This CQUIN has been achieved in full. **TBC.**

3.11 Care Quality Commission (CQC) registration and compliance

Milton Keynes University Hospital NHS Foundation Trust is required to register with the Care Quality Commission and it is currently registered to provide the following regulated activities:

- Urgent and emergency services
- Medical care
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Milton Keynes University Hospital NHS Foundation Trust has no conditions on its registration. It received no enforcements actions during the reporting period.

Review of Compliance of Essential Standards of Quality and Safety
The Trust underwent an unannounced focused CQC inspection on 12, 13 and 17 July 2017 to check how improvements had been made in urgent and emergency care, end of life care and maternity services.

The other areas of Surgery, Critical Care, Children's Services and Outpatients were not inspected and so their ratings remain from the previous inspection in October 2014. All of these services were rated as "Good" at that time.

Overall Ratings for Milton Keynes University Hospital

Milton Keynes University Hospital NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Key findings from the report

- All staff were passionate about providing high quality care
- The emergency department was meeting the four hour target with clear escalation processes to allow for proactive plans to be put into place for patient flow.
- The HSMR 9 Hospital standardised mortality (ratio) was significantly better than the expected rate.
- Improvements had been made in the completion and review of patients “do not attempt cardio pulmonary resuscitation” forms.
- There was a lower rate than the average of neonatal deaths. The Maternity Improvement Board was monitoring this to make further improvements to the service.
- Staffing levels were appropriate and met patients’ needs at the time of the inspection
- Staff morale was positive and staff spoke highly of the support from their managers
- Local ward leadership was effective and ward leaders were visible and respected.

Areas of Outstanding Practice

- The Medical Care Service had a proactive elderly care team that assessed all patients over 75 years old.
- The Medical Care Service ran a dementia café to provide emotional support to patients living with dementia and their relatives.
- Ward 2 had a dedicated bereavement box that contained soft lighting and furnishings to provide a homely environment for patients requiring end of life care.

Areas of Compliance or enforcements
The Trust received no notifications of compliance or enforcements actions as a result of this report.

Areas for Improvement identified by the inspection and how we have improved these since inspection

- The Emergency Department did not comply with guidance relating to both paediatric and adult mental health facilities – The trust has built a dedicated mental health assessment room and improved security at the paediatric emergency department.
- Staff, patients and visitors did not appear to observe the handwashing protocols in the emergency department – We have introduced more regular audits of the handwashing protocols in the department.
- The non-invasive ventilation policy was out of date - This has been re written and approved.
- The Medical Care Service did not have a policy for dealing worth outlying patients - This has been updated due to recent ward reconfigurations.
- In the Maternity Service examples were shared of inappropriate behaviours and lack of teamwork at consultant level in the service. These behaviours were not observed during the inspection. – The Trust has invested in multi-disciplinary leadership and human factors training which includes all of the consultant body. In addition timetables have been rescheduled to allow for team meetings and more multi-disciplinary ward rounds.
- Not all medical staff in maternity have completed the required level of safeguarding children's training. - compliance is now over 90%
- There was poor compliance with assessing the risk of venous thromboembolism in the maternity service. A new process is now in place.

3.12 Data Quality

Milton Keynes University Hospital has data quality procedures in place to ensure data and information is accurately reported to support informed decision making. These data quality procedures range from ensuring data is input to transactional systems correctly and information is extracted and interpreted accurately and reported in a way that is meaningful and precise. All staff members who have responsibility for the input of data are trained fully in the use of the relevant systems.

Furthermore, the Trust actively provides context to the importance of accurate data collection and the subsequent use of relevant key data items, thereby promoting understanding across all staff groups.

In addition, the Trust is actively engaged with its commissioners to monitor the quality of clinical services delivered through the delivery of local and national targets; these include both quality and performance indicators and hence data quality is important to ensure accurate reporting.

The Trust submitted data records during 2016/17 to the Secondary Uses Services (SUS) for inclusion in the Hospital Episode Statistics (HES). It has maintained data completeness over the national average and across the activity areas of admitted care, outpatients and A&E for both NHS number and ethnicity. The table below provides further information on the data completeness for national indicators NHS number and ethnicity*, with national averages.

Data item	Admitted	Outpatients	A&E
Completeness NHS number	99.5 (99.3)	99.8 (99.5)	98.1 (96.8)
Completeness ethnicity	99.3 (96.6)	98.9 (94.4)	98.4 (95.5)

*Figures from the SUS data quality dashboard M11 – national average in brackets.

The Trust recognises the importance of data quality and has established a Data Quality Compliance Board (DQCB). The DQCB was not setup as a traditional governance committee, but more akin to a committee with a “regulatory focus”, where the focus was to ensure compliance is achieved through regulatory action. On the establishment of the DQCB, a number of actions were immediately delegated to appropriate departments to implement, allowing the committee itself to provide the level of assurance against these actions as appropriate. One of the key actions related to the production of a data quality policy which was line with our peer Trusts to ensure we at least maintained a consistent level of expectation to other Trusts. Another key action involved the production of a data quality dashboard. The over-arching vision is to get all teams to work together for better and improved data quality.

3.13 Reporting against core indicators

Set out in the table below are the quality indicators that Trusts are required to report in their Quality Accounts.

Additionally, where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) is included for each of those listed in the table with

a) The national average for the same; and

b) With those NHS Trusts and NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.

Where data is not included this indicates that the latest data is not yet available from the NHS Information Centre.

3.14 Indicator 1: Summary Hospital-Level Mortality Indicator (SHMI) value and banding

Domain 1: Preventing People from dying prematurely					
12. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Summary Hospital-level Mortality Indicator (SHMI)	**MKUHFT**	1.04 (Band 2)	0.95 (Band 2)	1.04 (Band 2)	1.04 (Band 2)
	National	1.0	1.0	1.0	1.0
	Other Trusts Low/High	*It is not appropriate to rank trusts by SHMI*			

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons*:* The data sets are nationally mandated and internal data validation processes are in place prior to submission.

Milton Keynes University Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality. Banding 2 means that the mortality rate is 'as expected'.

There is an increasing level of scrutiny of mortality information across services provided by the trust and in depth analysis where mortality levels are outside the normal range. We are also now reviewing all unexpected deaths using the new national protocols.

Our priorities this year continue to focus on improving this result as they include management of sepsis and the early recognition of the deteriorating patient.

(The Trust is no longer required to report against indicators 2 and 3)

3.15 Indicator 4 – 7: PROM scores for groin hernia surgery, varicose veins surgery, hip replacement surgery, knee replacement surgery

What are PROMS (Patient Reported Outcome Measures)?

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This assists the NHS to measure and improve its quality of care.

Milton Keynes University Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services: by improving the response rate of post-operative questionnaires and reviewing the newly released data when available. The latest data for 2016/17 was released in February 2017 and relates to the period of April 2016 to September 2016 only. Currently there is insufficient data to present a representation of the Trust.

Full provisional data is available for April 2015 to March 2016 (data published Feb 2017) this shows there were 648 eligible hospital episodes and 644 pre-operative questionnaires returned a participation rate of 99.4% (74.9% in England). Of the 637 post-operative questionnaires sent out, 392 were returned a response rate of 61.5% (69.8% in England)

EQ-%D Index results

Patient reported outcome measure for	Level	2014/15	Provisional results 2015/16	Provisional Apr- Sep 2016
Groin Hernia Surgery	MKUHFT	82.3%	88.8%	Insufficient data
	National	87.7%	87.8%	88.0%
Varicose veins surgery	MKUHFT	Insufficient data	Insufficient data	Insufficient data
	National	84.1%	83.7%	84.2%
Hip Replacement surgery	MKUHFT	78.0%	83.1%	Insufficient data
	National	79.7%	80.0%	81.1%
Knee replacement surgery	MKUHFT	81.0%	74.6%	75.5%
	National	0.7%	74.3%	Insufficient data

As can be seen in the table above, there was a slightly greater average health gain reported following hip surgery on the Eq-5D Index than the national figure. (Scores on the EQ-5DTM Index range from -0.594 (worst possible health) to 1.0 (full health))

Figure 1: Adjusted average health gain on the EQ-5D™ Index by procedure

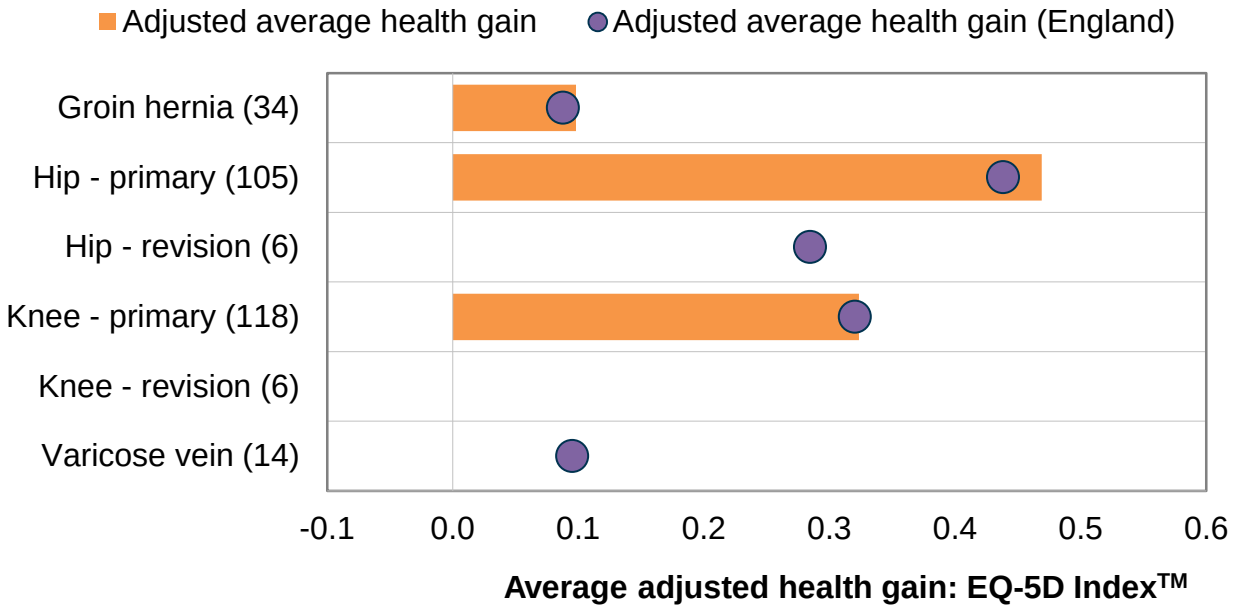
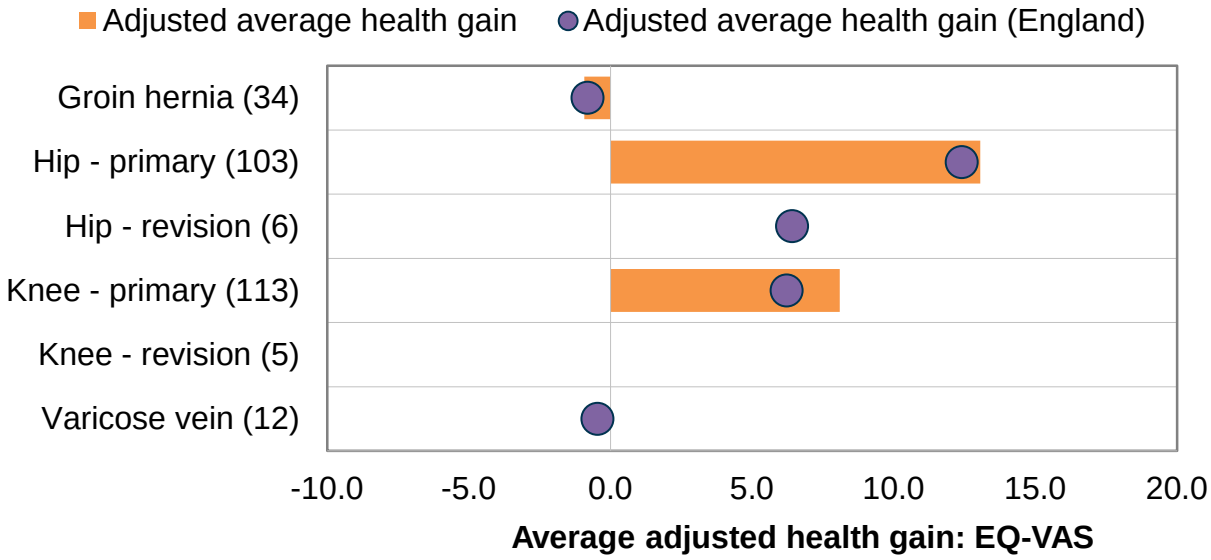


Figure 2 identifies slightly better than national average health gain following knee surgery and hip surgery using the EQ-VAS tool. (Scores on the EQ-VAS range from 0 (worst) to 100 (best))

Figure 2: Adjusted average health gain on the EQ-VAS by procedure



The other surgeries did not highlight a significant difference from the national average or insufficient numbers of patients either received the treatment or participated in the questionnaires.

3.16 Indicator 8: Emergency Readmissions to hospital within 28 days

Domain 3: Helping people to recover from episodes of ill health or following injury					
19. Domain of Quality	**Level**	***2013/14**	***2014/15**	***2015/16**	****2016/17**
Patients readmitted to a hospital within 28 days of being discharged	**MKUHFT**	12.20%	11.14%	11.47%	11.14%
	National	11.61%	12.00%	12.20%	12.33%
	Other Trusts Low/High	*7.87%/16.95%*	*7.94%/15.98%*	8.52%/16.44%	*8.45%/16.19%*

*Data sourced from Dr Foster (full fiscal year)
**Data sourced from Dr Foster (fiscal year to January 2017)

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.

Milton Keynes University Hospital NHS Foundation Trust has taken action to improve this rate, and so the quality of its services: by continuing to review why patients are readmitted. We have developed new discharge pathways with our colleagues in the community health services and local social care teams which allow patients to be discharged earlier and also receive greater support at home to prevent re-admission. This project is called “discharge to assess” and early evidence suggests patients are staying at home for longer periods. We are also implementing the SAFER bundle as described in our quality priorities

3.17 Indicator 9: Responsiveness to inpatient personal needs

Domain 4: Ensuring that people have a positive experience of care					
20. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Responsiveness to the personal needs of patients	**MKUHFT**	65.3%	68.9%	68.0%	Next update August 2017
	National	68.7%	68.9%	69.6%	
	Other Trusts Low/High	*54.4%/84.2%*	59.1/86.1%	58.9%/86.2%	

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons*:* The data sets are nationally mandated and internal data validation processes are in place prior to submission.

In 2015/16, the Trust established a new patient experience team, and that team is continuing to work with the clinical teams to improve patients' experience of receiving care. That team includes a medical lead and a full time patient experience manager. The team have been working on how best to use the valuable information that the public give us about our services. Our priorities are:

- Improving food selection for patients;
- Wayfinding around the hospital in light of development of the site; and
- Improving booking and communication of hospital appointments and elective surgery.
- Reducing noise at night

3.18 Indicator 10: % of staff who would recommend the provider to friends or family needing care

Domain 4: Ensuring that people have a positive experience of care					
20. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Staff who would recommend the trust to their family or friends	**MKUHFT**	59%	61%	64%	69%
	National	66%	59%	69%	65%
	Other Trusts Low/High	40/94%	35/84%	46/89%	48%/91%
Patients who would recommend the trust to their family or friends (Inpatient FFT - February in each year available)	**MKUHFT**	*Not a comparable methodology (FFT Score)*	96%	95%	96%
	National		95%	96%	96%
	Other Trusts Low/High		82%/100%	74%/100%	76%/100%

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons*:* The data sets are nationally mandated and internal data validation processes are in place prior to submission.

Milton Keynes University Hospital NHS Foundation Trust has taken action to improve this rate, and so the quality of its services by, continuing to ensure that staff feel supported and their feedback is heard and responded to. Staff have a number of ways of giving feedback, face to face and anonymously. Weekly messages from the Chief Executive also include individual accolades received and achievements by teams. We have seen a year on year improvement in this score which we believe represents the general improvements the Trust has made in care and engagement of staff in this process.

3.19 Indicator 11: % of admitted patients risk assessed for VTE

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.

Milton Keynes University Hospital NHS Foundation Trust has not met this target this year due to administration issues which have been resolved. The Trust continues to check the robustness of its process to ensure continued delivery.

3.20 Indicator 12: Rate of C difficile

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons*:* The data sets are nationally mandated and internal data validation processes are in place prior to submission.

The Trust has seen a continuous reduction in the number of C-difficile cases this year. We have achieved this by strict infection control processes and by restricting the use of anti-biotics linked to C-difficile. This year we will continue to extend this successful programme.

3.21 Indicator 13: Rate of patient safety incidents and % resulting in severe harm or death

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm					
23. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Patients admitted to hospital who were risk assessed for venous thromboembolism (Q3 results for each year)	**MKUHFT**	96.0%	96.0%	95.1%	85.6%
	National	96.0%	96.1%	95.6%	95.8%
	Other Trusts Low/High	80%/100%	90%/100%	79%/100%	80%/100%
24. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2015/16**
Rate of C.difficile infection (per 100,000 bed days)	**MKUHFT**	22.5	23.4	10.5	*Next update due July 2017*
	National	14.7	15.0	14.9	
	Other Trusts Low/High	0/37.1	0/62.6	0/66.0	
25. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Rate of patient safety incidents per 100 admissions (and the rate that resulted in severe harm or death)	**MKUHFT**	5.1 (0.01)	27.5 (0.06)	28.4 (0.01)	
	National (Acute)	8.7 (0.07)	37.1 (0.19)		
	Other Trusts Low/High	1.2 (0)/15.5 (0.37)	3.6 (0.02)/82.2 (1.53)		

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission

The is taking action to improve this rate, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality as we are below the national average for this indicator.

Part 4 Other Information

4.1 Review of Quality 2016/2017

PATIENT SAFETY				
Indicator	**Measurement used**	**2014/15**	**2015/16**	**2016/17**
Hand hygiene compliance	Internal target – percentage compliance as measured by exception	87.95%	91.1%	(TBC)
Hospital-acquired pressure ulcers (Grades 3 and 4)	Internal target – total number recorded on Datix and investigated through Serious Incident framework (electronic incident reporting system)	23 gd 3 1 gd 4 5 gd 3 (downgraded)	9 grade 3 1 grade 4 (3 gd 3 downgraded, 1 gd 4 downgraded)	15 (grades to be confirmed)
Patient falls	Internal target – total number of reported incidents	776	12 moderate harm (change in reporting)	17
Medication incidents	Internal target – total number of reported incidents	713		105
Serious incidents	Internal target – total number of reported incidents	125	91	74
"Never events	This is based on a nationally accepted list of events published by the National Patient Safety Agency	1	3	2

4.2 Hand hygiene compliance

Ensuring that all hospital staff clean their hands between patients has contributed towards a reduction in health care associated infections across the NHS.

The data collection tool reflects the World Health Organisation's five moments of hand hygiene and bare below the elbow standard. The 38 areas complete the audit and this is reported on a monthly basis. Those areas that have a lapse in compliance or fail to return the audit are written to by the Chief Nurse. The Infection Prevention Control Team and clinical teams continue to promote the effective hand hygiene and bare below the elbow standards.

4.3 Hospital Acquired pressure ulcers (grade 3 and 4)

There continues to be improvement in the identification of patients with pressure ulcers and those at risk of developing of pressure ulcers at admission with the appropriate actions being implemented in a timely manner to reduce the risk of further skin damage. As can be seen by the overall reduction in the number of grade 3 and 4 pressure ulcers developed over the past year. All hospital acquired grade 3 and 4 pressure ulcers are reported as a potential Serious Incident and require a 72 hour report to be completed. On receipt of this report a decision is made about whether the pressure ulcer reported could have been prevented or whether all preventative care had been provided and therefore the ulcer was unavoidable.

All grade 3 and 4 pressure ulcers are reported through the safeguarding process as a potential safeguarding concern regardless of the decision about it being avoidable or unavoidable or a SI being declared.

The root cause analysis of the pressure ulcers is monitored from divisional level through to management board. Pressure ulcer prevention has been a quality priority for 2016/2017 and will continue to be a key indicator of quality and ongoing improvement action for the year ahead.

4.4 Patient Falls

As suggested in last year's Quality Account, measuring the level of harm that a fall causes is a better indicator of how we have improved through falls prevention. Low or 'no harm' indicates effective falls prevention as not all falls can be prevented but the impact can be reduced.

As the number of patients attending the hospital increases it is probable that the number of falls will increase. Comparing the number of falls with the number of occupied bed days makes it possible to assess whether the rate of falls is changing. A rate of 4.7 falls per 1000 bed days was reported in February 2017 (compared to 4.02 in February 2016. It is noted that an increased number of patients were admitted after a fall, which increases the likelihood that they may fall again.

Falls prevention training and education continues to be provided and for all registered nurses and Health Care Assistants as part of the essential skills

programme. The Post Falls protocol which initiates a whole team approach to reviewing why a patient has fallen and to reduce the risk and harm if they are to fall again has been successfully embedded with all relevant members of the multi professional team completing their relevant areas.

4.5 Medication Incidents

Medication incidents are reported onto our incident reporting system when errors have been made. An error is reported even if no harm has been caused to a patient. Errors can be about prescribing, dispensing (when the pharmacy department issues medications) or administering (when medication is given to the patient). Reporting medication incidents is the right thing to do and investigations into incidents often provide all staff with learning and sharing of improvements in practice.

4.6 Never Events

NHS Improvement describes Never Events as “serious, largely preventable patent safety incidents that should not occur if existing national guidance or safety recommendations have been implemented by healthcare providers”. There are 20 listed categories of Never Events, and a total of 380 Never Events were recorded nationally in 2016/17. This Trust reported two Never Events during this timeframe.

NHS England Never Event 10 – A patient falling from a poorly restricted window:

At approximately 22.30hrs on 8th December 2016 there was a Code Victor call to Ward 8 where a 52 year old male patient had managed to fully open the right sided window in bay 4, stand on a footstool and exited, falling and suffering a significant compound fracture to his left lower leg and a fracture to his right lower leg.

Although the Trust did not initially declare this as a never event since the patient had disclosed during his recovery post fall that he “fiddled with the window” which could be interpreted as he “disabled the restrictors” to enable to window to be opened prior, this decision after further analysis was amended in March 2017.

Following this incident and the subsequent investigation all window restrictors have been replaced and there is an ongoing scheduled maintenance programme with Estates, with each window being specifically numbered and easily identified on a site plan. The checking of window restrictors has also been added to the departmental quarterly health and safety checklist compliance from which be monitored by the Health and Safety Committee.

NHS England Never Event 1 – Wrong site surgery:

A patient was scheduled and consented for left ureteric stent insertion. During the World Health Organisation (WHO) sign out it was noted that stent had been inserted in to the right ureter instead of the left (as per consent form). The patient was still anaesthetised, and instrument trays were still sterile. The Consultant Urologist was

contacted, who attended theatre, the incorrectly placed stent was removed and a stent was inserted to the left ureter.

The incident remains under investigation, but early analysis indicates that it was caused by human error, and that there was full compliance with Trust processes and procedures at the time.

Learning

The Trust takes learning from serious incidents, incidents, claims and complaints very seriously to ensure patient safety, patient experience and to help mitigate future occurrences. The Trust's Serious Incident Review Group (SIRG), chaired by the Medical Director/Associate Medical Director robustly review all RCA investigations, action plans and any incidents reported with a moderate grading or above to ensure that appropriate investigation and learning is in place.

The Trust held a 'learning from serious incidents' plenary session on the audit afternoon of the 22nd November 2016, with presentations and group discussions on the key learning to ensure cross specialty learning and to embrace the Trust's open and honest approach to learning from incidents.

The Trust's Datix system allows feedback to staff reporting incidents on an individual basis. All specialty governance group meetings further include learning from incidents/serious incidents at their meetings, with newsletters also circulated to ensure as wide an audience is included.

Following some serious incident investigations the Trust has arranged subsequent simulation training for staff with similar scenarios to facilitate practical and skills based learning for teams, with a view to expanding this more in 2017 – 2018.

Mock Inquest

A mock inquest was held on the 20th October 2016 which involved the Trust's legal team, Trust staff and HM Coroner to allow staff to appreciate how an inquest is run and to identify the key requirements for giving evidence and providing statements. This was recorded so it can be used subsequently as a teaching aid across the organisation.

4.7 Duty of Candour

The Trust looks to proactively be open and honest in line with the Duty of Candour requirements and looks to advise/include patients and/or next of kin in investigations. From March 2017 a covering letter was included in the Trust bereavement packs informing that all deaths across the organisation are investigated and if relatives had concerns regarding care or treatment we would look to include this in the Trust mortality reviews and feedback the findings.

In addition for all serious incidents the Head of Risk and Clinical Governance writes

formally advising that a root cause analysis (RCA) investigation is being undertaken and inviting patients/next of kin to be involved if they wished. This is subsequently followed up on completion of the RCA with a copy of the report and the opportunity to meet the investigation leads to discuss the findings.

This process has received positive feedback and helped to give reassurances that as an organisation we look to actively learn from incidents and put in place mitigation against other similar incidents in the future.

4.8 Sign up to Safety Campaign

The Trust signed up to the Sign up to Safety Campaign in September 2014 in the five areas below:

Reducing avoidable harm by referencing it's priorities for 2015/2016 of:

1. Reducing the number of deaths from sepsis
2. Reducing the number of inpatient falls by 5%
3. Eliminating hospital acquired grade 3 and pressure ulcers
4. Ensuring that patients admitted emergencies are reviewed by a consultant within 48hrs
5. Increasing medication error reporting by 20%

These were seen to be replicable to the incident and serious incident trends noted in the Trust at the time, and in line with ongoing work streams to ensure safe and effective patient care. Monitoring of the campaign and progress with the work streams projects is managed through the Serious Incident Review Group (SIRG).

4. 9 Clinical Effectiveness

CLINICAL EFFECTIVENESS					
Indicator	**Measurement used**	**2013-14**	**2014-15**	**2015-16**	**2016-17**
Hospital standardised mortality ratio (HSMR)	Risk of death relative to national average case mix adjusted from national data via Dr Foster Intelligence: this is a national definition. Target is below 100	88.1	90.0	82.9	89.5
Perinatal death rate (per 1,000)	This data is provided to the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries)	7.8	4.8	3.9	4.2
Still birth rate	Per 1,000 deliveries	5.7	2.1	3.2	3.4
Readmissions within 30 days	Emergency admissions within 30 days of elective discharge, including day cases. Internally set target	8.1%	7.3%	6.8%	7.2%

4.10 Patient Experience

PATIENT EXPERIENCE				
Indicator	**Measurement used**	**2014-15**	**2015-16**	**2016-17**
Complaints	**The number of complaints from patients received by the Trust**	**609**	**897***	**838**
Midwife : birth ratio	Birth Rate Plus Midwifery Workforce planning tool	1 to 30	1 to 32	1:31

In 2016/17 the Trust undertook the national patient surveys within Emergency Department; Adult Inpatient; Children & Young people Inpatients and Maternity. Results from these surveys and other insight gained from patients, families and carers are collated, analysed and shared with colleagues to create action plans for change and improvement.

The Trust receives approximately 24000 Friends and Family Test (FFT) responses a month, from over 65 wards and departments 'collection points'. The averages recommend rate for the Trust is 93%. The FFT responses can now be fed back using SMS text messaging in Emergency Department (ED). The new supplier for FFT can also support responses by website link and a QR code link for smart phones as well as the standard 'paper survey'. This additional methodology to feedback on care has created a shift to electronic feedback in the ED department. We believe this will increase the FFT response rate. FFT forms are available for children, as an 'Easy Read' format, large print and additionally can be printed on yellow paper for example for patients in our eye clinic.

FFT responses and feedback received via social media (e.g. Facebook, Twitter, NHS Choices and Patient Opinion) are being shared as quickly as possible to department heads and clinician's. This prompt feedback can mean that appropriate actions can immediately in response to concerns raised. In addition to feedback received from patients and families/ carers there is a regular programme of '15 Step Challenge' visits to wards and departments, where feedback is shared promptly to facilitate change and improvement in patient experience. The Patient Experience Manager in partnership with the Complaints / PALS team produce a quarterly report for divisions and management board detailing information collated from patient feedback including complaints and compliments.

Performance against key national priorities and regulatory requirements 2010 to 2017				
Indicator	**Target and source (internal /regulatory /other)**	**2014-15**	**2015-16**	**2016-17**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	>96% set by NHSI	98%	99%	TBC
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	>85% set by NHSI	87%	84%	TBC
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	>93% set by NHSI	95%	95%	TBC
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	>98% set by NHSI	100%	100%	TBC
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	>94% set by NHSI	100%	98%	TBC
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	>93%	96%	95%	TBC
Referral to treatment in 18 weeks - patients on incomplete pathways	Patient on an incomplete pathway: 92%	93%	86%	93%
Diagnostic wait under 6 weeks	>99%	99%	98%	100%
A&E treatment within 4 hours (including Walk-In Centre)	95% set by NHSI	92%	94%	92%
Cancelled operations: percentage readmitted within 28 days	>95%	99%	86%	87%
Clostridium difficile	Set by DH	39	29	10

infections in the Trust				
MRSA bacteraemia (in Trust)	Zero tolerance set by DH	0	2	2
MRSA bacteraemia (across Milton Keynes total health economy)		3		Awaiting data

Milton Keynes University Hospital NHS Foundation Trust

ANNEX 1 – Statements from NHS: Milton Keynes and Milton Keynes Healthwatch

Milton Keynes University Hospital NHS
NHS Foundation Trust

Statement from Milton Keynes Council Quality Account's Panel

Milton Keynes University Hospital NHS
NHS Foundation Trust

Statement from Central Bedfordshire Council Health Overview and Scrutiny Committee

Trust Response

The Trust welcomed the constructive comments of Milton Keynes Council, Quality Account Panel on xxxx. A more detailed index has been included in the Quality Account and a glossary added to the document.

Milton Keynes University Hospital NHS Foundation Trust

Statement from Milton Keynes Clinical Commissioning Group dated xx May 2017

MKCCG comments to MKUHFT Draft Quality Account 2016-17

Trust Response

ANNEX 2 –Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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 2016/17;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to May 2017
    - papers relating to quality reported to the Board over the period April 2016 to May 2017
    - Feedback from the commissioners dated
    - Feedback from governors on quality priorities dated 6 March 2017
    - Feedback from the local Healthwatch organisation dated
    - Feedback from Local Authority dated
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, being reported to Trust Board in July 2017.
    - The national patient survey received April 2017
    - The national staff survey February 2017
    - The Head of Internal audit's annual opinion over the Trust's control environment dated April 2017
- 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 Monitor's annual reporting 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

.....Date.....Chairman

.....Date.....Chief Executive

Annex 3: Independent Auditor's report

Milton Keynes University Hospital
NHS Foundation Trust

Glossary (to be updated)

A & E	**A & E**	**Accident & Emergency**	**hospital department specialising in the acute care of patients who arrive without a prior appointment**
AHP	**AHP**	**Allied Healthcare Professional**	**Generic term for professionals other than doctors and nurses who treat patients, therapists, physios, dieticians etc**
ALOS	**ALOS**	**Average Length of Stay**	**the average amount of time patients stay in hospital**
Amber		**Amber**	**Projects will be assessed as having an overall risk rating of amber where it is considered that the project is not delivering to plan in respect of progress and/or impact, however, appropriate action is planned and/or is underway.**
AO	**AO**	**Accountable Officer**	**A person responsible to report or explain their performance in a given area.**
APR	**APR**	**Annual Plan Return**	**Submission of the annual plan to the regulator**
BAF	**BAF**	**Board Assurance Framework**	**Board document to assure the Board that risks to strategic priorities are being managed**
BoD	**BoD**	**Board of Directors**	**Executive Directors and non Executive Directors who have collective responsibility for leading and directing the foundation trust**
Caldicott Guardian		**Caldicott Guardian**	**Chief clinician who is held responsible for clinical record keeping (from Caldicott enquiry outcomes)**
CAMHS	**CAMHS**	**Children and Adolescent Mental Health Services**	**Specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties**
CBA	**CBA**	**Cost Benefit Analysis**	**A process for calculating and comparing the costs and benefits of a project.**

CCG	**CCG**	**Clinical Commissioning Group**	**Replaced Primary Care Trust. Led by local GPs to commission services**
CDiff	**Cdiff**	**Clostridium difficile**	**A bacterial infection that most commonly affects people staying in hospital**
CDU	**CDU**	**Clinical Decisions Unit**	
CE/CEO	**CE/CEO**	**Chief Executive Officer**	**Leads the day to day management of the Foundation Trust**
CF	**CF**	**Cash Flow**	**The money moving in and out of an organisation**
CGF	**CGF**	**Clinical Governance Facilitator**	**Co-ordinates senior leadership team (doctor, nurse and manager) in new CSUs (replace HCFs.**
CIP	**CIP**	**Cost Improvement Programme**	**Also known as Transformation programme**
CIG	**CIG**	**Clinical Improvement Group**	
CoA	**CoA**	**Chart of Accounts**	**A list defining the classes of items against which money can be spent or received.**
Code Victor		**Code Victor**	**Major Emergency Alert**
CoG	**CoG**	**Council of Governors**	**The governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public**
Common Front Door		**Common Front Door**	**Area where urgent care and A & E services can be co located**
CoP	**CoP**	**Code of Practice**	**A set of regulations**
CPD	**CPD**	**Continuing Professional Development**	**Continued learning to help professionals maintain their skills and knowledge**
CQC	**CQC**	**Care Quality Commission**	**Regulator for clinical excellence**

CQUIN	**CQUIN**	**Clinical Quality Incentive Scheme**	**The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation.**
CSU	**CSU**	**Clinical Service Units**	**Business units in MK Hospital**
CTG	**CTG**	**Cardiotocography**	**a technical means of recording the fetus fetal pulse heartbeat**
Datix		**Datix**	**Risk management system**
DD	**DD**	**Due Diligence**	**Is the term used to describe the performance of an investigation of a business or person**
DGH	**DGH**	**District general hospital**	
DH/DoH	**DH/DoH**	**Department of Health**	**The ministerial department which leads, shapes and funds health and care in England**
DIPC	**DIPC**	**Director of Infection Prevention Control**	
DNA	**DNA**	**Did not Attend**	**A patient who missed an appointment**
DOC	**DOC**	**Doctor on call**	
DOCC	**DOCC**	**Department of Critical Care**	
DoF	**DoF**	**Director of Finance**	**The Board member leading on finance issues in the trust; an executive director**
DOSA	**DOSA**	**Day of Surgery Admission**	**When patients are admitted on the day of their surgery rather than the day before**
DPA	**DPA**	**Data Protection Act**	**The law controlling how personal information is used**
DTOCs		**Delayed Transfer of Care**	**Patients who are medically fit but have not been discharged**
Dr Foster		**Dr Foster**	**Benchmarking tool to assess relative performance**

Duty of Candour		**Duty of Candour**	**Consultation on including a contractual requirement for health providers to report and respond to incidents, apologise for errors etc**
ED	**ED**	**Executive Directors' (meeting)**	**Semi-formal meeting of Executive Directors on Monday morning and Thursday afternoon**
EDD	**EDD**	**Expected Delivery Dates**	
EHR	**EHR**	**Electronic Health Record**	**Health information about a patient collected in digital format which can theoretically be shared across different healthcare settings**
ENP	**ENP**	**Emergency Nurse Practitioner**	**Specialist A&E nurse**
EOC	**EOC**	**Exec on Call**	
EPR	**EPR**	**Electronic Patient record**	
ESR	**ESR**	**Employee Staff Record system**	**HR system in use**
FOI	**FOI**	**Freedom of Information**	**The right to ask any public sector organisation for the recorded information they have on any subject**
Formulary		**Formulary**	**Approved NHS list of prescribed drugs**
FP10	**FP10**		**Forms used to prescribe drugs to outpatients that they can pick up at the hospital pharmacy, rather than having to pay themselves**
Francis Report		**Francis Report**	**report into Mid Staffs hospital**
FT	**FT**	**Foundation Trust**	**A part of the NHS in England that provides healthcare to patients/service users and has earned a degree of operational and financial independence**
FTE	**FTE**	**Full Time Equivalent**	**A measurement of an employees workload against that of someone employees full time e.g. 0.5 FTE would be someone who worked half the full time hours.**

FTGA	**FTGA**	**Foundation Trust Governors' Association**	**National membership association for governors of NHS foundation trusts**
FTN	**FTN**	**Foundation Trust Network**	**The membership organisation and trade association for the NHS acute hospitals and community, mental health and ambulance services that treat patients and service users in the NHS**
FY	**FY**	**Financial Year**	**The year used for accounting purposes, in the UK from 6 April to 5 April**
GMC	**GMC**	**General Medical Council**	**The independent regulator for doctors in the UK**
GI	**GI**	**Gastrointestinal**	
GMS	**GMS**	**General Medical Services**	
GP	**GP**	**General Practitioner**	**Doctor who provides family health services in a local community**
Green		**Green**	**Projects will be assessed as having an overall risk rating of green where it is considered that the project is delivering to plan in respect of progress and/or impact.**
GUM	**GUM**	**Genito-unitary medicine**	**For sexually transmitted diseases/infections**
HCA	**HCA**	**Healthcare Assistant**	**staff working within a hospital or community setting under the guidance of a qualified healthcare professional**
HCAI	**HCAI**	**Healthcare Associated Infection**	**These are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile are both classed as HCAIs**
Healthwatch		**Healthwatch**	**Local independent health and social care critical friend**
HEE	**HEE**	**Health Education England**	**the NHS body responsible for the education, training and personal development of staff**

HR	**HR**	**Human Resources**	**the department which looks after the workforce of an organisation e.g. Pay, recruitment, dismissal**
HSCA	**HSCA**	**Health and Social Care Act 2012**	**an Act of parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors**
HSDU	**HSDU**	**Hospital Sterile Decontamination Unit**	**Part of Clinical Support Services CSU**
HSMR	**HSMR**	**Hospital Standardised Mortality Rate**	**Number of deaths which is compared with other trusts**
HWB/HWBB	**HWB/HWBB**	**Health and Wellbeing Board**	**a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector**
IBP	**IBP**	**Integrated Business Plan**	**a strategy for connecting the planning functions of each department in a trust to align operations and strategy with financial performance**
ICU	**ICU**	**Intensive Care Unit**	**specialist unit for patients with severe and life threatening illnesses**
Intrapartum		**Intrapartum**	**During childbirth (as opposed to pre-natal and post-natal)**
IBP	**IBP**	**Integrated Business Planning**	
IG	**IG**	**Information Governance**	
IP	**IP**	**Inpatient**	**a patient who is hospitalised for more than 24 hours**
IT	**IT**	**Information Technology**	**the study or use of systems(especially computers and telecommunications) for storing, retrieving and sending information**
Keogh Reviews		**Keogh Reviews**	**Reviews of Hospitals led by Sir Bruce Keogh, originally targeted hospitals with high mortality rates.**

Kings Fund		**Kings Fund**	**independent charity working to improve health and care in England**
KPIs	**KPIs**	**Key Performance Indicators**	**indicators that help an organisation define and measure progress towards a goal**
LD	**LD**	**Learning Disabilities**	**a disability which affects the way a person understands information and how they communicate**
LETB	**LETB**	**Local Education and Training Board**	**these are the local arms of Health Education England, now called by their region rather than LETB - e,g, training and workforce issues**
LHE	**LHE**	**Local Health Economy**	**the supply and demand of health care resources in a given area and the effect of health services on a population**
LOS	**LOS**	**Length of Stay**	**a term commonly used to measure the duration of a single episode of hospitalisation**
MDP	**MDP**	**Maternity Development Plan**	
MHA	**MHA**	**Mental Health Act**	**the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital , detained and treated without their consent - either for their own health and safety, or for the protection of other people**
MI	**MI**	**Major Incident**	**a major incident affects, or can potentially affect, hundreds or thousands of people and can cause a significant amount of casualties e.g. closure of a major facility due to fire, or persistent disruption of services over several weeks/months**
MIU	**MIU**	**Minor Injuries Unit**	**somewhere you can go to be treated for an injury that's not serious instead of going to A & E, e.g. For sprains, burns, broken bones**
MKUHFT	**MKUHFT**	**Milton Keynes University Hospital Foundation Trust**	**Abbreviation of Milton Keynes University Hospital NHS Foundation Trust**

MKUCS	**MKUCS**	**Milton Keynes Urgent Care Centre**	**Consortium with GPs (40% owned by Trust) based in the hospital to alleviate A&E**
MOC	**MOC**	**Manager on call**	
Monitor		**Monitor**	**Regulatory Body "Independent' organisation to monitor foundation trusts**
Morbidity		**Morbidity**	**the proportion of sickness or of a specific disease in a geographical locality.**
Mortality		**Mortality**	**the relative frequency of deaths in a specific population; death rate.**
MoU	**MoU**	**Memorandum of Understanding**	
MRI	**MRI**	**Magnetic Resonance Imaging**	**a medical imaging technique**
MRSA	**MRSA**	**Methicillin-Resistant Staphyloccus Aureus**	**a bacterium responsible for several difficult-to-treat infections in humans**
MSA	**MSA**	**Mixed Sex Accommodation**	**wards with beds for both male and female patients**
MUST	**MUST**	**Malnutrition Universal Screening Tool**	**MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.**
NE	**NE**	**Never Event**	
NED	**NED**	**Non Executive Director**	
NHS	**NHS**	**National Health Service**	**publicly funded healthcare system with the UK**
NHS Direct	**NHS Direct**	**NHS Direct**	**24-hour telephone helpline and website providing confidential information on health conditions**

			local healthcare services, self help and support organisations
NICU	**NICU**	**Neonatal Intensive Care Unit**	
NHSLA	**NHSLA**	**NHS Litigation Authority**	**Manages Clinical Negligence Scheme for Trusts**
NHSTDA	**NHSTDA**	**NHS Trust Development Authority**	**provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline**
NICE	**NICE**	**National Institute for Health and Care Excellence**	**provides national guidance and advice to improve health and social care**
NMC	**NMC**	**Nursing and Midwifery Council**	**nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands**
NPSA	**NPSA**	**National Patient Safety Agency**	
NRLS	**NRLS**	**National Reporting and Learning System**	**Database for recording patient safety incidents (held by MPSA)**
NSfs	**NSFs**	**National Service Frameworks**	**set clear quality requirements for care**
OP	**OP**	**Outpatients**	**a patient who is not hospitalised for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment**
OSCs	**OSCs**	**Overview and Scrutiny Committees**	**established in local authorities by the Local Government Act 2000 to develop and review policy and make recommendations to the council**
PA	**PA**	**Programmed Activities**	**4 hour blocks that are used to make up a consultant's contract.**
PALS	**PALS**	**Patient advice and liaison service**	**You can talk to PALS who provide confidential advice and support to patients, families and their carers, and can provide information on the NHS and health related matters.**
PbR	**PbR**	**Payment by Results or 'tariff'**	**a way of paying for services that gives a unit price to a procedure**

PDR	**PDR**	**Personal Development Review**	**Appraisal system**
PFI	**PFI**	**Private Finance Initiative**	**a scheme where private finance is sought to supply public sector services over a period of up to 60 years**
PLACE	**PLACE**	**Patient-Led Assessments of the Care Environment**	**local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food cleanliness and general building maintenance**
POA	**POA**	**Pre-operation assessment**	
PPI	**PPI**	**Patient and Public Involvement**	**mechanisms that ensure that members of the community - whether they are service users, patients or those who live nearby - are at the centre of the delivery of health and social care services**
PROM	**PROM**	**Patient Reported Outcome Measures**	
Productive Ward		**Productive Ward**	**Initiative to streamline operation of wards - included in Maternity Development Plan, due to be rolled out across the hospital**
PTS	**PTS**	**Patient Transport Services**	**free transport to and from hospital for non-emergency patients who have a medical need**
QA	**QA**	**Quality Assurance**	**monitoring and checking outputs and feeding back to improve the process and prevent errors**
QGAF	**QGAF**	**Quality Governance Assurance Framework**	**assess the combination of structures and processes in place, both at and below board level, which enable a trust board to assure the quality of care it provides**
QIPP	**QIPP**	**Quality, Innovation, Productivity and Prevention**	**12 work streams to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements.**

Quality Accounts		**Quality Accounts**	**An annual report to the public from providers of NHS healthcare services about the quality of their services**
RAG	**RAG**	**Red, Amber, Green classifications**	**a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)**
RCA	**RCA**	**Root cause analysis**	
RCGP	**RCGP**	**Royal College of General Practitioners**	**professional membership body for GP's**
RCP	**RCP**	**Royal College of Physicians**	**professional membership body for doctors**
RCS	**RCS**	**Royal College of Surgeons**	**professional membership organization representing surgeons**
R&D	**R&D**	**Research & Development**	**developing new products or processes to improve and expand**
Red		**Red**	**Projects will be assessed as have an overall risk rating of red where it is considered that the project is not being delivered as planned in respect of progress and/or impact.**
RGN	**RGN**	**Registered General Nurse**	**a nurse who is fully qualified and is registered with the nursing and Midwifery Council as fit to practice**
RTT	**RTT**	**Referral to treatment**	**Used as part of the 18 week indicator**
Rule 43		**Rule 43**	**Issued by Coroners to organisations. Must be responded to within 56 days. Lord Chancellor's office keep a record of all rule 43s issued**
SFI	**SFI**	**Standing Financial Instructions**	**Found on the intranet under 'Trust Policies'**
SHMI	**SHMI**	**Summary Hospital Level Mortality Indicator**	**reports mortality at trust level across the NHS in England using standard and transparent methodology**

SI	**SI**	**Serious incident**	**A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care**
SID	**SID**	**Senior Independent Director**	**a non executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair**
SIRG	**SIRG**	**Serious incident Review Group**	**to review serious incidents and identify learning points**
SLM	**SLM**	**Service Line Management**	**A framework for the delivery of clinical services**
SLA	**SLA**	**Service Level Agreement**	**an agreement between two or more parties**
SLR	**SLR**	**Service Line Reporting**	**A reporting system which by comparing income against expenditure gives a statement of profitability at service line level**
SRR	**SRR**	**Significant risk register**	**Risks scored 15 and over**
SSA	**SSA**	**Same sex accommodation**	
T&C	**T&C**	**Terms and conditions**	**set the rights and obligations of the contracting parties, when a contract is awarded or entered into**
TDA	**TDA**	**Trust Development Authority**	**Regulator for Non foundation trusts**
T&O	**T&O**	**Trauma & Orthopaedics**	
TRR	**TRR**	**Trust risk register**	
TTO	**TTO**	**To Take Out**	**Medicines given to discharging patients**
VTE	**VTE**	**Venous thromboembolism**	**Blood clotting, usually caused by inactivity. Should be assessed for routinely to ensure care pathways take into risk**

Milton Keynes University Hospital NHS Foundation Trust

WiC	**WiC**	**Walk in Centre**	**Provided jointly with the hospital and local GPs under a commercial arrangement as the Urgent Care Centre**
WTE	**WTE**	**Whole time employees**	**Member of staff contracted hours for full time**
YTD	**YTD**	**Year to Date**	**a period, starting from the beginning of the current year and continuing up to the present day. The year usually starts on 1st January**

Bedford Hospital NHS Trust

Appendix B

Bedford Hospital NHS Trust

Quality Account 2016 / 17

Contents Page

Part one:

Statement on quality from the chief executive 5

Part two:

Quality improvement priorities 2016/17 7

- improve learning following never events, incidents and complaints 8
- maintaining privacy, dignity and respect 11
- improve outcomes against national audits 13

Quality improvement priorities for 2017/18 15

- improve patient experience 16
- improve care for patients whose condition is deteriorating 17
- reduce the number of patients experiencing a fall while in hospital 18

Statements of assurance from the board 19

Participation in clinical audits 20

National Audits 20

Local Audits 27

National confidential enquiries 35

Commissioning for Quality and Innovation (QCUIN) framework 37

Care Quality Commission registration and compliance 39

Duty of Candour 41

Sign Up To Safety 42

Data quality 45

Information governance toolkit 45

Clinical coding accuracy 45

Part three:

Overview of the quality of our care in 2016/17 46

Summary Hospital-Level Mortality Indicator (SHMI) 48

Patient Reported Outcome Measures (PROMs) 50

- Varicose vein surgery 51
- Hip replacement surgery 52
- Knee replacement surgery 53

Emergency readmissions to the hospital within 28 days of discharge 54

Responsiveness to the personal needs of patients 55

Staff who would recommend the trust 56

VTE assessment 57

Rate of Clostridium difficile infections 59

Patient safety incidents 62

Summary of 2016/17 66

Serious Incidents – reducing patient harm 66

Safety Thermometer 68

- Falls 68
- Pressure Ulcers 69

Drug incidents 70

Never events 71

Complaints and PALS 72

Parliamentary and health service ombudsman (PHSO) 73

Friend and Family Test 73

Dementia wards recognised for innovative improvements 76

Discharge planning 78

NHS Staff Survey results 80

Seven Day Services Clinical Standards 81

Quality improvement Strategy 89

Annex one services provided by Bedford Hospital NHS Trust in 2016/16 90

Annex two: statements from commissions, Healthwatch and overview 92

Part one: Statement on quality from the chief executive

I am pleased to present the quality account for 2016/17. Over the last year, the trust has improved its performance significantly in many areas thanks to the dedication of our staff and the support of our patients. We really appreciate the support of our local community and partner organisations such as Friends of Bedford Charity and Healthwatch for their unfailing commitment to support the important services provided by and in Bedford Hospital NHS Trust.

It has been a successful yet challenging year for the trust, where we have seen ever increasing numbers of patients through our doors, especially as emergency admissions and A&E attendances; this has in turn put significant pressure on our services across the hospital.

I am incredibly proud of the fact however, that despite these, at times, overwhelming operational pressures, we have maintained results in the upper quartile of the country by focusing on improving the systems and processes underpinning the quality of care our patients receive.

Bedford Hospital has a single quality improvement strategy which integrates recommendations of the Care Quality Commission (CQC) in its report published in April 2016 with our own quality priorities. All actions related to quality and safety is implemented in a consistent and robust way across the organisation.

I am pleased to say that we have implemented all of the four CQC Requirement Notices and the majority of the remaining recommendations. The completed action plan was sent to the CQC, NHS Improvement and the Clinical Commissioning Group at the end of January 2017.

Aligned to this, we implemented a monthly integrated performance report for our trust board which gives a robust overview of all key areas and enables the board to better scrutinise the impact of the changes we have implemented on patient care. A range of key quality indicators are supported by exception reports and discussion of specific issues; this includes maternity indicators arising from a new maternity services dashboard. This dynamic report allows clinical quality and patient experience to be measured alongside financial performance and workforce information, as well as the relationship and impacts of each on the other.

Some key quality achievements for 2016/17 include:

- The reduction in serious incidents from 2015/16
- The significant reduction in complaints and the decision of the Parliamentary and Health Service Ombudsman investigations in favour of the trust
- Dementia ward (Harpur and Elizabeth wards) accreditation – recognising the support given to older people by the quality mark from the Royal Colleges of Psychiatrists and Physicians

- Development of the ambulatory care unit
- The implementation of Red/Green days
- Preparations for new scanner from charity which will be operational in 2017/18

Running in parallel, there have been a number of initiatives which have further driven our quality improvements and which we should be very proud of - namely our patient safety programme (run in conjunction with the University of Bedfordshire), the implementation of best practice protocols for staff training, and a recruitment drive resulting in fewer nurse vacancies requiring agency cover.

It has been as important as ever this year to listen to our patients, visitors, staff, volunteers, regulators and partner organisations as part of our efforts to drive improvements. We do this by carrying out surveys, learning from investigations when things go wrong, dealing with complaints and recording compliments, and working closely with patient representation groups such as Healthwatch and our own Patients' Council. Looking forward, we will use the feedback gained this year to develop our priorities and focus on the areas that require further improvement as part of the final year of our quality improvement strategy.

Our progress to date and our ambitions moving forward has only been possible thanks to the hard work of all of our staff and volunteers, who continually show a fantastic commitment to improving the quality of our patient care. I am looking forward to working with our teams' right across the trust next year as we implement yet more improvements for our patients.

To the best of my knowledge and belief, the information contained in this report is accurate

Stephen Conroy, Chief Executive

Part two: Quality improvement priorities 2016/17

In the 2015/16 quality account the trust identified three quality improvement priorities for 2016/17 based on the outcome and recommendations of the trust's CQC inspection. The actions that delivered on the outcomes underpinned the quality improvement strategy's priorities and the top three that were identified are:

- Patient safety: improve learning following never events, incidents and complaints to prevent avoidable harm.
- Patient experience: build on good practice in maintaining privacy, dignity and respect in outpatient areas and further improve the range of patient information in languages other than English.
- Clinical effectiveness: improve the implementation of plans to improve outcomes against national audits.

The trust's progress in achieving these improvement priorities is presented in pages 8 to 13

Patient safety priority for 2016/17: improve learning

In the 2015/16 quality account the trust identified a priority to improve learning following never events, incidents and complaints to prevent avoidable harm.

Progress made in 2016/17

The CQC inspection provided an opportunity for the trust to review the development of a learning culture.

Access to learning comes from a range of sources including:

- Incidents
- Complaints
- Serious incident investigation
- Clinical audit
- Good practice

To understand good practice the trust carried out scoping with partner organisations that have positive learning experiences and cultures especially around those identified by the CQC as good or outstanding.

Culture

To ensure the trust identified immediate learning to ensure patient safety, serious incident investigations (SI) were centralised. While investigations continued to have a senior clinical lead, centralising the investigation meant that immediate learning was identified and themes linked to various clinical areas highlighted that may not have been if investigations had happened locally.

The trust's clinical governance team historically focused on patient safety, risk and incident management but focus changed in 2016/17 to shared learning. This meant working with clinical divisions and nursing to support identifying factors that may contribute to patient harm and to reduce the risk of re-occurrences which can be seen in the reduction of Si, complaints and thematic reviews of incident themes.

In year, the trust appointed two clinical governance business partners who support the divisions to establish speciality quality groups and other infrastructure, to understand the root causes of harm and therefore how to change processes to prevent recurrence of similar incidents. The business partners have also worked with the communications team to establish a cascade infrastructure to ensure flow of information through divisions and ensure that front line staff have access to learning from outcomes and understand that behaviour change is driven as a result of learning. The flow of information from our board to ward and ward to board has ensured that not just learning is shared but a sense of ownership of the behaviour change.

To support cultural change, all new staff inductions and clinical updates include shared learning with examples of quality and process improvements implemented following previous learning and how to identify incidents of harm report it and ensure robust investigation of current incidents and dissemination of learning to prevent future harm.

There were five audit half days in which the findings were presented and outcomes from clinical audits to help shape clinical practice and in some cases treatment. The audit days were attended by clinical staff, in particular consultants and junior doctors and are usually held within a speciality. All audit days have a centralised trust-wide presentation regarding incident management and learning which feeds discussion and debate about practice.

During the year the trust expanded its development of its SI investigation process in continuing RCA (root cause analysis) training with courses held during the year. The purpose of the training is to ensure that key staff understand the principles and values of a good investigation and how to develop the findings into outcomes for learning and action plans. This has improved the quality and consistency of our SI investigations.

The training now incorporates 'human factors' where staff understand how teamwork, tasks, working environment, and individuals' learning can impact and affect actions and incidents. Understanding the foundation of human factors can help a wider knowledge of contributing factors while undertaking an investigation; and therefore provide an opportunity for a more considered approach to prevent reoccurrences by helping staff understand what went wrong with practical ways for avoiding similar occurrences.

During the year the trust welcomed the CQC report 'Learning from deaths' and the principles of patient involvement, openness and transparency are already central to the trust's values and current process. The central principles are included in the 16/176 quality strategy and we will continue to review and revise as needed.

The trust launched the QI (quality improvement newsletter) in October 2015 which shares learning on a monthly basis across the hospital to all clinical staff. To date 18 editions of the newsletter have been published and key topics covered include: anticoagulation, deteriorating patients, sepsis, falls and safeguarding has a theme across the edition and will present examples of cases, either an inquest or an incident which will support understanding of what influenced the incident and how staff can prevent it happening again.

Supporting the development of QI, learning is also shared through 'information triangles' within the trust restaurant where both staff and members of the public can see how the trust uses learning and feedback to further develop safe services and improve the patient experience.

A number of specialities have been supported in developing newsletters for their area which provide staff with a sense of ownership of information and incidents. Linking these newsletters to the trust wide quality improvement team has given opportunities for wider shared learning throughout the trust.

We recognised the need to strengthen the repository of learning on the trust intranet, where staff will be able to access both examples of learning but also the background to the learning incident. Implementation is underway and carried forward to 16/17 improvement plan.

The trust uses Datix as the incident management system and substantial work has taken place during the past year to improve the dynamics of the system so it supports learning. Workflow through the DatIx system have been implemented/improved and incident investigations and reporting back to staff on the outcome of the investigations is faster allowing earlier implementation of learning and change at front line level.

Further development of the Datix mortality module now allows clinical peer-reviews on all hospital deaths to be electronically recorded, root cause analysis performed robustly and any findings shared automatically.

In addition to training staff, the trust has improved the robustness of validation of incident data to provide more assurance as well understanding the true extent of patients harm. For example, a clearer understanding of harm caused by medication errors, rather than simply recording a failure of providing TTOs (discharge medication) has helped us provide assurances that harm to patients from medication errors is and remains very low.

There is an annual plan of thematic reviews and spotlights on emerging issues to establish common themes and influences so that the trust can develop and mitigate against patient harm. Oversight of this process is by a sub-committee of the board – quality and clinical risk committee (QCRC).

Patient experience priority for 2016/17: maintaining privacy, dignity and respect

In the 2015/16 quality account the trust identified a priority to build on good practice in maintaining respect for patients by ensuring privacy and dignity in outpatient areas and further improve the range of patient information in languages other than English.

Progress made in 2016/17

Privacy and dignity

The CQC identified an issue with a lack of privacy and dignity for patients, particularly in outpatients where at times female patients had to sit in hospital gowns in a waiting area where other patients, including males, were clothed. In addition, some ward areas had reduced washing facilities for personal care.

We undertook an immediate review of all areas and implemented good practice including:

- Patients currently waiting in this area no longer wear a gown until they go into the scan room to maintain privacy and dignity.
- Reviewed and changed information that patients received prior to coming to hospital so they would be aware of the what clothes to wear for specific appointment and ensured that had access to private sitting areas if they chose to wear a gown between tests
- Communicated to all staff to raise awareness within all staff groups involved in the provision of breast clinic services
- Use of privacy clips for curtained areas
- Used internal intelligence to identify areas where patients have feedback, complained, about issues for privacy and dignity the review showed there were no complaints received in a six month period.
- Reviewed sound proofing in examination rooms to ensure patients are not overheard. A problem in phlebotomy did identify a problem and the service was moved from main outpatients to Weller Wing where both privacy and capacity have been enhanced
- Development of the Cauldwell Centre in Weller Wing providing patients with on-site direct access to primary care

To support our implementation of good practice, we invited Healthwatch Bedford along with other partners including patient council and CCG, to carry out ‘enter and view’ inspections. The inspections, which took place over a number of months, identified in the final report that patients feel they are treated with privacy and dignity.

Accessible patient information

Following data collection from the (most recent) 2011 census and the number of translation episodes we have provided since January 2016; the trust identified the top six languages for the hospital catchment area as:

- Polish (113 translation episodes since January*)
- Punjabi (79 translation episodes since January*)
- Italian (26 translation episodes since January*)

- Bengali (15 translation episodes since January*)
- Lithuanian (12 translation episodes since January*)
- Romanian (11 translation episodes since January*)

Since September 2016 the trust reviewed both models of communications – patient leaflets – as well as the accessibility of that information. The trust identified the top ten leaflets used by patients and had those translated into the top six languages as well as provided access of those leaflets through braille and easy to read.

The leaflets are available at service level as well as through the internet.

Clinical effectiveness priority for 2016/17: improve outcomes against national audits

In the 2015/16 quality account the trust identified a priority to improve the implementation of plans to improve outcomes against national audits

Progress made in 2016/17

During 2016/17, 45 national clinical audits covered relevant health services that the trust provides and it participated in all 45 (100%) of these national clinical audits. Of these, 32 audits comprise continuous data collection and are therefore undertaken annually.

For the remaining 13 audits these are created by the royal colleges on an annual basis to reflect current priorities such as:

- Royal College of Emergency Medicine (RCEM) focusing on severe sepsis and septic shock
- Adult and paediatric asthma and consultant sign off
- The British Thoracic Society (BTS) in conjunction with the Royal College of Physicians, undertook audits on adult asthma, smoking cessation and paediatric pneumonia

National audit published reports

To date HQIP (Healthcare Quality Improvement Partnership) has released 33 reports this financial year. These cover audits that submitted data this year, together with reports from 2014 and 2015, e.g. National COPD Audit programme (chronic obstructive pulmonary disease) – outcomes from the clinical audit of COPD exacerbations admitted to acute units in 2014 – national supplementary report.

Other sources of national audit providers include Intensive Care National Audit & Research Centre (ICNARC) whereby quarterly and annual reports are forwarded directly to the relevant hospital specialties on topics including the national cardiac arrest audit, national intensive care unit audit and the case-mix programme.

Learning

HQIP publishes a schedule at the beginning of each financial year with report publication dates. On report publication, they are sent to the relevant clinical audit lead to signpost them to the audit results and dissemination of the outcomes and learning across their speciality. The outcome of the audits are also shared in.

There are five trust wide audit meetings annually where the clinical audit team encourage discussion of the findings of recent reports. However there is perception from some national audit leads that often the audit subject is too specific to be shared across a wide audience and should be targeted departmentally.

Examples of national audits shared at trust wide audit meetings during the year:

Anaesthetics discussing the findings and instigating action relating to the second patient report of the national emergency laparotomy audit (NELA) at their 16/09/16 and 15/11/16 audit meetings which has led to a formal pre and post op risk scoring system	Integrated Medicine are planning to discuss the findings from the national audit of percutaneous coronary interventions, pacing from the national audit of cardiac rhythm management and COPD outcomes from the COPD audit programme at the April 2017 meeting.	National cardiac arrest audits are discussed at monthly resuscitation group meetings and reported monthly to the mortality board, national cancer audits are shared at their multidisciplinary meetings and operational meetings while the Trauma committee bi monthly meetings share the findings of the Trauma & Audit Research Network (TARN).

Quality improvement priorities for 2017/18

In January the trust undertook a one-month consultation with patients, stakeholder and staff to identify the top three priorities the trust should deliver in 2017/18. These priorities are supported by the quality improvement strategy, our quality indicators, as agreed with the commissioners, and an awareness of issues that affect the quality of patients care and experience. These indicators are:

- To improve our performance; as measured by our inpatient survey, specifically:
    - Patients feeling they are involved in their care and decision-making
    - Delivering on our commitment to treat and care for patients with dignity and respect
    - Improving communication with patients especially with regard to care and treatment

- To improve care for patients whose condition is deteriorating:
    - Implementing care plans for all patients which consider the patient's health and treatment priorities and advanced planning to allow implementation of end of life preferences wherever possible
    - By escalation and use of NEWS activation
    - Communicating well and at the earliest stage possible with patients and family regarding deterioration potential outcomes and patient's care preferences

- To reduce the number of patients experiencing a fall while in hospital

Patient experience improvement priority 2017/18: improve our performance; as measured by our inpatients survey

Target for 2017/18

To improve our performance as measured by our inpatients survey, specifically:

- Patients feeling they are involved in their care and decision-making
- Delivering on our commitment to treat and care for patients with dignity and respect
- Improving communication with patients, especially with regard to care and treatment

Planned improvements for 2017/18

The trust plans to implement the following improvement activities in 2017/18:

- Using patient surveys to benchmark and improve the discharge journey for patients
- Using the current survey, complaints and general feedback mechanisms, understand what are the key issues affecting patient experience
- Ensure all elements of the quality improvement strategy underpin excellent patient experience
- Work with patient council and representatives to provide 360° review of patient experience outcomes and sharing of information
- To link with and learn from other trusts who demonstrate excellent results in patient surveys
- Maternity Services: To maintain the patients feedback on 1:1 care while in labour

How we will monitor and report on our progress

Progress against this improvement priority will be reported monthly to the quality board and quarterly to QCRC.

Measure of success

- An improvement in internal and external patient survey results
- Change in behaviour and feedback will be measured by targeted patient surveys and linking to patient gatekeeping organisations.

Patient safety priority 2017/18: to improve care for patients whose condition is deteriorating

Target for 2017/18

To improve care for patients whose condition is deteriorating:

- By escalation and use of NEWS (national early warning score) activation, including to end of life team
- Communicating with patients and family regarding deterioration and outcomes
- Planned improvements for 2017/18

Planned improvements for 2017/18

The trust plans to implement the following improvement activities in 2017/18:

- Undertake technical and awareness training for identifying deteriorating patients
- Ensure all staff understand their responsibilities in escalating deteriorating patients
- Ensure deteriorating patients are reviewed and best-interest decisions taken in consultation with the patient and family
- Use monthly audits to highlight key areas and themes that should have targeted improvements

How we will monitor and report on our progress

In addition to the regular mortality peer review, the trust will audit monthly, those patients who have died with a 'failure to escalate' flag and report to the mortality board and quality board.

Measure of success

- A reduction in complaints, where relatives have been unaware of the deterioration in the patient (resulting in them being unable to attend before the patient dies).
- A reduction in the number of patients undergoing resuscitation intervention which is not in their best interests or within the patient's preferred treatment pathway.
- Trust wide roll-out of 'point of care' (nursing technology fund) using electronic recording of observations with alerts that automatically alarm

Patient safety improvement priority 2017/18: reduce the number of patients experiencing a fall while in hospital

Target for 2017/18

Reduce the number of patients experiencing a fall with harm while in hospital

Planned improvements for 2017/18

The trust plans to implement the following improvement activities in 2017/18:

- Older people should be observed and tested for balance and gait deficits.
- Falls assessment tools will be reviewed across all settings to ensure that they reflect current NICE guidance 161.
- Patients admitted, who have previously fallen, combined with a condition that affects their cognitive ability or physical movement, appear to be at higher risk of suffering a consequence of severe harm and therefore should be prioritised in terms of cohort nursing or 1-2-1 special nursing.
- Patients who have fallen within the last year should be offered intentional rounding (where nurses carry out regular checks at set intervals on patients to ensure their fundamental care needs are met), 1-2-1 nursing, or cohort nursing, to ensure their needs are met.
- The trust will establish a multi-professional 'falls steering group' which will work with partners across the healthcare system to oversee the implementation of a falls-reduction action plan.

How we will monitor and report on our progress

Progress against this improvement priority will be reported monthly to the quality board.

Measure of success

- A reduction in patients suffering harm from avoidable falls in hospital

Statements of assurance from the board

Review of services provided by Bedford Hospital NHS Trust

During 2016/17, Bedford Hospital NHS Trust provided 45 relevant health services and sub-contracted 11 relevant health services. A list of all services provided by the trust is located in annex one.

Bedford Hospital NHS Trust has reviewed all the data available to it on the quality of care in 100 percent of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100 percent of the total income generated from the provision of relevant health services by Bedford Hospital NHS Trust for 2016/17.

Participation in clinical audits

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. National clinical audit is designed to improve patient outcomes across a wide range of health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. It also allows hospitals of similar size the opportunity to benchmark their practice with each other.

During 2016/17, 45 national clinical audits covered relevant health services that Bedford Hospital NHS Trust provides.

During 2016/17 Bedford Hospital NHS Trust participated in 100% (45/45) of national clinical audits.

The national clinical audits that Bedford Hospital NHS Trust was eligible to participate, and for which data collection was completed during 2016/17:

Table two: Bedford Hospital NHS Trust participation in national clinical audits National Audit	Percentage participation/Continuous
Acute coronary syndrome or acute myocardial infarction	Continuous
Adult Asthma (BTS)	72% (18/25) Completed
Asthma (Paediatric and Adult) Care in Emergency Departments (RCEM)	100% (50/50) Completed
Bowel Cancer (NBOCAP)	Continuous
Breast & Cosmetic Implant Registry (BCIR)	Continuous
Cardiac arrhythmia (NICOR)	Continuous
Case mix programme (CMP)	Continuous
Consultant Sign-Off (RCEM)	100% (50/50) Completed
Coronary angioplasty (NICOR adult cardiac interventions audit)	Continuous
Diabetes (paediatric) (NPDA)	Continuous
Elective surgery (national PROMS programme)	Continuous
Endoscopy audits (38 topics)	Continuous
Endocrine and thyroid national audit (BAETS)	Continuous
Falls and Fragility Fractures Audit Programme (RCP) Fracture Liaison Database	 Continuous

Inpatient Falls National Hip Fracture Database	Continuous Continuous
Head and neck oncology (DAHNO)	Continuous
Inflammatory bowel disease audit	Continuous
Learning disabilities mortality review programme (LeDeR)	Continuous
Major trauma audit (Trauma Audit & Research Network)	Continuous
Maternal, new-born & infant clinical outcome review programme (MBBRACE)	Continuous
National audit of Dementia	100% (50/50) Completed
National cardiac arrest audit (NCAA)	Continuous
National chronic obstructive pulmonary disease audit programme – pulmonary rehab	In progress
National chronic obstructive pulmonary disease audit programme - (BTS)	Continuous
National comparative audit of blood transfusion programme: blood management in scheduled surgery use of blood in haematology	 In progress In progress
NDA National diabetes audit	Continuous
NADIA National diabetes inpatient audit	Continuous
National pregnancy in diabetes audit	Continuous
National diabetes foot care audit	Continuous
National emergency laparotomy audit	Continuous
National heart failure audit	Continuous
National joint registry (NJR)	Continuous
National lung cancer audit (NLCA)	Continuous
National paediatric pneumonia (BTS)	In progress (Data Collection ends 30th April 2017)
National prostate cancer audit	Continuous
National vascular registry	Continuous
Neonatal and intensive special care (NNAP)	Continuous
Oesophago-gastric cancer (NAOGC)	Continuous

Percutaneous nephrolithotomy (PCNL) audit	Continuous
Sentinel stroke national audit programme (SSNAP)	Continuous
Severe Sepsis and Septic Shock (RCEM)	100% (50/50) Completed
Smoking Cessation (BTS)	98% (98/100) Completed
Stress urinary incontinence audit	Continuous

In 2015/16 Bedford Hospital NHS Trust did not participate in one national audit for the following specific reason, identified in Table three.

Table three: Bedford Hospital NHS Trust non-participation in national clinical audits

National Audit	Reason
Community acquired pneumonia audit (BTS	Lack of resources

Table two: national clinical audit reports received during 2016/17 with action taken/planned

National Audit	Actions
British Thoracic Society Emergency Oxygen Audit Report (BTS) (15 August – 1 November 2015)	Discussed at 15/06/16 Integrated Medicine Audit meeting Training being provided for medical and nursing staff on oxygen prescribing and the reaching and recording of patient target saturations at induction, drop-in sessions and online.
National Audit of Percutaneous Coronary Interventions (January to December 2014)	To be discussed at 13/04/17 Integrated Medicine Audit meeting
Trauma & Audit Research Network (TARN)	Trauma Committee 11/05/16 (bi-monthly meetings)
National Cardiac Arrest Audit 2015/16 (NCAA)	Discussed at monthly Resuscitation Committee meetings Information monitored and reported monthly to Mortality Group, Quality Board and included in divisional quality packs
Procedural Sedation in Adults Clinical Audit 2015/16 (RCEM)	Awaiting discussion
VTE Risk in Lower Limb Immobilisation in Plaster Cast	Awaiting discussion

Clinical Audit 2015-16	
Vital Signs in Children Clinical Audit 2015-16	Awaiting discussion
National Oesophago-Gastric Cancer Audit 2016	Under discussion To discuss at May 2017 operational service meeting
National Audit of Cardiac Rhythm Management Devices (2014/15)	To be discussed at 13/04/17 Integrated Medicine Audit meeting
National Diabetes Inpatient Audit 2015	Awaiting discussion
National Heart Failure Audit (2014/15)	Discussed at December Cardiology Audit meeting No action required
National Cancer Patient Experience Survey (2015)	Integrated Medicine Divisional Quality Group meeting 11/08/16 Cancer Management meeting 25/08/16 Bedford Cancer Action meeting September 2016 Wards to extend safety huddle and establish communication questions between Nurses and patients for that day. Macmillan GP Liaison to discuss with GP colleagues and discharge summaries are transferred electronically to GP's. Staff to ensure that patients are referred to pain team or palliative care team in a timely manner. PCA training on wards have been completed and a recent inpatient survey has also taken place on pain relief.
National clinical audit of biological therapies UK inflammatory bowel disease (IBD) audit	Discussed at 15/11/16 Integrated Medicine Audit meeting Awaiting action plan
Sentinel Stroke National Audit Programme (SSNAP	Awaiting lead for topic & discussion

Acute organisational audit report 2016	
BTS Smoking Cessation Audit Report – Smoking Cessation Policy & Practice in NHS Hospitals (1 April – 31 May 2016)	Report circulated, awaiting confirmation of shared learning
National Lung Cancer Audit Annual Report 2016	Awaiting discussion at operational service meeting March/April 2017
Myocardial Ischaemia National Audit Project report 2014/15	To be discussed at 13/04/17 Integrated Medicine Audit meeting
National Diabetes Audit, 2015-2016: Report 1: Care Processes and Treatment Targets, England and Wales Learning Disability - Supplementary Information	Report circulated, awaiting confirmation of shared learning
COPD: Who cares when it matters most: National COPD Audit programme - Outcomes from the clinical audit of COPD exacerbations admitted to acute units in 2014 - National supplementary report & Results and Data analysis	Report circulated, awaiting confirmation of shared learning
National Audit of Cardiac Rhythm Management Devices (2015/16)	To be discussed at 13/04/17 Integrated Medicine Audit meeting
National Pregnancy in Diabetes 2015	Report circulated, awaiting confirmation of shared learning
• ICNARC (Intensive care national audit and research centre) Case mix programme:	• Discussed at departmental meetings
The Second Patient Report of the National Emergency Laparotomy Audit (NELA) December 2014 to November 2015	Discussed at 16/09/16 & 15/11/16 Anaesthetics Audit meetings All emergency laparotomies should have a formal pre and post-operative risk score High risk patients should have active consultant input intra-operatively and be admitted to critical care

National Comparative Audit of Lower Gastrointestinal Bleeding and the Use of Blood	Awaiting discussion
Treat the Cause: A review of the quality of care provided to patients treated for acute pancreatitis A report published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Awaiting discussion
National Vascular Registry 2016 Annual Report	Awaiting discussion
National Prostate Cancer Audit - Third Year Annual Report - 2016	Awaiting discussion at operational service meeting March/April 2017
National Bowel Cancer Audit Annual Report 2016	Awaiting discussion at operational service meeting March/April 2017
National Joint Registry 13th Annual Report (NJR)	Awaiting discussion
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE -UK)	Awaiting discussion
National Paediatric Diabetes Audit Report 2014-15 Part 1: Care Processes and Outcomes	Discussed at 15/11/16 Paediatrics Audit meeting Clinical Psychologist to see all newly diagnosed diabetic patients Patient/parents must sign a pump contract before this is agreed and funded Education to be offered for different age groups focusing particularly on patients transitioning from primary to secondary or middle school
BTS Paediatric Asthma report 1-30 November 2015	To be discussed at 24/01/17 Paediatrics Audit meeting
National Paediatric Diabetes Audit Report 2015-2016	To be discussed at 13/04/17 Paediatrics Audit meeting

The trust also submitted continuous data for 38 audits (including a patient experience survey) in endoscopy throughout the year as part of the Joint Advisory Service accreditation incorporating the endoscopy global rating scale requirements.

Local audit

The reports of 76 local clinical audits were reviewed by Bedford Hospital NHS Trust in 2016/17 and the trust intends to take the following actions to improve the quality of healthcare provided:

Table three: local clinical audits and associated actions

Local clinical audit	Actions
Integrated medicine	
Emergency medicine	
Investigation and Management of Acutely Delirious Patients	Teaching sessions to be provided to AAU staff covering required investigations and management in cases of delirium, specifically targeting blood cultures and use of haloperidol
Respiratory	
EBUS Referral Audit (Endobronchial Ultrasound Guided Needle Aspiration)	Results to be disseminated to the management team and other respiratory team members EBUS service to start
Acute Respiratory Assessment Service (ARAS)	Liaising with the Estates Department to introduce additional and improved signage to the ARAS room
Early Supported Discharge Scheme (ESD)	Improve referral to pulmonary rehab, inhaler technique and offering PHP by implementing a respiratory discharge bundle to address the following: Inhaler technique Offering PR Offering PHP Improve patients understanding of lung condition by reviewing and delivering a lung anatomy talk at rehabilitation Improve referral to physio technicians by referring all patients discharged from ESD to the technicians Re-audit in October 2017
Home Oxygen Service	Ensure patients are aware of frequency of their review by informing them at each review when they will be seen next No negative feedback was received for this service
Oncology	
Patient satisfaction	Findings discussed at operational meetings between June

questionnaires for: Brain cancer, Breast cancer, Colorectal cancer, Gynaecology cancer, Haematology cancer, Head and Neck cancer, Lung cancer, Skin cancer, Upper GI cancer, Urology cancer, Acute cancer and CUP	and August 2016. Discussed further at October 2016 CMG meeting Patients are routinely offered a copy of their consultation letter and written information provided on treatment and side effects. 3 CNS's now in post and nurses are present in all clinics. Demand during clinics has on occasions caused a delay in nurses being able to get to clinic promptly. Possibility of Breast Oncology CNS post being explored by division. HNA is completed with all relevant patients at the point of diagnosis and during nurse led follow ups. Macmillan E HNA pilot to commence Autumn 2016 CNS's and Consultants routinely provide education sessions to staff on the pathway. Formal presentations also given at junior doctor inductions Work ongoing with L&D to ensure that patients receive a full explanation of their treatment options (L&D and MV) GPs provide leaflets about CXR and CT and radiology provide information on CT guided biopsy. CNS's/Consultants explain bronchoscopy to patients
All specialties	
Endometrial Cancer Histopathology Reporting	To continue to type and provide a FIGO grade in the surgical reports of all the endometrial cancers diagnosed on pipelle endometrial biopsies. This is vital to determine the need for full surgical staging and whether the operation takes place in a cancer unit or cancer centre. To remain compliant with the Royal College minimum dataset guidelines. Pathology peer review verifies and improves the accuracy and quality of pathology diagnoses and interpretations, and thereby appropriately reflecting the pathology data.
Compliance with Core Data Items in the Royal College of Pathology Dataset for Malignant Melanoma Reporting	Circulate this audit to all pathologists within Bedford Cellular Pathology Department. Following discussion with all consultant colleagues, introduce a standardised proforma for melanoma reporting. Re-audit in 2018 the reports produced in 2017, i.e. following the introduction of standardised proforma reporting.
Rectal MRI Audit	Continue use of standardised template reporting to meet RCR standards To "double report" in difficult cases

	To update/attend courses to improve reporting standards Re-audit in 2018
Appropriateness for Blood Component Requests, Usage and Wastage	The Surgical bleeding guide in the Transfusion Policy is not currently being followed. Most surgery can have a Group & Save. With the introduction of the 2 patient sample blood can be issued electronically in 15 minutes The Trust Transfusion Policy states that platelets need to be reviewed by a consultant haematologist, this is working well, and recommend this continues The Trust Transfusion policy has triggers for giving RBC asymptomatic Hb<70 and Hb<80 symptomatic. These do not seem to be followed. The recommendation are from Patient Blood management, NICE 24 Blood Transfusion (Nov 2015), Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee, suggest a restrictive regime In conventional meta-analyses restrictive transfusion strategies compared with liberal transfusion strategies were associated with a:- reduction in the number of red blood cells used and the number of patients being transfused but were not associated with benefit or harm regarding mortality Do not transfuse asymptomatic non-bleeding patients whose HB is > 70g/L. Serious Hazards of Transfusion 2013 recommend that 1 RBC is given and then reviewed (Berger et al 2012)
Planned Care	
Anaesthetics	
Pain Management after Day Surgery	Present findings to Recovery staff Pain Scale teaching for Recovery staff by Pain Nurse Specialist Introduce use of IV Fentanyl for Recovery use in Day Surgery cases Re-audit in 2018
Preoperative and Requirement of Blood Transfusion in Patients Undergoing Lower Limb Joint Replacements	Develop and implement a Patient Blood Management programme by August 2017 Senior management of Planned Care aware and also agreed for a Lead Person to lead on patient blood management project
Trauma and orthopaedics	

Management of Intra-Articular Distal Radius Fractures	Teaching session for A&E and orthopaedic team on intra-articular distal radius fractures to ensure prompt referral and expedite fracture clinic appointments Ensure adequate equipment is available in theatres for operative management of fractures Re-audit in 3 months after teaching session to monitor progress
Surgical Procedures in Fracture Neck of Femur (NOF)	Implement a Protocol regarding surgical treatment of fractured neck of femurs (NOF) in accordance with NICE guidelines to increase compliance, improve care, rehabilitation and financial savings.
Timing of Surgery in Fracture Neck of Femur	Each action should:- Planned trauma theatre over weekend Availability of theatre supporting staff for theatres that over run in weekdays
Obstetrics and gynaecology	
Neonatal Abstinence Scoring and Maternal use of SSRI	Repeat audit with a larger sample size in order to draw a more robust conclusion Review of literature around scoring system for SSRI in revised Finnegan scoring Discussion with the neonatal team regarding the length of stay for NAS scoring.
GAP (growth assessment protocol)	To look into whether gestation related optimal weight training can be linked to the trust's mandatory training record, WIRED GAP project team established Continuous monthly audits
Reduced Foetal Movements	Women to be provided with leaflets regarding reduced fetal movements from 16 weeks Women to be explained what "pattern of fetal movements is" Detect Intrauterine Growth Restriction (IUGR) and reduced fetal movements Detect other co-morbidities for example or including smoking and reduced fetal movements Perform a prospective study
Outpatient Cervical Ripening in Low Risk Women	Any fetal/neonatal/maternal mortality or significant morbidity in outpatient IOL patients should have a Datix submitted Re-audit using mentioned standards in 2018 to ensure continuing good practice

• Routine enquiry audit - • maternity services • Bedford Hospital NHS Trust	Monthly audit, monitoring and investigation the by safeguarding team. Safeguarding team to circulate how future enquiries are made and how the re-recording of documentation will serve as a reminder to doctors
Miscarriage audit	Review case notes of patients who had emergency surgery to identify specific risk factors Annual re-audit
Foetal Blood Sampling	Audit to be modified to improve capture of Foetal Blood Sampling Re-audit in 2017
Paediatrics	
• Review of abnormal Echo results	All abnormal echo reports to be copied to cardiac lead All echo reports need to be signed by clinician before filing To ensure administration staff are aware awareness All abnormal echo reports to be discussed with cardiac lead and appropriate follow up to be organised
• ROP screening in newborn babies	Future audits to be based on EPR data collection from Badgernet To audit provision of information leaflet to parents from documentation in nursing notes. To record this on Badgernet if possible
• Opinions of teenagers attending ADHD clinic in CDC	Create a pre-appointment questionnaire either to be sent out with the appointment letter given when they check-in at clinic Ask patients if they would like some appointment time without parents present at the start of the clinic Create a standardised information pack including: Information on ADHD – what it is, what causes it, how it is treated Information about ADHD medication Information about sleep and sleep hygiene A list of useful publications and websites Information about available support groups
Trust wide	
Pain scoring and inpatient satisfaction with pain control	Obstetrics and Gynaecology (O&G) patients now included in audit Regular ongoing education in pain control management to include O&G staff Re-audit annually

Discharge medicines returned to pharmacy audit	*Ward:* Plan for discharge ahead of time and liaise with the ward pharmacist Give To Take Out (TTO) medicines to the ward pharmacist for screening with enough time to allow them to be dispensed before patient discharge Track the progress of the TTO on the online tracking system and contact the ward pharmacist if a delay occurs Contact patients/ their relatives that have gone home without their medicines to inform them that TTO is ready to collect Return items to the pharmacy department on a regular basis, in the correct manner Return fridge items separately and in a fridge bag to ensure that they are identified as fridge items upon receipt *Pharmacy:* Ensure that ward pharmacists continually work with ward staff to ensure they know how to return medicines, particularly fridge items and high cost drugs Ensure that all ward pharmacists prioritise TTO provision and discharge as the trust's priority Ensure that returned items are dealt with immediately on arrival back in Pharmacy, and returned to stock where appropriate Offer a delivery service run by a member of the pharmacy team – will also allow appropriate counselling Introduce a returns team in pharmacy that will deal with the previous day's returns before starting new work for the day Engage with the CCG for community pharmacies to take on discharge medication dispensing. This could also be considered for outpatient dispensing Re-audit
Antimicrobial prescribing point prevalence audit	Antimicrobial guideline review Training of medical and nursing staff in the importance of antimicrobial stewardship Establish an antimicrobial ward round – microbiologist and antibiotic pharmacist review To explore the use of "stop review" date stickers in medical notes Re-audit
Audit of DNACPR for patients with a learning	Continue use of the categories of reason for use of DNACPR Develop clear identification on the form of the need for

disability	mental capacity assessment and best interest decisions Continue delivery of Mental Capacity Act training Re-audit

The reports of four local patient experience surveys were reviewed by Bedford Hospital NHS Trust in 2015/16 and the trust intends to take the following actions to improve the quality of healthcare provided.

Table four: patient experience surveys and associated actions

Local patient experience survey	Actions
Integrated medicine	
Acute respiratory assessment service	On movement of treatment room, estates will review signage to assist patients with locating the clinic Annual survey
Early supported discharge scheme for chronic obstructive pulmonary disease patients	All patients offered a choice of am/pm visits to offer more flexibility Annual survey
Home oxygen service	Findings fed back to Respiratory team Respiratory network Commissioners of home oxygen service BOC Healthcare All patients requesting support have been contacted by the Respiratory nursing team Annual survey
ENT Patient Satisfaction Survey	ENT performed well with the majority of patients happy with the service provided. Patients are now informed of waiting times with an introduction of a white board in the reception area displaying the length of the delay. Delays are considerably less now due to the more manageable twenty minute slots for each appointment.

Monitoring of action

The clinical audit team will be developing processes to receive assurance that audit actions are implemented in a timely fashion.

National confidential enquiries

The national clinical audits and national confidential enquiries that the trust was eligible and participated in, and for which data collection was completed during 2016/17, are listed below. Alongside the audit title are the numbers of cases submitted for each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table five: Bedford Hospital NHS Trust participation in national confidential enquiries

National confidential enquiry	Percentage participation
Mental Health	100%
Acute pancreatitis	100%
Chronic Neurodisability	Data submitted, study still open and figures have not been finalised by NCEPOD
Young People's Mental Health	Data submitted, study still open and figures have not been finalised by NCEPOD
Cancer in Children, Teens and Young Adults	Data submitted, study still open and figures have not been finalised by NCEPOD

Participation in clinical research

The number of patients receiving health services provided or sub-contracted by the trust in 2016/17, that were recruited during that period to participate in research approved by a research ethics committee was 599. This includes both portfolio and non-portfolio studies. In addition to the above there are 282 patients in the follow up process.

Participation in clinical research demonstrates the trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay informed of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The trust was involved in conducting 33 clinical research studies in 2016/17 including the following areas oncology, ophthalmology, cardiology, haematology, dermatology, surgery, midwifery, paediatrics and respiratory medicine.

There were over 40 clinical staff participating in research approved by a research ethics committee at the trust during 2016/17. These staff participated in research covering 10 medical specialties.

In the last three years, 90 publications have resulted from our involvement in National Institute for Health Research (NIHR), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Bedford Hospital NHS Trust's income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between Bedford Hospital NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework. Further details of the agreed goals for 2016/17 and for the following 12 month period are available online at:

https://www.innovation.nhs.uk/pg/cv_blog/content/view/40573/network

In 2016/17 six CQUINs applied to the trust (listed in table six).

Three of the six were mandated nationally:

- Health and wellbeing
- Sepsis
- Antimicrobial

The remaining three were negotiated locally with Bedfordshire Clinical Commissioning Group:

- Cancer waits
- High resource patients
- Reducing care home admissions

Table six: Bedford Hospital NHS Trust achievement against 2015/16 CQUINs

Indicator identifier	Description	Overall achievement of target (%) for 2015/16
1a	Health and wellbeing	NOT AVAILABLE UNTIL 7 MAY
1b	Healthy Food	
1c	Flu Vaccine	
2a	Sepsis in ED	
2b	Screening	
2c	Sepsis inpatients	
2d	Screening	
3a	Antimicrobial Resistance	
3b	Antimicrobial Stewardship	

Indicator identifier	Description	Overall achievement of target (%) for 2015/16
4a	Cancer 62 day waits	NOT AVAILABLE UNTIL 7 MAY
4b	RCAs on >104 days	
5	High resource patients	
6	Reducing care home admissions	

Care Quality Commission registration and compliance

Bedford Hospital NHS Trust is required to register with the Care Quality Commission and its current registration status is with no conditions.

The trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Following inspection by the CQC in December 2015 (and outcome report published in April 2016), the trust developed an action plan to deliver the recommendations arising from the inspections and to further advance the quality improvement strategy.

The outcome of the inspection was the trust was rated as requires improvement and the overall rating grid is shown in table seven

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Urgent & Emergency Services	Requires Improvement	Good	Good	Good	Good	Good
Medical Care	Good	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Critical Care	Good	Good	Good	Requires Improvement	Good	Good
Maternity & Gynaecology	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Children & Young People	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
End of Life Care	Good	Requires Improvement	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	**Requires Improvement**

The action plan underpinned the four Requirement Notices from the CQC and the trust delivered on these actions by December 2016. The requirement notices related to:

- Dignity and respect: overcrowding and lack of privacy and dignity within the phlebotomy service
- Need for consent: explicit MCA (mental capacity act) documentation within decision making process
- Good governance: improve mandatory training and learning

- Staffing: ensure safe staffing in the paediatric assessment unit

Actions taken to deliver on the inspection outcomes provided an opportunity to reflect and develop systems and processes to enhance quality of care and which included:

- Privacy and dignity (enter and view) inspection by Healthwatch Bedford
- New privacy area (pod) for streaming in A&E
- Increased in the number of staff trained in safeguarding
- Implemented a chaperone policy
- Introduction of trust-wide learning newsletter supported by divisional and speciality bulletins
- Leaflets translated into common languages of Bedford residents
- New DNACPR/TEP form implementation and audited
- Maternity external review progress leading to the development of a transformation board and a dashboard to provide oversight on key standards for patient safety and experience

Assurance

The quality improvement monitoring group has now evolved into the CQC steering group, with formal minutes, action log and exception reports and meets on a monthly basis. Regular mock inspections across all departments and divisions have been implemented since November 2016 monitoring improvements and compliance.

- Outcomes of mock inspections are fed back to ward/service managers and matrons and where there are specific themes, these are monitored by clinical governance.
- Regular confirm and challenge meetings have been held with clinical leaders and the director of nursing. Each service that received a rating of requires improvement, was a priority followed by other services. This was to establish preparedness and triangulation of information, complaints, audit, serious incidents, guidelines and risk registers.
- This has provided assurance that improvements have been made and sustained and , where risks remain that they are recorded on the trust risk register with appropriate mitigation. Supporting the internal reviews, the trust's internal auditors reviewed and assessed the trust in delivering the action plan and readiness for future inspections and rated the trust 'amber/green' with reasonable assurance.

Next steps

- The CQC has consulted on the next phase of regulation; a more targeted, responsive and collaborative approach. The trust has responded to this consultation.
- To support our internal mock inspections, the trust is planning to invite external bodies, such as royal colleges, professional organisations, to assure the trust on its level of preparedness

Duty of candour

The trust continues to comply with its statutory duty under the duty of candour legislation which was published in 2014.

The trust has a culture of being open and transparent in recognising where standards have not met the level we would consistently like. Duty of candour legislation supported that culture and provided a corporate infrastructure to encourage all staff to actively engage with patients and relatives in that openness.

The trust promotes its culture of openness and sees it as an integral part of a safety culture that supports organisational and personal learning. Individual members of staff who are professionally registered are separately subject to the professional duty of candour, which is overseen by the professional regulatory bodies.

To ensure the trust is consistently compliant with its duty, quarterly audits are under taken. Duty of candour compliance is also a key quality metric on the trust's quality scored and compliance is monitored monthly. Compliance with duty of candour requirements also forms part of the trust's monthly quality performance report to the Bedfordshire Clinical Commissioning Group.

Learning from openness

When responding to complaints the principles of duty of candour are complied with, the response letters from the chief executive are open and transparent and include an apology where necessary. The trust encourages those involved in claims to observe duty of candour requirements, and the standard letter to clinicians informing them of claims, which have not previously been considered as incidents or complaints, asks if the clinician has observed the requirement.

Duty of candour is integral to the SI process and all SI lead investigators will provide an opportunity to meet with a patients or relative and include their concerns into the investigation as well as presenting what the incident and level of potential harm may be.

Sign Up To Safety

The trust joined the national Sign up to Safety campaign in July 2015. The trust's targets against the campaign pledges are detailed below:

Pledge one: put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

Bedford Hospital's pledge: progressively reduce avoidable harm. The trust commits to progressively supporting the development of safety projects that will:

- ✓ Improve our mortality rates to the top 25 percent of safest hospitals
- ✓ Increase the number of patients who receive harm free care to more than 95 percent
- ✓ Reduce the number of MRSA blood infections to zero each year
- ✓ Sustain low levels of clostridium difficile
- ✓ Reduce the number of cardiac arrests by 20 percent
- ✓ Reduce numbers of category two pressure ulcers by 20 percent per 1000 bed days
- ✓ Reduce category three pressure ulcers by 20 percent per 1000 bed days
- ✓ Reduce the numbers of patients who suffer harm from falls by 20 percent
- ✓ Zero avoidable VTE
- ✓ Improve discharge communication with the wider team
- ✓ Improve clinical systems and clinical information technology systems so they meet the needs of the user and contribute to safer practice and more effective communication

Pledge two: continually learn - make organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

Bedford Hospital's pledge: Develop effective and innovative ways to share and learn from patient safety incidents and patient experience. Bedford Hospital aims to be open and accountable to the public and patients and always driving improvements in care. In the spirit of openness and transparency, we pledge to publish a set of patient outcomes, patient experience and staff experience measures. The trust will:

- ✓ Improve in-patient survey scores to show that patients are involved in choices about their care
- ✓ Patients report an increased satisfaction in being treated with dignity
- ✓ Each ward/ department will have an identified dignity champion, as a resource for staff, patients and relatives
- ✓ Staff Friends and Family Test shows that staff feel valued as part of the care delivery team
- ✓ Ensure that clinical leadership development includes setting the quality agenda and quality improvement
- ✓ 95 percent of staff have an appraisal in which goals are aligned with the trust's vision and values
- ✓ 95 percent of staff access induction which reflects the organisations vision, values and strategy
- ✓ Implement annual staff awards for quality
- ✓ Ensure that the board is visible and can be challenged through different channels

- ✓ Recommendations from Freedom to Speak Up are implemented in order to create an honest and open reporting culture
- ✓ There are clear systems for reporting and learning from incidents

Pledge three: honesty - be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

Bedford Hospital's pledge: be open and honest about patient safety issues and avoidable harms by:

- ✓ Sharing trust board reports on the trust's website and develop further safety information about harm and mortality and make this available
- ✓ Continue to invite partners to participate in internal compliance reviews
- ✓ Support patients and carers in delivering self-care to reduce harm from pressure ulcers
- ✓ Continue to implement duty of candour requirements and review our approach to support staff to ensure that implementation is effective
- ✓ Work with key stakeholders to support internal and external surveillance of our performance on patient safety and quality
- ✓ Listen to and engage with staff and patients through patient feedback sources such as listening events
- ✓ Carry out root cause analysis investigations where serious incidents occur and share these with the patient and/or their carers
- ✓ Offer face-to-face meetings with clinical and senior management staff to better understand the care and treatment that has been provided and learn from it
- ✓ Develop and implement a programme an awareness and training programme with staff and patients awareness of mental health first aid and develop a programme for
- ✓ Keep the patient voice at the forefront of our business by ensuring a patient story is heard at the trust board meeting every month
- ✓ Continue to encourage staff to speak up if they have any concerns about the quality and safety of patient care

Pledge four: collaborate - take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

The trust will participate in regional and national quality and safety programmes to review and improve the care it gives to patients. The trust will work with others, including the trust's patient council and local Healthwatch organisations, to develop and improved understanding of measuring and monitoring safety and it will continue the collaborative and work with commissioners and local community healthcare to reduce harm from pressure ulcers and supporting complex and discharges and acute care in community settings.

The trust will share its safety plans with the public, patients, staff and partners. The trust will improve communication between hospital, primary care and other partner as patients move between different settings. The trust will work across healthcare via our transformation programme to ensure patient focussed integrated care pathways that deliver safe and effective care

Pledge five: support - help people understand why things go wrong and how to put them right.

The trust will seek to ensure continuous quality improvement is a core value of the organisation and its staff. This means that staff must respond well to change and embrace initiatives, be open to new ideas and encourage forward thinking, taking ownership for continuous learning and self-development. Supporting this, the trust has invested in a programme of organisational development to manage a change in cultural. An example is incorporating human factors training in the maternity transformation programme and in trust wide root cause analysis training.

The trust is committed to ensuring that its workforce has the capacity and capability to deliver quality improvement. The trust has started this work and has now recruited 'safety leads' and 'safety champions' who provide the driving force to improvements at a ward and team level. Safety Leads have the opportunity to report any challenges and seek support from trust board members. Safety leads access the safety development programme which the trust has commissioned from the University of Bedfordshire.

The trust is committed to the development of a safety improvement plan to support its Sign up to Safety pledge, which includes:

- ✓ A trust wide quality improvement capability approach that supports teams to lead and manage their own improvement work with a focus on coaching in quality improvement methodology
- ✓ Implementing service improvement programmes, with partners, across the STP
- ✓ Developing a patient safety brief to encourage involvement and understanding of our safety work
- ✓ Ensure on-going improvement in the quality and safety of patient care through the clinical quality strategy
- ✓ Ensure staff understand their responsibilities for patient safety through the trust's core values framework
- ✓ Continue to deliver root cause analysis investigation training to middle and senior managers
- ✓ Continue a programme of incident investigation and risk management to all department and front-line managers
- ✓ Routinely monitor the quality of care being provided across all services
- ✓ Challenge poor performance or variation in quality
- ✓ Incentivise and reward high quality care and quality improvement through promotion of vision and values, staff awards and listening events and roadshows

Data quality

Bedford Hospital NHS Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

That included the patient's valid NHS number was:

- 99.83 percent for admitted patient care;
- 99.92 percent for outpatient care; and
- 98.73 percent for accident and emergency care.

That included the patient's valid General Practitioner registration code was:

- 100% percent for admitted patient care;
- 100% percent for outpatient care; and
- 99.98 percent for accident and emergency care.

Information governance toolkit

Bedford Hospital NHS Trust's information governance assessment report overall score for 2016/17 was 73 percent and was graded green (achieved attainment level two or above) on all requirements.

Clinical coding accuracy

Bedford Hospital NHS Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

IGT clinical coding audit undertaken in March 2017 attained a level three for requirements 505 and 510. This is an improvement on last year with a primary diagnosis accuracy score of 95.5%

Bedford Hospital NHS Trust will be taking the following actions to improve data quality:

- Education and training for junior doctors
- Feedback and sharing of coded data for clinician
- Continue the data quality training workshops for all staff

Part three: overview of the quality of our care in 2016/17

Part three of the quality account presents data relating to national quality indicators. A quality indicator is a measure that can help inform providers of healthcare, patients and other stakeholders about the quality of services provided compared to the national average, the best performing trust and the worst performing trust. The indicators are also used by the Secretary of State to track progress across the whole of the NHS in meeting the targets that make up the NHS Outcomes Framework.

The NHS Outcomes Framework identifies five domains relating to clinical effectiveness, patient experience and safety. Progress in each domain is measured using many indicators, some of which must be included in a trust's annual quality account. The five domains are presented in figure four.

Figure eight: the five Domains of the NHS Outcomes Framework

Domain one	Preventing people from dying prematurely	Clinical effectiveness
Domain two	Enhancing quality of life for people with long-term conditions	
Domain three	Helping people to recover for episodes of ill health or following injury	
Domain four	Ensuring that people have a positive experience of care	Patient experience
Domain five	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

Our performance against 2015/16 quality indicators

Eight quality account indicators apply to Bedford Hospital NHS Trust in 2016/17:

- Summary Hospital-Level Mortality Indicator (SHMI) including SHMI banding and percentage of patient deaths with palliative care coded at either diagnosis or specialty level
- Patient Reported Outcome Measures (PROMs) for:
    - Groin hernia surgery
    - Varicose vein surgery
    - Hip replacement surgery
    - Knee replacement surgery
- Readmissions to the hospital within 28 days of discharge for patients aged 0 to 15 and 16 and over
- Responsiveness to the personal needs of our patients
- Percentage of staff who would recommend the trust to friends or family needing care
- Percentage of admitted patients who were risk assessed for venous thromboembolism (VTE)
- Rate of Clostridium difficile infections per 1,000 bed days
- Rate of patient safety incidents and the percentage resulting in severe harm or death

Summary Hospital-Level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital, (previously Health and Social Care Information Centre).

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 there.

The SHMI indicator relates to two NHS outcomes framework domains: the first is preventing people from dying prematurely; and the second is enhancing the quality of life for people with long-term conditions.

Table nine

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	108.7 Band two 'As expected' 23.0% Palliative care	0.989 Band two 'As expected' 27.4% Palliative care	1.033 Band two As expected Not available
England average	100.00	100.00	100.00
Best performing Trust	59.7 Band three 'Lower than expected' 0% Palliative care	0.652 Band three 'Lower than expected' 0.2% Palliative care	0.690 Band three Lower than expected Not available
Worst performing Trust	119.8 Band one 'Higher than expected' 32.2% Palliative care	1.177 Band one 'Higher than expected' 29.6% Palliative care	1.164 Band one Higher than expected Not available

Source: Health and Social Care Information Centre (https://indicators.ic.nhs.uk/webview)

Notes:

- 2014/15 data = October 2013 to September 2014 (published April 2015)
- 2015/16 data = October 2014 to September 2015 (published March 2016)
- 2016/17 data = October 2015 to September 2016 (published March 2017)

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The trust continues to improve its SHMI

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- Using the electronic mortality module on Datix to analyse mortality data
- Continued review of mortality indices via the mortality review board in conjunction with CHKS data analysts
- Commission reviews of outliers diagnostic groups
- Individual review of NCEPOD ‘E’ deaths

Patient Reported Outcome Measures (PROMs)

PROMs collect information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The data adds to the wealth of information available on the care delivered to NHS-funded patients to complement existing information on the quality of services.

Since 1 April 2009, hospitals providing four key elective surgeries for the English NHS have been inviting patients to complete questionnaires before and after their surgery. The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations.

PROMs for groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery relate to NHS Outcomes Framework domain three: helping people to recover from episodes of ill health or following injury.

Groin hernia surgery

The scores of patients having undergone groin hernia surgery are based on the responses to a standard measure of health questionnaire. This questionnaire covers five areas:

- Mobility
- Self-care
- Usual activities
- Pain and discomfort
- Anxiety and depression

Patients indicate whether they experience no problems, some problems or severe problems in relation to each of the five areas in question. A higher overall score indicates better reported overall health following groin hernia surgery.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	0.069	0.078	0.084
England average	0.084	0.088	Awaiting publication
Best performing Trust	0.154	0.135	Awaiting publication
Worst performing Trust	0.000	0.008	Awaiting publication

Source: Health and Social Care Information Centre (http://www.hscic.gov.uk/proms)

Notes: Adjusted average health gain data to allow for case-mix (EQ-5D)

- 2014/15 - data (published February 2015) for period April 2014 to December 2014
- 2015/16 - data (published February 2016) for period April 2015 to September 2015

- 2016/17 - provisional data (published February 2017) for period April 2016 to September 2016

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- Although the trust's score improved in 2016/17 it recognises the need to increase the rate of return of PROMs questionnaires to ensure the data represents as many patients as possible

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- The trust awaits the publication of official 2016/17 data to understand what improvements need to be made.

Varicose vein surgery

The Aberdeen Varicose Veins Questionnaire (Aberdeen Questionnaire) is a condition-specific questionnaire that measures health status for patients with varicose veins. The questionnaire consists of 13 questions relating to key aspects of the problem of varicose veins. The questionnaire has a section in which the patients can indicate diagrammatically the distribution of their varicose veins. There are questions relating to the amount of pain experienced, ankle swelling, use of support stockings, interference with social and domestic activities and the cosmetic aspects of varicose veins.

A lower negative score indicates better reported outcomes by the patient.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	6.06	-0.021	Awaiting publication
England average	-8.25	8.99	Awaiting publication
Best performing Trust	14.39	13.14	Awaiting publication
Worst performing Trust	5.59	4.26	Awaiting publication

Source: Health and Social Care Information Centre (http://www.hscic.gov.uk/proms)

Notes: Adjusted average health gain data (Aberdeen Varicose Vein Score; a negative score indicates improvement)

- 2014/15 - data (published February 2015) for period April 2014 to December 2014
- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 –no data available for the reporting period

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The trust did not receive PROM score for varicose vein surgery for the reporting period

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- The trust awaits the publication of official 2016/17 data to understand what improvements need to be made.

Hip replacement surgery

The Oxford hip and knee scores are joint-specific outcome measure tools designed to assess symptoms and function in patients undergoing joint replacement surgery. The scores comprise of twelve multiple choice questions relating to the patient's experience of pain, ease of joint movement and ease of undertaking normal domestic activities such as walking or climbing stairs.

Each of the 12 questions on the Oxford Hip Score and Oxford Knee Score are scored in the same way with the score decreasing as the reported symptoms increase, i.e. become worse. All questions are presented similarly with response categories denoting least (or no) symptoms scoring four and those representing greatest severity scoring zero.

The individual scores are then added together to provide a single score with 0 indicating the worst possible and 48 indicating the highest possible score.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	21.56	0.306	0.439
England average	21.44	22.09	Awaiting publication
Best performing Trust	22.95	24.61	Awaiting publication
Worst performing Trust	16.29	18.13	Awaiting publication

Source: Health and Social Care Information Centre (http://www.hscic.gov.uk/proms)

Notes: Adjusted average health gain data (Oxford Hip Score)

- 2014/15 - data (published February 2016) for period April 2014 to December 2014
- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 - provisional data (published February 2016) for period April 2015 to September 2015

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The trust received provisional receive PROM score for varicose vein surgery for the reporting period

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- The trust awaits the publication of official 2016/17 data to understand what improvements need to be made.

Knee replacement surgery

In relation to the reported outcome of knee replacement surgery, individual scores on patient questionnaires are added together to provide a single score with 0 indicating the worst possible and 48 indicating the highest possible score.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	14.40	No score	Awaiting publication
England average	16.14	16.79	Awaiting publication
Best performing Trust	18.48	19.34	Awaiting publication
Worst performing Trust	11.48	12.40	Awaiting publication

Source: Health and Social Care Information Centre (http://www.hscic.gov.uk/proms)

Notes: adjusted average health gain data (Oxford Knee Score)

- 2014/15 - data (published February 2016) for period April 2014 to December 2014
- 2015/16 – provisional data (published February 2016) for period April 2015 to September 2015
- 2016/17 – no data available for the reporting period

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The trust did not receive PROM score for knee replacement surgery between April 2015 and September 2015 because there were too few records to model (10 records)

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- The trust awaits the publication of official 2016/17 data to understand what improvements need to be made.

Emergency readmissions to the hospital within 28 days of discharge

Emergency readmissions to the hospital within 28 days of discharge relates to NHS Outcomes Framework domain three: helping people to recover from episodes of ill health or following injury.

	2014/15	2015/16	2016/17
0 to 15 years of age	6.9%	8.5%	9.19%
16 years and over	10.3%	10.7%	7.4%

Source: Health and Social Care Information Centre (https://indicators.ic.nhs.uk/webview)

Notes:

- 2014/15 - data provided via CHKS source – admitted patient care dataset
- 2015/16 - data provided via CHKS source – admitted patient care dataset
- 2016/17 - data provided via CHKS source – admitted patient care dataset

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The trust awaits the official publication of 2014/15, 2015/16 and 2016/17 data.

Bedford Hospital NHS Trust intends to take the following actions to improve the percentage, and so the quality of its services, by:

- The trust awaits the publication of official 20116/17 data to understand what improvements need to be made.

Responsiveness to the personal needs of patients

Responsiveness to the personal needs of patients relates to NHS Outcome Framework Domain four: ensuring people have a positive care experience.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	73.3%	63.7%	Awaiting publication
National average	76.6%	64.4%	Awaiting publication
Best performing trust	87.4%	78.6%	Awaiting publication
Worst performing trust	67.4%	51.9%	Awaiting publication

Source: Health and Social Care Information Centre (https://indicators.ic.nhs.uk/webview)

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- Data for 2016/17 is unavailable.

Bedford Hospital NHS Trust intends to take the following actions to improve the percentage, and so the quality of its services, by:

- The trust awaits publication of data for 2016/17 to understand where to focus its improvements.

Percentage of staff who would recommend the trust to friends or family needing care

The percentage of staff who would recommend the trust to friends or family needing care related to NHS Outcomes Framework domain four: ensuring that people have a positive care experience.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	75%	78%	72%
England average	67%	69%	70%
Best performing Trust	89%	89%	85%
Worst performing Trust	38%	46%	49%

Source: Picker Institute Staff Survey (http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results/)

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The trust has a lower score in 2016 (when compared to both 2014 and 2015) but is still above the national average.

Bedford Hospital NHS Trust intends to take the following actions to improve the score, and so the quality of its services, by:

- Continuing to provide staff opportunities to feedback their experience of working at the trust
- Listening events are currently taking place until the end of April into early May to develop an engagement and improvement plan based on staff feedback. These listening events will continue during the year as a permanent engagement cycle of meetings.

Percentage of admitted patients who were risk assessed for venous thromboembolism

The percentage of admitted patients who were risk assessed for venous thromboembolism related to NHS Outcomes Framework domain five: treating and caring for people in a safe environment and protecting them from avoidable harm.

The scope of the indicator includes all adults (those aged 18 at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients
- in-patients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease)
- trauma inpatients
- patients admitted to intensive care units
- cancer inpatients
- people undergoing long-term rehabilitation in hospital
- patients admitted to a hospital bed for day-case medical or surgical procedures
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission
- people attending hospital as outpatients
- people attending emergency departments who are not admitted to hospital
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	95.19%	95.64%	97.64%
England average	95.99%	95.75%	Awaiting publication
Best performing trust	100%	100%	Awaiting publication
Worst performing trust	88.46%	75.15%	Awaiting publication

Source: NHS England (http://www.england.nhs.uk/statistics/statistical-work-areas/vte/)

2016/17 - not yet published nationally

Bedford Hospital NHS Trust considers that this data is as described for the following reasons:

- The trust has maintained its performance in relation to the 95 percent assessment target.

Bedford Hospital NHS Trust has taken the following actions to improve the percentage of patient assessed, and so the quality of its services, by:

- Continuing to provide trust wide support and expertise via the VTE committee.

Rate of Clostridium difficile infections

The rate of clostridium difficile infections relates to NHS Outcomes Framework domain 5.2.ii: treating and caring for people in a safe environment and protecting them from avoidable harm.

The rate per 100,000 bed days of cases of clostridium difficile infections that have occurred within the trust amongst patients aged two or over during the reporting period.

The scope of the indicator includes all cases were the patient shows clinical symptoms of clostridium difficile infection and has a positive laboratory test result. A clostridium difficile infection episode lasts for 28 days, with day one being the date the first positive specimen was collected. A second positive result for the same patient, if collected more than 28 days after the first positive specimen, should be reported as a separate case, irrespective of the number of specimens taken in the intervening period, or where they were taken. Specimens taken from deceased patients are included.

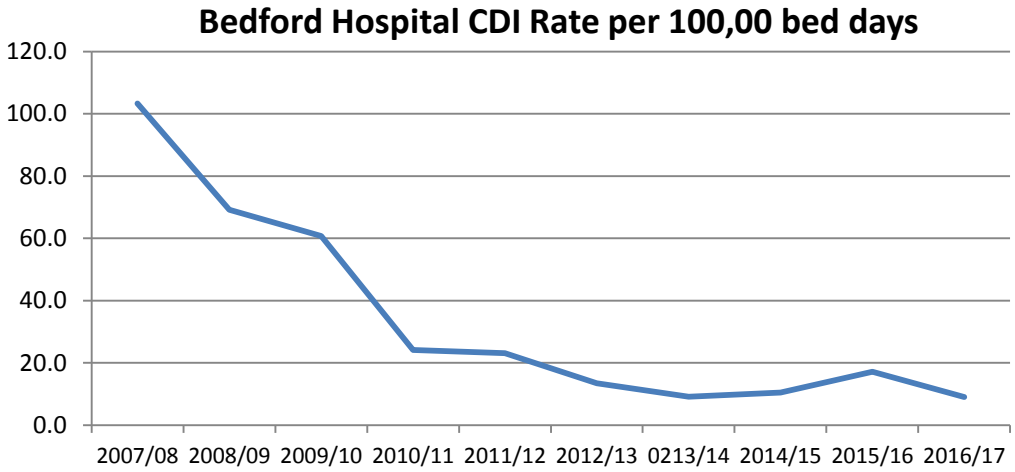
The following cases are excluded from the indicator:

- people under the age of two at the date the sample of taken; and
- where the sample was taken before the fourth day of an admission to the trust (where the day of admission is day one).

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	10.9	17.8	9.0 prov*
England average	15.1	14.9	Awaiting publication
Best performing Trust	0	0	Awaiting publication
Worst performing Trust	62.2	66.0	Awaiting publication

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

* data for 2016/17 (11months) = incomplete internal figures based on 11 reported cases / 122,243 bed days up to 28th February 2017



As last year, Bedfordshire Clinical Commissioning Group (BCCG) have set the trust a ceiling trajectory of 10 hospital apportioned cases of laboratory confirmed (GDH positive and toxin positive) cases of clostridium difficile. To date the trust has been apportioned 11 cases, of which three have been successfully appealed and a further two are awaiting appeal. In all cases there is no evidence to suggest cross infection between patients has occurred, as the ribotyping is different for each specimen and following a root cause analysis of each case, all cases were designated as being unavoidable and no lapses in care were identified.

Bedford Hospital NHS Trust has continued to implement the actions identified last year, which were:

- Prompt identification and escalation of patients with potential symptoms or at risk of other harms
- Prompt escalation of patient with diarrhoea to the infection prevention and control team
- Prompt isolation of patients on request
- Prompt specimen collection from the patient
- Implementation of safety huddles to improve communication of information
- E-prescribing to enable 14 day course treatment for C. difficile

Building on the implementation of last year's interventions, additional actions have been taken to improve the rate, and so the quality of its services, these are:

- Participated with NHSi in an, "IPC Collaborative: 90 Day Improvement Programme" (a cohort of 39 NHS trusts), which resulted in a revised bowel habit recording tool (stool chart) and associated education.
- Implementing an infection prevention and control admission risk assessment form.
- Revised Infection, Prevention and Control (IPC) education, both curriculum and varied delivery methods, taking account of new technologies.
- A review and change in the cleaning / decontamination policy and schedule – a rationalisation.
- A review and change of the cleaning / decontamination products used in the Trust.
- Producing an operational procedure for "Cleaning and Disinfecting Medical Patient Equipment (Medical Devices)".

- Implementing a “Patient medical device / equipment cleaning / disinfection audit tool”, undertaken monthly by Matrons / Ward Managers.
- Developed a Patient Specialist Care Plan for the, “Management of Patients with Acute clostridium difficile Infection”.
- Weekly multidisciplinary clostridium difficile ward round, reviewing each symptomatic case.
- Review of antibiotics that are highly associated with predisposing to clostridium difficile infection and advising treatment regimens that are effective but less likely to induce a clostridium difficile infection (antibiotic stewardship).

Rate of all patient safety incidents and the percentage resulting in severe harm or death

The rate of patient safety incidents and the percentage resulting in severe harm or death relates to NHS Outcomes Framework domain five: treating and caring for people in a safe environment and protecting them from avoidable harm.

Number of patient safety incidents per 1000 bed days

	2014/15*	2015/16**	2016/17***
Bedford Hospital NHS Trust	34.21 incidents	36.2 incidents	38.2 incidents
National average	35.9 incidents	39.3 incidents	Not available
Best performing trust	0.24 incidents	18.1 incidents	Not available
Worst performing trust	74.9 incidents	74.8 incidents	Not available

Percent of patient safety incidents resulting in severe harm

	2014/15**	2015/16***	2016/17***
Bedford Hospital NHS Trust	0.32%	1.2%	0.7%
National average	0.39%	0.35%	Not available
Best performing trust	0%	0.017%	Not available
Worst performing trust	2.3%	2.9%	Not available

Percent of patient safety incidents resulting in death

	2014/15**	2015/16***	2016/17***
Bedford Hospital NHS Trust	0.5%	0.59%	0.2%
National average	0.11%	0.12%	Not available
Best performing trust	0%	0%	Not available
Worst performing trust	0.8%	0.72%	Not available

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The trust's performance is an improvement on the previous year and will benchmark itself once national data is published.

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services:

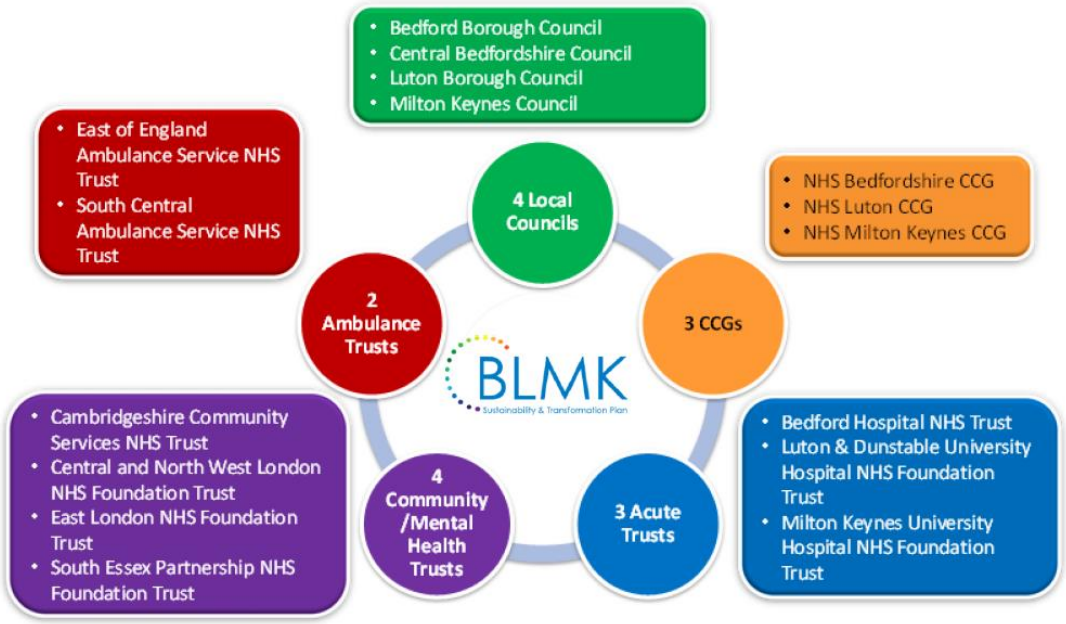
- The trust will continue to review patient deaths through its mortality review group
- Patient safety incidents continue to be uploaded to the NRLS on a weekly basis.
- Incidents resulting in moderate, severe harm and death are validated on a weekly basis through the Datix group meetings and prior to uploading of the data to the NRLS.
- The trust's governance work steam to improve learning from incidents, never events and complaints

Summary of 2016/17

Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP)

In spring 2016, 16 health and social care partners came together to form the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). The aim of the STP is to support delivery of the 'triple aim' of the NHS 5 year Forward View – improved heah and wellbeing, transforming quality of care and financial sustainability.

The 16 BLMK STP partners



Locally the STP has developed five priority areas which were set out in the initial plan submitted to NHS England in November 2016:

- Prevention
- Primary, community and social care
- Secondary care
- Digital programme
- System Redesign

Bedford Hospital is well engaged within the programme, in particular in Priority 3. Public engagement events have been held in January and March 2017 and there is a series of staff communication events taking place throughout March 2017 which culminate in the creation of a Staff Voice Partnership, which will bring together staff from all the partner organisations.

Priority 3 has grouped hospital services into six areas of focus:

- Emergency Care
- Planned Care
- Centres of Excellence
- Care Closer to home
- Maternity Care
- Paediatrics

The thinking on potential hospital models in these areas is expected to emerge in spring 2017, with public consultation later in 2017 / early 2018.

The trust believes the STP offers a real opportunity to support the delivery of its Clinical Strategy (developed in 2014) and in particular its aims of integration with community services and with other acute and specialist providers through clinical networks and pathways. The geography of the STP provides for a stronger planning footprint that had not previously been exploited and will support the development of more sustainable services without the need for significant service reconfiguration.

Serious Incidents – reducing patient harm

Serious Incidents in healthcare are relatively uncommon but when they occur, the NHS organisation has a responsibility to ensure there are systematic measures in place for safeguarding people, property, NHS resources and reputation. This includes the responsibility to learn from these incidents to minimise the risk of them happening again.

'Never events' are a particular type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic barriers are available at a national level and should have been implemented by all healthcare providers. Each never event has the potential to cause serious patient harm or death (Never Events Framework April 2015).

Bedford Hospital NHS Trust takes this responsibility seriously and is continually strengthening its safety culture to ensure that serious incidents are reported and investigated thoroughly. The trust reports all serious incidents and never events to Bedfordshire Clinical Commissioning Group and provides an investigation report, outlining the root causes of the incident, lessons learnt and action plans to prevent recurrence of the incident, within 60 days.

Serious incidents declared in 2016/17

During the financial year 2016/17, the trust declared a total of 37 Serious Incidents compared with 55 in 2015/16. A monthly breakdown of Serious Incidents is provided.

Table 1: Serious Incidents by Month 2015/16

Month	Number of Serious Incidents
April 2016	2
May 2016	7
June 2016	7
July 2016	4
August 2016	3
September 2016	3
October 2016	2
November 2016	3
December 2016	3
January 2017	2
February 2017	1
March 2017	0 (to date)
Total 2016.17	37

A breakdown of the categories of Serious Incidents that occurred in 2016/17 is presented in.

Type of incident	Number of Serious incidents
Falls resulting in serious injury	10
Diagnostic incident including delay	7
Drug Incident	56
Pressure Ulcers	3
Baby born in poor condition/NNU admission	3
IUD	2
Infection Control	2
Deteriorating patient/failure to rescue	1
Surgical complication	1
Never Event: Retained guidewire	1
Patient absconsion and suicide	1
Human tissue Incident	1
Total	37

Safety Thermometer

Falls

In 2016/17 there was one fall that resulted in death and nine falls with severe harm that were investigated under the SI process.

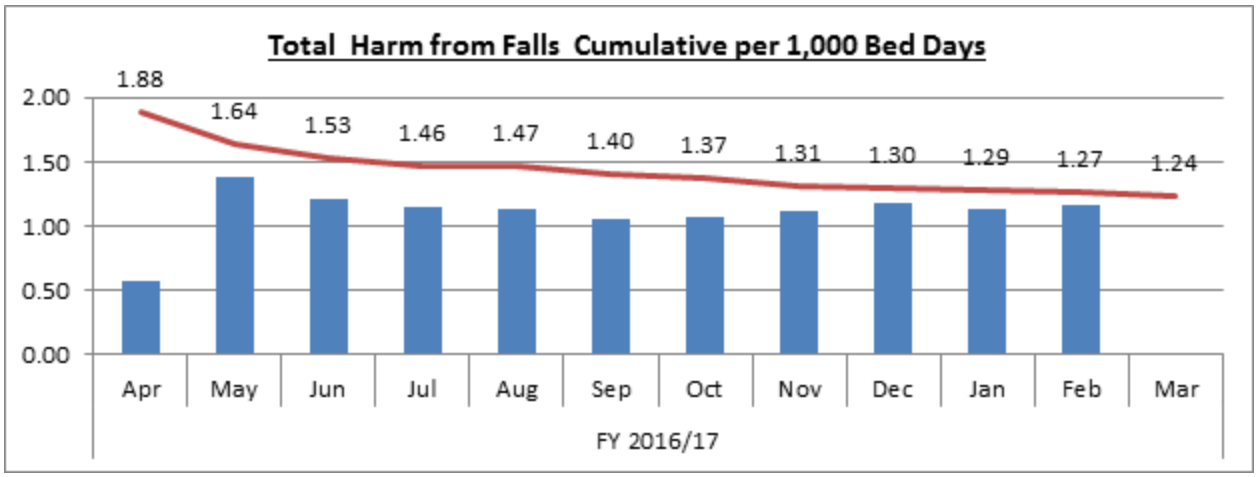
Falls counted numerically does not take into account fluctuations in hospital activity, therefore we are now measuring and reporting harm from falls in per 1,000 bed days. Improvement activity we have undertaken has led to a 58% reduction in total harm from falls per 1,000 bed days over the last two years (1.17 in 2016/17 from 2.77 in 2014/15).

A Falls Review Panel (including CCG representation) met in July 2015 and again in January 2017 to review all falls resulting in severe or moderate harm. The themes identified were:

- polypharmacy and high risk medications
- age if over 75
- impaired cognitive ability and
- previous falls in the last 12 months.

Recommendations were shared at a health economy-wide falls group which met for the first time in March 2017. We are now working collaboratively with our commissioners to ensure that community prevention strategies are aligned with hospital focused post fall strategies. It is recognised for example that elderly patients decondition for each day they are in hospital, so aligning falls improvement strategies with wider hospital work is vital, these include:

- Frail elderly work streams (Get me up, get me dressed, keep me moving)
- Discharge Improvement Group (Red2Green)
- Launch of a pilot programme of an activities coordinator
- Enhanced observation of patient pilot project across Bedford, Luton and Milton Keynes



It is important however that learning from the panel is shared more immediately and so lessons will be shared through:

- Quality Improvement Newsletter and a safety alert specifically relating to the findings of the thematic review.

- Quality board update on cohort / enhanced observation of patient pilot project.

Pressure Ulcers

Bedford Hospital has undertaken an improvement program since 2014 to reduce the prevalence of Hospital Acquired Pressure Ulcers (HAPU) and improve wound management.

In 2016/17, there were two avoidable category three pressure ulcers declared (compared to six in the previous financial year). This is a further improvement on last's year's performance.

In 2015 our Quality Improvement Strategy (QIS) identified HAPU as a key factor that required improvement and we have achieved substantial reductions in harm (greater than 50%) from HAPU since 2014/15 and predict a further reduction of 20% at year-end 2016/17.

We have achieved this through a number of activities outlined below:

- Pressure ulcer assessments risks are monitored monthly by matrons in the Nursing Quality Dashboard. This is reported monthly to the Quality Board and by exception to Clinical Risk and Quality Committee.
- A central database tracks all Hospital Acquired Pressure Ulcers (HAPU) and progress against trajectories.
- Link nurses are now in place on each ward and have quarterly meetings.
- Implementation of a trust-wide electronic referral to the Tissue Viability Nurse. This means that wards can now make referrals 24/7 rather than in office hours only.
- We have developed, with Hospedia (Extramed), and are rolling out an electronic SSKIN Bundle (Nurse Technology Fund) and repositioning chart. This will enable the Nurse at a glance to see what assessments are due and what risk the patient is at.
- To improve dynamic mattress availability, we reviewed our contract, changed suppliers and put a risk escalation process in place if a mattress could not be sourced for a patient within two hours.
- We have undertaken a full evaluation of equipment and medical devices used to relieve pressure and as a result over the last year have changed a number of devices which have improved pressure relieving properties including off-loading foam boots, silicon pads, oxygen masks and foam mattresses.

As part of our ongoing work, actions for next year include:

- Undertake a multi-disciplinary team thematic review of all HAPU and identify actions to improve reduction in HAPU and to share lessons learned
- Test new innovations to reduce harm from pressure, including trialling a new barrier cream for incontinence-associated dermatitis.
- Ensure clinical staff attendance at annual update by reviewing core staff groups who require annual clinical update in Stop the Pressure and report compliance monthly
- Review and develop STP-wide standardised education and training program for staff in each care setting.

Drug incidents

There were five serious incidents reported relating to medication in 2015/16. The five incidents were relating to different drugs/themes as follows:

- Omission of medication due to e-prescribing incident (Metavision)
- Anticoagulants prescribed when clinically contraindicated
- Ineffective anticoagulant dose prescribed
- Two anticoagulants concomitantly prescribed
- Anaesthetic drug inadvertently given to patient in error

As a result of these SIs, the trust is undertaking the following:

- E-prescribing (MetaVision) process on ITU updated to include further double checking of prescriptions
- Extensive work with e-prescribing company to build further fail-safes in to their processes
- Reminders to prescribers not to prescribe medication without reviewing patients notes
- Overarching Haemostasis & Thrombosis committee set up
- VTE risk assessment completion closely monitored and reported up via Quality governance structures
- Medical teams reminded to review entire drug chart at least once a day
- Trust anticoagulant bridging guidelines reissued to all prescribers
- Warning put in place on e-prescribing system (Medchart) to flag if tinzaparin is prescribed concomitantly with a NOAC
- Change to default anaesthetic agents used in obstetrics
- Procedure regarding drug preparation in theatre updated and disseminated
- Incidents discussed at Junior doctor teachings and audit meetings; continued publication of monthly Medication Safety Newsletter

Never events

In 2016/17 the trust reported one never event.

Synopsis:

A patient was admitted to critical care for haemofiltration. On admission a central venous catheter was inserted into the right internal jugular vein and a vascath for haemofiltration was also placed into the same vessel. Following insertion the doctor performing the procedure noted that the central line guidewire, that should have been removed post-insertion, was missing. A CXR was performed and reviewed by two doctors who were unable to see the guidewire. An abdominal x-ray was completed which identified the guidewire in the inferior vena cava/R iliac vein. The patient had the wire removed uneventfully by an interventional radiologist the following day.

Learning:

The learning from this case relates to the importance of carefully checking all equipment post-procedure. A reminder to staff was placed in the QI newsletter.

Patient experience

Complaints

The trust has a statutory obligation for the handling and consideration of complaints to ensure that they are dealt with efficiently, properly investigated and action is taken if necessary. Supporting the formal elements of complaints, the trust has a PALS which works with patients, relatives and carers to try and resolve their concerns informally and at local level.

A formal complaint involves a thorough investigation and the Chief Executive responds directly to the complainant. When investigating a complaint the trust is guided by national requirements, and has a local target of 45 working days to complete an investigation and respond to the complainant; for the majority of the year complaints have been responded to within 35-40 working days, this was driven by feedback from complainants who felt they had to wait too long for a response.

The trust offers complainants the opportunity to have access to an independent advocacy service free of charge should they wish support through the complaints process.

The trust endeavours to always provide a timely and satisfactory response to every complaint it receives. However, there are occasions when a complainant may not be satisfied with the initial response provided by the trust. If the trust's further efforts to resolve the issues; i.e. a further letter of response and offer a meeting for the complainant and the clinicians involved, are unsatisfactory to the complainant, the complainant is advised they can refer their complaint to the Parliamentary and Health Services Ombudsman (PHSO).

Overview

The trust has achieved a significant reduction in complaints over the last three years, this has been achieved by:

- 2014 - improved accessibility to PALs and complaints, streamlined administration process.
- 2015 – staff training on induction and clinical update, targeted training using patient videos, volunteers engaged to collect data on compliments, complainant survey, added actions to complaint responses.
- 2016 – improving quality of responses and proactive management of concerns, building a relationship with PHSO, reduce response time from 45 to 35 working days.

There were 252 complaints in 2015/16 compared to 120 in 2016/17 which is a reduction of 52%.

Parliamentary and health service ombudsman (PHSO)

The PHSO will investigate the case using information we provide and consider further investigation and recommendations. This year the trust has received nine final investigation reports.

One complaint which was partially upheld was originally accepted by the PHSO in 2014 and does not reflect the current robustness of our investigations or transparency of findings.

The other eight investigations have not been upheld as the trust has managed the complaints to the standard the PHSO would expect.

When a complaint is received by the trust it is triaged, to establish if the complaint is a formal complaint, a PALs concern, safeguarding concerns have been raised or the complaint may meet the criteria of a serious incident. Once the status of the complaint is established the categories are reported, this information is then used to establish themes of complaints and tailor training to fit the current trends.

Patient Advice and Liaison Service

The trust's PALS offers patients and their families or carers a point of contact for any concern, query or other feedback. It can facilitate communication between a patient and clinical areas. At times, a PALS concern may be escalated to a formal complaint either as a result of the Trust's process for managing complex issues or at the patient's request to ensure a detailed investigation.

In 2016/17, the trust recorded over 1000 formal PALS contacts.

Friends and Family Test (FFT)

Supporting the information from the in-patient survey, complaints and PALS information and general feedback through listening events, the trust uses the FFT data, each patient is surveyed at discharge or following an appointment by either text or paper survey form. FFT data is analysed into two main categories:

- Response rate
- Positivity of response

And these relate to three core service areas:

- Accident and emergency
- Inpatients
- Maternity

The trust overall receives a response rate that is in line with the national average or above, while the percentage of positivity on average sits within the national range of best practice for A&E and below for maternity and inpatients.

In 2017/18 the trust will:

- Analyse the detail of responses especially where services may have low returns with negative scores which can affect the overall score
- Develop a programme of engaging with difficult to reach patients to improve response rates eg. in the care of the elderly.

- Review the qualitative feedback to form a development plan to improve the patient experience

Compliments

The trust is fortunate to receive a significant number of compliments including feedback, thank you cards, gifts and donations with this year the trust receiving over 4,500 compliments. These kind gestures from patients are provided at ward and service levels and include acknowledgements of individual members of staff and of services as a whole. Individuals and teams named in compliments are included in the weekly staff newsletter as part of our drive to celebrate achievements and successes. The donations category includes both monetary donations to the trust and donations of equipment. Small gifts, such as sweets and chocolates, are given frequently by patients to staff and are always gratefully received. Any larger gift items are declared to the trust board secretary. The trust aims to acknowledge each compliment and formally records them on the Datix system.

The general themes of compliments include:

- The treatment has been invaluable in helping the patient understand and improve her - should there be more here??

Learning from complaints and PALS

During 2016/17 the trust introduced a clearer process to identify learning to the complainant and staff. Responses from the chief executive inform the complainant where we have changed our practices as a result of their complaint:

- A monthly newsletter – QI - quality improvement newsletter - is circulated to all staff by email and hard copies are taken to each department by volunteers.
- Information and learning are shared on information triangles on tables in the staff canteen.
- Learning is shared at staff training at induction, clinical updates and targeted training at ward departmental level.
- The complaints team participate in training staff in root cause analysis, statement writing and giving evidence at coroner's court.

Next steps

- To further reduce the target response time to below 35 working days.
- To improve complainant satisfaction, by showing how their complaint has improved services for other service users, both these actions will be monitored by the complaint satisfaction survey.
- Continue to engage with staff to ensure prompt local resolution to further reduce concerns.
- Improve patient experience by responding to when things go wrong and sharing good practice when patients have a good experience.

Dementia wards recognised for innovative improvements

In July 2016 Harpur and Elizabeth wards received an award of the 'Elder Friendly Quality Mark' in recognition of the support our staff gives to older people.

This brings the total number of wards in Britain which have achieved the Quality Mark to 32.

The Quality Mark is run by the Royal College of Psychiatrists and was developed in partnership with organisations including Royal College of Physicians, Royal College of Nursing and British Geriatrics Society. It has been established to encourage hospital wards to become involved in improving the quality of essential care of older people and to recognise good care provision, as identified by patient feedback.

The initiative was set up in response to reports over several years, including the Francis Inquiry Report (2013), which have highlighted the need for improvements, the importance of avoiding adverse outcomes in older people's care, and variations in the quality of care among wards.

The Quality Mark for Elder Friendly Hospital Wards is a voluntary national improvement programme established in Autumn 2012, with 111 wards participating to date. The hospital wards have focussed on the quality of essential care of patients aged 65 and above. The patient questionnaire measures satisfaction expressed by older patients with a series of quality statements about essential care on the ward and is not standards-based.

Patients over the age of 65 have been asked for their feedback about care, including their experiences of comfort, food and drink, support from staff, getting help when needed, and privacy and dignity. Patients have also been asked if they would be happy if a friend or family member was cared for on the ward.

To achieve the Quality Mark wards have:

- Taken part in a two stage assessment. Stage I involves assessing quality of care, which includes identifying areas of achievement and what could be improved. Stage II requires the ward to demonstrate continued focus on improving care for older people, and their progress.
- Collected information from patients, carers and visitors, ward staff and members of the multi-disciplinary team, the ward manager, a lead consultant working on the ward, hospital governors and the senior managers of the hospital/trust.

The Quality Mark is awarded to wards that have achieved high scores in stage II of the assessment. The award is for three years with an interim review. Wards joining the quality ward mark scheme commit to continuous focus on improving essential care based on feedback from our patients.

To find out more about the Quality Mark visit: www.wardqualitymark.org.uk

Ambulatory care launched

The trust launched the Ambulatory Emergency Care Unit (AECU) in September 2016 to assess, treat and discharge patients without the requirement for an overnight stay. We are a member of the NHS Ambulatory Emergency Care Network Cohort 9 (2016 - 2017) which includes 128 hospitals across the UK who have taken part and set up AECUs over the past 9 years.

AECU is staffed with a dedicated medical, nursing and administration team who review on average 20% of the daily emergency A&E likely admissions; and aim to discharge all patients following appropriate treatment. In addition, the service sees patients who return for routine procedures post DVT and Cellulitis diagnosis.

The next phase in our development will see:

- Our AECU move from the current temporary location to a dedicated area on the first floor in the main out-patient block. This move will enable there to be consultation rooms available in which surgical patients may receive minor treatments.
- Closer integration with our AAU medical team.
- Enhanced data collection.
- An increase in ward referrals for diagnostics, reviews and treatments.
- Strengthen weekend working.
- The establishment of direct access ambulance pathways for patients who meet the AECU inclusion criteria.
- Increase speciality in-reach to review patients on the day.
- Increased access to daily speciality HOT clinics.

Discharge planning

This has been a positive year for discharge planning. We have expanded our team and have seen several projects conclude resulting in positive changes being made that will further enhance the patients discharge.

Expanding the discharge team.

- We have recruited two band 6 nurses into the complex discharge team. They will undertake continuing Health Care assessments mainly in the community, enabling our patients to be discharged to a safe destination and have a period of convalescence before the assessment.
- A proposal to increase the team further has been approved. Further expansion will ensure that there is a discharge support worker on each ward managing the non-complex and the complex discharges. A qualified discharge nurse will manage two support workers.
- This will help to push our discharges to earlier in the day which will free up acute beds,thus reducing the wait time for patients in ED.

Moving the Hospital social work team and the Discharge team together.

- Plans are in place to locate the discharge team and the hospital team together in Weller Wing on site at the hospital. This will mean better face to face communication between the two teams. This can only benefit the patient discharge journey and I feel very positive that it will help to reduce length of stay.

Step-down community beds.

- We now have 18 step-down beds in the community. We use these beds for patients with complex discharge needs who are medically optimised and are waiting for assessment, new care, an increase in care, or for a permanent placement. This has worked really well with a patient's discharge still being managed by the hospital on a virtual ward. There are many benefits for the patient including avoiding the risks associated with deconditioning, acquiring infection, low mood and so on.

CHC Fast Tracks and End of Life patients

- A lot of joined up work has been done around our end of life patients. We have worked with our palliative nurse team and the Hospice at Home team to ensure that our processes are very tight and that we are not missing patients or seeing them too late. Our local audits revealed that some patients were not being identified as being end of life in time to transfer them out of the acute setting. It also identified that some junior doctors were reluctant to verbalise that a patient was at the end of their life making it very difficult to approach patients and their families to talk about where they wanted to die. Work is in progress and we are seeing an improvement. We are also now tracking all end of life patients on the complex discharge tracker so that they are discussed each day with the relevant professionals.

Greater collaborative working with our community colleagues

- We have set up a new pathway for the community alerts to be addressed by the hospital and have shared important contact numbers across organisations to enable the right person to be contacted first time thus reducing the amount of time it was taking to contact the hospital, especially for the community nurses. We have invited different community teams in to meet with the discharge team to talk through some of the frustrations they sometimes have with a discharge. This week we invited in key members of the rehab and enablement team. The meeting was very fruitful and benefited both teams which can only benefit our patients discharge.

NHS Staff Survey results

The trust performed well in the 2016 NHS Staff Survey, with a score of 3.82 (national average is 3.81) for overall staff engagement placing it in the top 20 percent of acute trusts nationally.

Table 3: Bedford Hospital NHS Trust's staff survey results 2016

Indicator	Bedford Hospital score 2016	Median national score 2016
KF21: percentage of staff believing the organisation provides equal opportunities for career progression/promotion	86%	85%
KF26: percentage of staff not experiencing harassment, bullying or abuse from staff in the last 12 months	22%	24%

Seven Day Services Clinical Standards

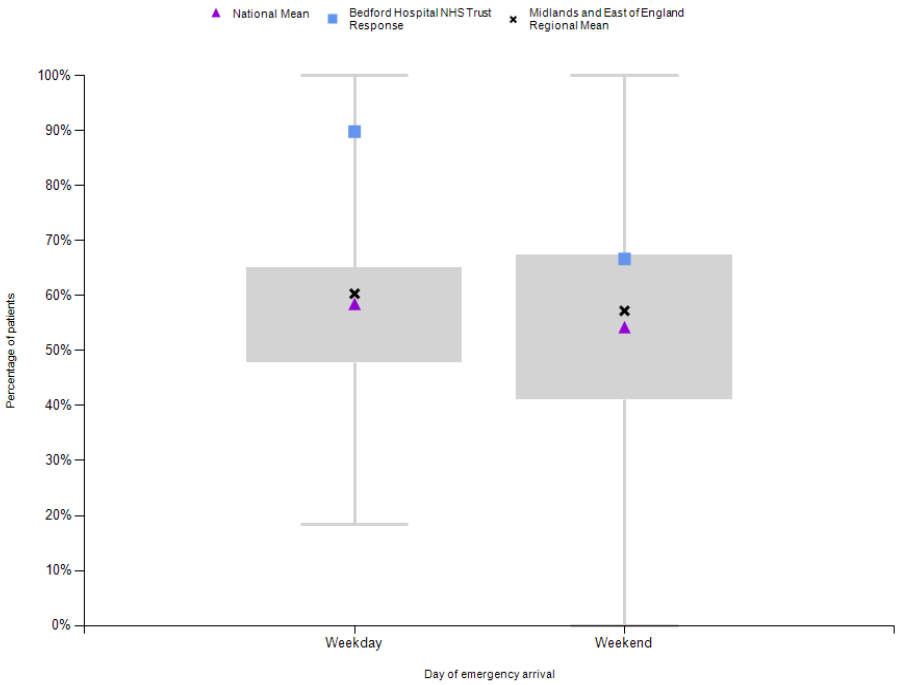
These were revised in February 2017 taking into account clinical feedback between June and December 2016. Relevant extracts are below.

Standard 2: time to first consultant review

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 hours from the time of admission to hospital. A suitable consultant is a doctor who has completed all of their specialist training and been placed on the GMC's specialist register and is therefore trained and competent in dealing with emergency and acute presentations in the specialty concerned and is able to initiate a diagnostic and treatment plan.

The standard applies to emergency admissions via any route, not just the emergency department, for example admissions via radiology, consultant clinic and direct admission to AMU. If a patient is admitted from clinic, this consultation amounts to a first consultant review and meets this standard.

Chart 3: Proportion of patients who received a first consultant review within 14 hours of arrival to hospital



All patients should have a National Early Warning Score (NEWS) established at the time of admission. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor promptly, and seen and assessed by a consultant within six hours. Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected), should be within one hour.

Patients with a clear diagnosis on a well-defined pathway (e.g. midwife-led maternity, simple superficial abscess management) may have their clinical care delegated from a consultant to another clinician under the following circumstances: there is a clear written local protocol for the pathway that has been agreed within the trust clinical governance system and that is supported by the commissioners; the protocol must describe actions to take in the event of clinical concern and that includes robust and rapid escalation to a consultant where appropriate e.g. a maternity patient who develops the need for an emergency Caesarean section or a patient with a superficial abscess who appears to be developing sepsis; and the patient's care is still recorded as being under a named consultant for the purpose of clinical governance (excluding patients specifically on midwife-led care pathways).

Standard 5: diagnostics

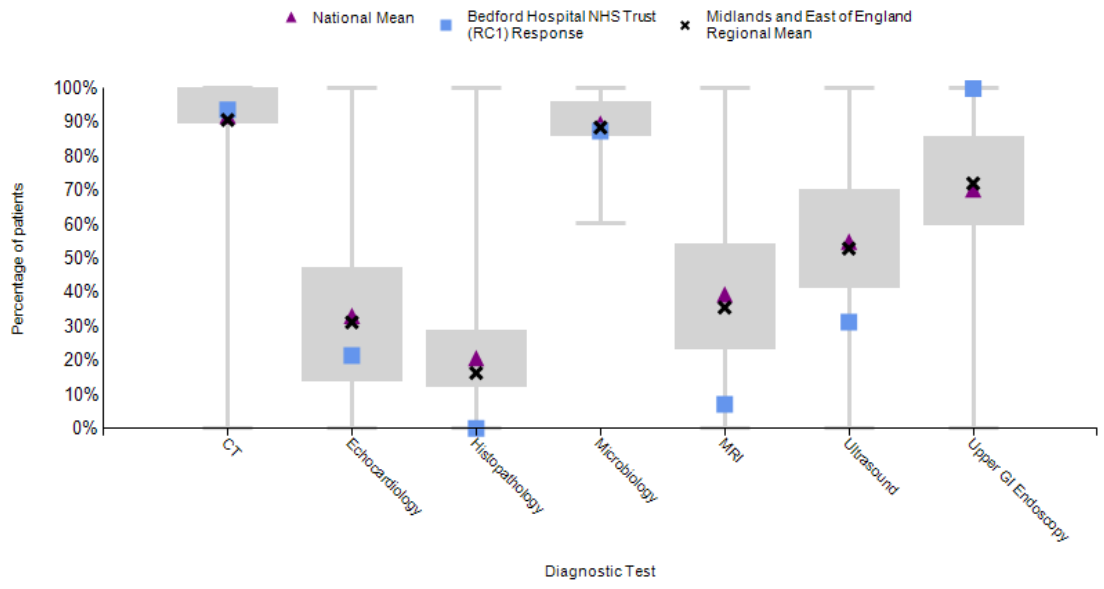
Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Acute trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances.

The intention of the standard is to ensure that diagnostic tests are done within a specified period of time after the clinician in charge of the patient has requested them. The standard requires that diagnostic services are made available for patients to access; it does not set an expectation that clinicians should order tests inappropriately early in the care pathway. There is a very important role for watchful waiting to see how a patient's condition progresses.

Chart 3: Consultant responses reporting the diagnostic test is always or usually available when there is urgent clinical need at the weekend



Unless it is clinically indicated, patients should not remain in hospital solely for the purpose of receiving the diagnostic test they require.

Critical patients are considered those for whom the test will alter their management at the time; urgent patients are considered those for whom the test will alter their management but not necessarily that day. Standards are not sequential; if critical diagnostics are required they may precede the thorough clinical assessment by a suitable consultant in standard 2.

Investigation of diagnostic results should be seen and acted on promptly by the MDT, led by a competent decision maker.

Seven-day consultant presence in the radiology department is envisaged

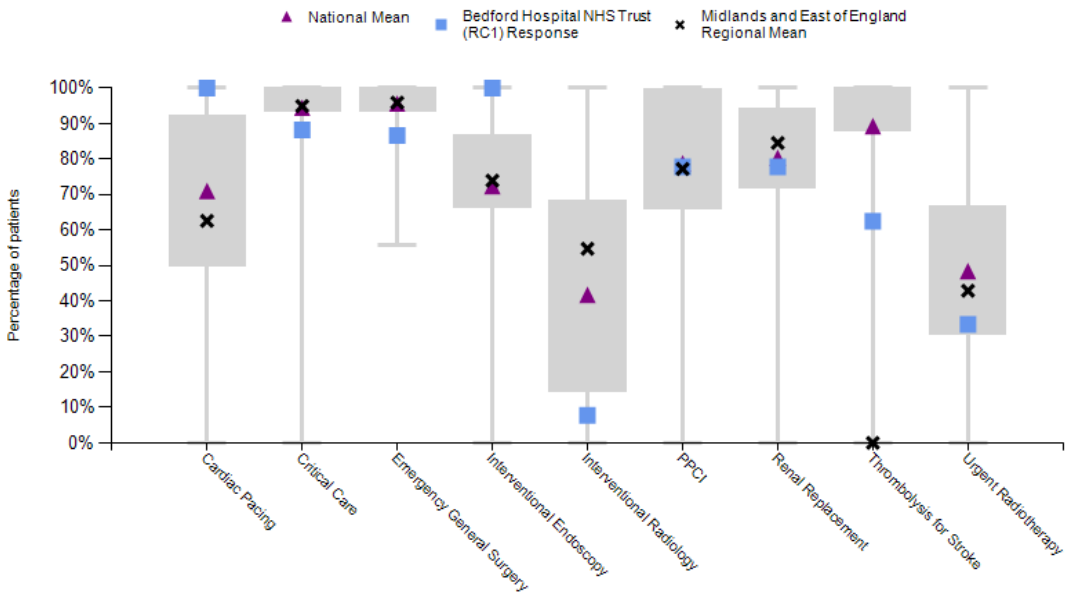
Standard 6: intervention / key services

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. These interventions would typically be:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous Coronary Intervention
- Cardiac pacing (either temporary via internal wire or permanent)

Standards are not sequential; if an intervention is required it may precede the thorough

Chart 3: Availability of interventions provided onsite or by formal provision (weekend)



clinical assessment by a suitable consultant in standard 2. The principle is that patients should receive urgent interventions within a timeframe that does not reduce the quality of their care (safety, experience and efficacy). Where there is evidence-based national clinical guidance regarding time to urgent treatment (e.g. thrombolysis for stroke, emergency laparotomy for peritonitis), trusts should implement systems to deliver to these standards and should monitor their performance.

Acute trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which interventions their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement.

Clear written protocols should describe any networked service arrangements, including a robust and transparent process for timely clinical assessment and patient transfer between sites. Such processes should be regularly audited to ensure that transferred patients receive timely high quality care. Trusts and their commissioners should have policies for managing a patient who is already in hospital and who develops another acute condition e.g. a general medical in-patient who then has a STEMI heart attack requiring primary PCI.

Standard 8: ongoing review

All 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 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Definition of a consultant for this standard:

Consultants in this context are defined as doctors on the Specialist Register, CCT-holders and those recognised as being equivalent in the view of the relevant Royal College. These senior decision-makers have a crucial role, not just in identifying and dealing with clinical issues but also in communication with patients and relatives, in taking active and appropriate decisions about discharge from hospital, and in providing support and supervision and education to junior clinical colleagues. The term 'consultant' is maintained because it is believed that this is a term broadly understood by doctors and the public. This description of the consultant is included in this supporting information, to align the standard with professional opinion, and provide clarity on which senior doctors could provide ongoing review without compromising patient safety.

The purpose of the consultant review is to see any patient who is not on a pathway, to address patient deterioration, to provide urgent important communication with patients and carers where appropriate, to speed flow and remove blockages in the care pathway. There should be clear escalation protocols so that if a patient deteriorates in-between daily ward rounds there is appropriate timely clinical escalation. ('Seeing the sickest quickest').

Clinical judgement should be used to determine frequency of consultant review required, but as a guide patients with Intensive Care Society levels of need of 2 (3 for paediatrics) and above may require twice daily review, and patients with needs of below level 2 (3 for paediatrics) may only require once daily review. The group of patients who need twice daily

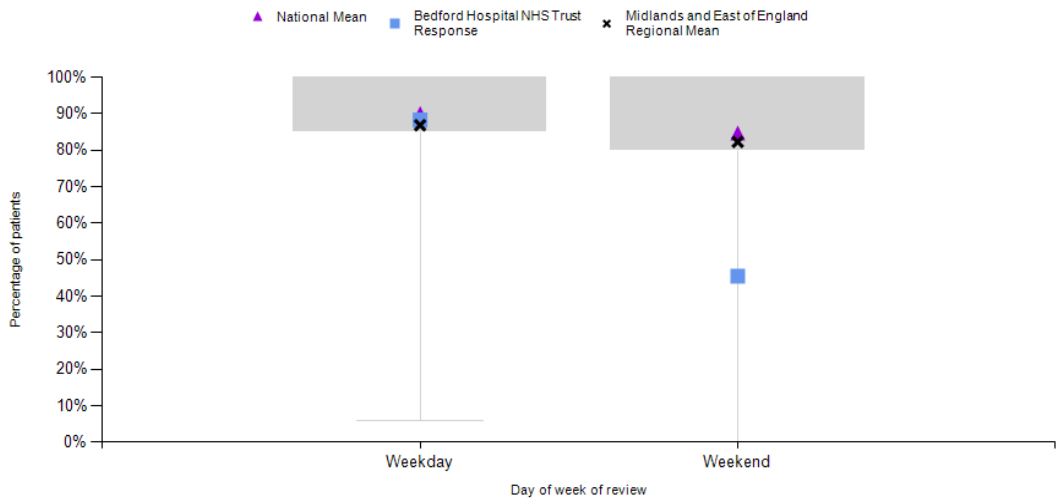
reviews should be based on the Intensive Care Society definitions of levels of illness and the Paediatric Intensive Care Society standards for the care of critically ill children rather than their geographical ward location in the hospital.

There should be consultant-led board rounds on every acute inpatient ward every day, and every patient should have a highly visible care plan (based on written protocols for individual conditions) that is updated daily at the Board round. At the Board round the consultant decides which, if any of the patients' reviews that day can be delegated to another competent clinician, such as a specialist nurse or senior medical trainee. The following are considerations that may be used to exclude individual patients from requirement for daily consultant review:

- The patient's physiological safety (low early warning score (EWS).
- The patient's level of need for further investigations and revision of diagnosis.
- The patient's level of need for therapeutic intervention.
- The level of need for communication with patient, carers, clinical colleagues.
- Their likelihood of imminent discharge.

For example patients who are medically fit for discharge and awaiting a social care placement (delayed transfers of care) may not need daily consultant review unless there are signs of clinical deterioration. The effective use of the skills and experience of a multidisciplinary team should be preserved, and this group will still need daily review with access to same day consultant advice.

Chart 2: Proportion of twice daily consultant reviews received



The decision that the patient does not need a daily consultant review should be documented, along with the plan for how the patient will be reviewed each day by the multi-disciplinary team (MDT) to ensure any signs of clinical deterioration are acted upon. Where a daily review is delegated the reviewer should feedback promptly to the consultant any concerns they have about a patient. Several examples exist of trusts that have segmented

their inpatient population to facilitate the appropriate level of daily review. Typically the groups are described as ‘medically active’, ‘medically optimised’ and ‘medically fit for discharge’.

The medically active group must be seen daily by a consultant and not delegated. This includes all patients causing nursing concern, all patients on end-of-life care pathways, all new admissions to a ward in the previous 24 hours and all patients in whom a potential same day discharge decision is required. The medically optimised group need daily consultant input via the board round, to ensure there is an MDT discussion around progress on therapy and social assessments, then for some in this group the consultant may choose to delegate that day’s face to face review to another member of the multi-disciplinary team.

What is required?

Standard 2

- Achievable within current resource
- Develop pathways for delegated care
- Midwifery-led care (assume pathway in place)
- Minor surgical conditions that do not require consultant review e.g. superficial abscess (Action: Planned Care); will require agreement of CCG
- Communicate to all consultants admitting acute patients (ongoing from MD); identify outliers and action by Divisional MD/CD if not comply

Standard 5

- Ultrasound
    - Business case required with the following options (Action: Integrated Medicine):
    - Daily Sat/Sun sonographer sessions (would achieve 24 hours standard)
    - On-call sonographer (to meet 12 hour standard for urgent)
    - Resident sonographer (to meet 1 hour standard for critical): likely to be unachievable/unaffordable
- CT
    - 24 hour standard for non-urgent requires change in mindset but should be achievable within current resource
    - 12 hour standard for urgent achievable within current resource
    - 1 hour standard for critical achievable but time-limited nature requires increased emphasis
- MRI
    - Business case required with the following options (Action: Integrated Medicine):
    - Daily Sat/Sun MRI sessions; requires onsite MR radiographer and radiologist reporting (STP networked solution? outsourcing?) (would achieve 24 hours standard)
    - Networked access to daily Sat/Sun MRI sessions (STP?) (would achieve 24 hours standard)
    - On-call MR radiographer or access to networked solution (STP/ tertiary) (to meet 12 hour standard for urgent)
    - Resident MR radiographer and access to reporting (to meet 1 hour standard for critical): likely to be unachievable/unaffordable

- Microbiology
    - Networked on-call service in place which will meet standards
- •Echo
    - Business case required with the following options (Action: Integrated Medicine):
    - Daily Sat/Sun echo sessions (would achieve 24 hours standard)
    - On-call echo technician (to meet 12 hour standard for urgent)
    - Resident echo technician (to meet 1 hour standard for critical): likely to be unachievable/unaffordable
- Endoscopy
    - Emergency endoscopy service in place; achievement of 1 hour critical target challenging

Standard 6

- Critical care
    - No additional resource required
- Interventional radiology
    - No resource available within the STP to deliver 24 hour, 12 hour or 1 hour standard. Requires a solution to be developed either with neighbouring STP or formal SLA to tertiary service (1 hour critical standard would be impossible to achieve with the latter). (Action: STP radiology lead; Integrated Medicine)
- Interventional endoscopy
    - Emergency endoscopy service in place; achievement of 1 hour critical target challenging.
- Emergency general surgery
    - Emergency general surgery service in place; achievement of 1 hour critical target challenging depending on availability of emergency theatre.
- Emergency renal replacement therapy
    - No additional resource required as available on CCC
- Urgent radiotherapy
    - Networked service with Addenbrooke's. 1 hour critical target may not be achievable if patient requires transfer
- Stroke thrombolysis
    - HASU L&D
- Percutaneous Coronary Intervention
    - Papworth service. 1 hour critical target may not be achievable if patient requires transfer
- Cardiac pacing (either temporary via internal wire or permanent)
    - Current status and gap analysis to achieve 24 hour, 12 hour and 1 hour standards (latter may be difficult to achieve unless resident on site) (Action: Integrated Medicine)

Standard 8

- Twice daily review

The definitions have been amended as to who should require twice daily review and this is now based on the ICS level of need. Level 2 equates to an HDU patient (or those requiring

CCC outreach). It should also relate to acutely admitted patients without a clear pathway. To meet the standard therefore we should review:

- all admissions to AAU unless deemed stable with a clear management plan in which case once daily review
- all inpatients who deteriorate and require CCC outreach

This should not require additional resource but managed within existing workload.

- Once daily review

Planned Care

Expectation is that all patients will be reviewed daily by a consultant in the relevant specialty. This needs reinforcement by the Divisional CD/ Divisional Director (Action: Planned Care).

Integrated Medicine

Consider segmenting inpatients to medically active, medically optimised and MFD using definitions above; for business planning purposes snapshot audit needed to determine the relative proportion. (Action: Integrated Medicine)

- medically active: require a consultant review daily
- medically optimised: require a consultant-directed board round and either consultant or delegated (middle grade) review
- medically fit for discharge require multidisciplinary review; this could be a matron.

Business case required on the basis of the snapshot audit to determine what additional staff are required to deliver this (Action: Integrated Medicine).

Quality improvement strategy

Following the CQC inspection in December 2015, the trust developed an action plan to deliver the inspection outcomes. The action plan, which supported the quality improvement strategy, concentrated on delivering the actions to support the CQC requirement notices.

The trust submitted a closed action plan on the requirement notices in January 2017 and continues to delivery on the 'should do' actions.

Background

There were four requirement notices which the trust closed formally with the CQC, NHSI and CCG in January 2017.

Currently, ten (out of 33) should-do actions remain open. Delivery of these actions are:

- The responsibility of the divisions
- Monitored through CQPs at quality board
- Challenged and monitored at the CQC steering group

To match the delivering of the action plan and to ensure the trust is prepared for the next inspection, the original quality improvement group developed into the CQC steering group.

CQC Steering Group

The steering group, which receives upward reports from the core service and support services leads, will move from monthly to fortnightly meetings to ensure momentum and acknowledge the positive achievements being delivered.

Monitoring action plan

The outstanding 'red risk' to delivery was regraded to amber with mitigation's in place. The risk related to a reduction in delays in transfer form critical care to ward. Due to capacity issues there are sometimes slight delays in good practice in transferring patients but:

- There has been no adverse effect on patients in being delayed
- There is no delay in accepting patients into critical care – which is a higher priority for the trust
- Critical care have safer care bundles in place to monitor and manage CC patients once they are able to leave but remain on the unit
- This action remains on the trust risk register
- The trust is working with CCG on wider capacity issues and adverse effects on patients

Regular confirm and challenge meetings (CCM) have been held with clinical leaders and the director of nursing. Each service that received the rating, requires improvement, was a priority followed by other services. This was to establish preparedness and triangulation of information, complaints, audit, serious incidents, guidelines and risk registers.

Annex one: services provided by Bedford Hospital NHS Trust in 2015/16

Service Description	
Accident and emergency	Ophthalmology***
Blood transfusion	Oral maxillofacial
Breast Surgery	Orthodontics
Cardiology	Paediatrics
Chemical pathology*	Pain management
Critical Care Medicine (ITU)	Plastic surgery
Dermatology	Podiatry (diabetic outpatients)****
Diabetic medicine	Radiology (includes MRI/CT/ultrasound)
Ear Nose and Throat (ENT)	Rheumatology
Elderly care	Thoracic medicine
Endocrinology	Trauma and orthopaedics
Gastroenterology	Tunable dye laser treatment
General medicine	Upper gastro-intestinal
General pathology*	Urology
General surgery	Vascular
Genito-urinary medicine/sexual health	Speciality support services
Gynaecology	Audiology
Haematology*	Dietetics
Histopathology*	Occupational therapy
Immunopathology*	Orthotics*****
Lower gastro-intestinal	Retinal screening
Medical oncology	Service departments
Microbiology*	Occupational therapy

Midwifery	Pharmacy
Neonatal	Physiotherapy
Nephrology**	Speech and language therapy****
Neurology	Theatres
Obstetrics	Acute admissions unit

* indicates a laboratory service provided by Viapath

** indicates a service provided by Lister Hospital - East and North Hertfordshire NHS Trust

*** indicates a service provided by Moorfields Eye Hospital NHS Foundation Trust

**** indicates a service provided by South Essex Partnership Trust (SEPT)

***** indicates a service provided by Patterson Healthcare

Annex two: statements from commissioners, Healthwatch and overview and scrutiny committees

Bedfordshire Clinical Commissioning Group

Bedford Borough Council Adult Services and Health Overview and Scrutiny Committee

Central Bedfordshire Council Adult Services and Health Overview and Scrutiny Committee

Healthwatch Bedford Borough

Healthwatch Central Bedfordshire

Annex three: statement of directors' responsibilities

To be inserted

Annex four: external audit limited assurance report

To be inserted

Annex five: acronyms and abbreviations

A&E	Accident And Emergency
AAU	Acute Assessment Unit
AKI	Acute Kidney Injury
ALERT	Acute Life Threatening Events Recognition And Treatment
ALS	Advanced Life Support
BEACH	Bedside Emergency Assessment Course For Healthcare Assistants
BLS	Basic Life Support
BNP	B-Type Natriuretic Peptide
BTS	British Thoracic Society
CAP	Community Acquired Pneumonia
CAU	Children's Assessment Unit
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CQC	Care Quality Commission
CQUIN	Commissioning For Quality And Innovation Payment Framework
CTG	Cardiotacography
DAHNO	Data For Head And Neck Oncology
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DVT	Deep Vein Thrombosis
ED	Emergency Department
ENT	Ear, Nose And Throat
FFT	Friends And Family Test
GMC	General Medical Council
GP	General Practitioner
GRS	Global Rating Scale
GUM	Genitourinary Medicine
HHS	Hyperosmolar Hyperglycaemic State
HPA	Health Protection Agency
HSCIC	Health And Social Care Information Centre
HSE	Health And Safety Executive
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease

ICNARC	Intensive Care National Audit & Research Centre
ILS	Immediate Life Support
ISO	International Organisation For Standardization
JAG	Joint Advisory Group
MHRA	Medicines And Healthcare Products Regulatory Agency (MHRA)
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin-Resistant Staphylococcus Aureus
NACR	National Audit For Cardiac Rehabilitation
NASH	National Audit Of Seizure Management
NBOCAP	National Bowel Cancer Audit Programme
NCDAH	National Care Of The Dying
NCEPOD	National Confidential Enquiry Into Patient Outcomes And Death
NCRN	National Cancer Research Network
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning System
NHFD	National Hip Fracture Database
NHS	National Health Service
NICE	National Institute For Health And Care Excellence
NIHR	National Institute For Health Research
NIV	Non-Invasive Ventilation
NJR	National Joint Registry
NMC	Nursing And Midwifery Council
NNU	Neonatal Unit
NRLS	National Reporting And Learning System
NT	Neural Tube
PACC	Professional Association Of Clinical Coders
PALS	Patients' Advice And Liaison Service
PAR	Patient At Risk
PCNL	Percutaneous Nephrolithotomy
PHSO	Parliamentary And Health Service Ombudsman
PLACE	Patient Led Assessment Of Care Environments
PPC	Post-Operative Pulmonary Complications
PREP	Post-Registration Education And Practice
PROM	Patient Reported Outcome Measure
PTWR	Post-Take Ward Round

QRS	Quality Review Scheme
RAG	Red, Amber, Green
RAM	Risk Adjusted Mortality
RCA	Root Cause Analysis
SHMI	Summary Hospital-Level Mortality Indicator
SHO	Senior House Officer
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit And Research Network
TDA	Trust Development Authority
TEP	Treatment Escalation Plan
UNICEF	United Nations Children's Fund
VBAC	Vaginal Birth After Caesarean
VTE	Venous Thromboembolism
WHO	World Health Organisation
WTE	Whole Time Equivalent

APPENDIX C

Local Services, Local Solutions

SEPT QUALITY REPORT 2016/17 (DRAFT)

EXECUTIVE SUMMARY

We recognise that for organisations like ours, providing a range of different services, in different geographic areas, this document can be somewhat complex. To help readers navigate our Quality Report, a summary of content and where you can find specific information that you may be looking for is provided below.

	Page No.
Part 1 is a statement written by SEPT Chief Executive, Sally Morris, on behalf of the Board of Directors setting out what quality means to the Trust and the processes in place to ensure the highest quality of services	**3**
Part 2 firstly sets out the priorities for improvement for our services in 2017/18 (as part of the new Essex Partnership University NHS Foundation Trust)	
Section 2.1 outlines the actions EPUT intends to take to ensure quality of services through 2017/18	**7**
Section 2.2 sets out the quality priorities agreed for the new organisation in 2017/18	**9**
Section 2.3 details the stretching goals for quality improvement that have been agreed with health commissioners of our services as part of the CQUIN scheme	**12**
Part 2 secondly reports the required statements of assurance from SEPT as well as performance against nationally mandated indicators for 2016/17	
Section 2.4 sets out the mandated statements of assurance from the Board appertaining to SEPT for 2016/17	**13**
Section 2.5 reports SEPT's performance against the national mandated quality indicators	**22**
Section 2.6 sets out information on SEPT's progress with implementing the Duty of Candour and the national *Sign Up To Safety* campaign	**31**
Part 3 focuses on 'looking back' at SEPT's performance against quality priorities, indicators and targets during 2016/17	**33**
Section 3.1 reports progress against SEPT's quality priorities for 2016/17, outlined in the Quality Report 2015/16 (including historic and benchmarking data, where this is available)	**34**
Section 3.2 provides examples of some achievements relating to local service specific quality improvement and Trust workforce development during 2016/17	**46**
Section 3.3 reports performance against SEPT Trust wide and service specific quality indicators	**54**
• Trust wide local quality indicators	**54**
• Community health services local quality indicators	**62**
• Mental health services local quality indicators	**65**
Section 3.4 reports performance against other national key indicators and thresholds defined by NHS Improvement which were relevant to SEPT in 2016/17 and have not been included elsewhere in this Quality Report	**67**
Section 3.5 details some of the work we have undertaken in relation to capturing patient experience and using this to help us to improve the quality of our services	**71**
Closing Statement by Sally Morris, Chief Executive	**73**
Annex 1 contains statements received from SEPT's partner organisations and Council of Governors. (to be inserted into final version prior to publication)	**74**
Annex 2 contains the Statement of Directors' Responsibilities in respect of the Quality Report. (to be signed by the Board of Directors of EPUT on behalf of SEPT on approval of final document)	**75**
Annex 3 contains the Independent Auditor's Report to the Council of Governors on the Annual Quality Report. (to be inserted into final version prior to publication)	**76**
A **glossary of terms** is provided at the end of the Quality Report in case it contains jargon which you are not familiar with.	**77**

PART 1: STATEMENT ON QUALITY FROM SALLY MORRIS, CHIEF EXECUTIVE OF SEPT 2016/17

I am delighted to present this Quality Report for 2016/17, which shows how South Essex Partnership University NHS Foundation Trust (SEPT) met its quality commitments for the past year and outlines the quality priorities in 2017/18 for our new, merged organisation – Essex Partnership University NHS Foundation Trust (EPUT).

This was an exciting year for SEPT as we prepared to merge with North Essex Partnership University NHS Foundation Trust (NEP) to form EPUT in April 2017. The merger is an excellent outcome for the people who rely on our services. We said from the start that we would be stronger together. Now we can harness the real enthusiasm we have to take the best from both organisations to deliver sustainable and transformative mental health, learning disabilities and community health services for the benefit of local people.

However, we didn't allow the proposed merger to distract SEPT's continued firm focus on the provision of high quality services. Much of the good practice outlined in this statement and throughout this report has been carried forward into the new organisation, taking us from strength to strength. The formation of EPUT enables us to continue to drive forward these quality improvements and more.

The preparation of this Quality Report has been particularly complex this year as we are required to look back on 2016/17 as SEPT and to look forward to 2017/18 as EPUT. We have tried to make the report as easy to follow as possible. There are contact points at the end of the report – please do not hesitate to get in touch if you have any queries.

Some of SEPT's quality highlights

Quality highlights from the past year include:

- Continuing high levels of achievement against the national safety thermometer, a national tool for measuring the achievement of harm free care.
- On-going reduction in the number of avoidable category 3 and 4 pressure ulcers acquired in our care, with two out of our three Community Health Services achieving no avoidable category 3 or 4 pressure ulcers across the entire year.
- Acceptance to be part of the NHS Improvement Falls Collaborative which is a 90 day programme, involving 21 volunteer Trusts, designed to improve the management of falls in an inpatient setting by ensuring that providers have the information, skills and tools to reduce injurious inpatient falls and improve reporting and care.
- On-going implementation of the Trust's Quality Academy with more than 65 quality champions being trained during the year and dates for training more quality champions scheduled.
- Development and implementation of a new "quality dashboard" for the Trust Board which provides the Board with an overview of key quality indicators, providing assurance and, where necessary, the opportunity for clarification and challenge.
- Implementation of a number of actions within the Sign up to Safety Initiative, with strong links to the national team supporting it.
- Awarded the Skills for Health Quality Mark Award for education and training.
- Family Food First – accreditation awarded for a number of local pre-school and nurseries in Bedfordshire.
- Installed a state-of-the-art X-ray machine at Saffron Walden Community Hospital.
- Launched the "Ask 3 Questions" programme in west Essex.
- Participated in the Essex-hosted Diabetes Games and Family Fun Day.
- Achieved excellent PLACE (clinical environment) results – above average in all categories.
- Received positive feedback following a visit from The Right Honourable the Lord Bradley to our Criminal Justice Liaison & Diversion Team.
- Achieved consistently excellent national Staff Survey results.
- Launched 2017's Buddy Scheme for training in mental health services.
- Dr. Ashish Patak, Consultant Psychiatrist, awarded Trainee Leader of the Year in the Health Education East Awards.
- Psychiatrists Dr David Ho, Dr Raman Deo and Dr Vivek Bisht, presented a symposium at the International Association of Forensic Mental Health Conference in New York (June 2016).

- Jacky Syme, practice development manager for 0-19 service in Bedfordshire, received the runner-up award for the Julie Crawford Award, given by the Baby Feeding Law Group (BFLG).
- Open Arts recognised again at the National Positive Practice in Mental Health Awards 2016.

You will find details of a number of these and many other achievements in this report.

Systems for ensuring quality at the highest levels throughout 2016/17

SEPT had a number of systems in place to ensure quality at the highest levels throughout the year. These systems have carried forward into EPUT and will continue to evolve as the new organisation develops.

As an NHS Foundation Trust, SEPT had a Council of Governors which included elected members of the public and staff, as well as a Board of Directors, both of which were led by the Chair of the Trust. Together they 'drove' the Trust, ensuring our staff were delivering services to the high standards to which we all aspire and they held me and my executive team to account for the day-to-day running of the Trust.

Our Board of Directors met in public and ensured proactively that we focused not only on national targets and financial balance, but also continued to place significant emphasis on the achievement of quality in our local services. Our performance was, therefore, monitored consistently and any potential areas for improvement addressed swiftly.

Robust quality governance systems were in place to safeguard patient safety and, ultimately, to provide assurance to the Board of Directors on the quality of SEPT services. These quality governance systems included production of comprehensive quality (including safety, experience and effectiveness) and performance dashboards on a monthly basis; undertaking compliance checks mirroring Care Quality Commission's (CQC) reviews and implementing any necessary remedial actions; an active national and local clinical audit programme; monitoring of patient experience and complaints and a robust risk management and escalation framework. Visits to services to assess quality and triangulate the information gained from these processes were made regularly by Non-Executive Directors, executive directors, Governors and commissioners.

I also place great importance on checking personally that things are as they should be in the Trust. I made unannounced visits to services at all times of the day and night throughout the year to observe the care provided and to hear directly from the people using the services at the time.

The quality governance system, actual quality performance and assurance on the arrangements in place were overseen by sub-committees of the Board of Directors and assurance provided to the Board of Directors.

How others feel about our services

SEPT placed great importance on listening to, involving and engaging with the people who come into contact with our services – patients / service users, carers and our staff and volunteers. This will also be a key priority for EPUT. During 2016/17, we continued to enhance our robust mechanisms for capturing feedback and also, and most importantly, acting on that feedback and using it to improve and shape services. We have included details of some of the activities undertaken, the feedback gained and changes made as a result in section 3.5 of this report.

Listening to our staff and their views on the quality of services was equally important to SEPT and will continue to be so in the new organisation. During 2016/17, we continued to ensure that our staff felt supported and encouraged to speak out about any issues, concerns or challenges. There were robust policies in place to enable staff to do this and a number of mechanisms by which they could raise any concerns. This included the "I'm worried about" intranet button for staff to raise issues anonymously directly with the senior leadership team, as well as the 'Freedom to Speak Up' initiative which gives staff the opportunity to speak to a 'Principal Guardian' about any concerns they might have.

Meeting the requirements of our external regulators

During 2015, we received an independent external assessment of the quality of our services under the CQC's comprehensive inspection national programme. SEPT's services were rated GOOD overall and GOOD for being effective, caring, responsive and well-led - a tremendous achievement. However, we were not complacent and the inspection reports indicated areas where we could improve further.

Since then, we have driven forward all the actions required to address the CQC's findings and undertook a detailed assessment of our progress in September 2016. As a result, the Board agreed that all actions with the exception of one had been implemented successfully. It was felt that whilst it was evident that action had been taken to improve access to psychology provision, further work was required. A thorough review of our service has been carried out and recommendations are being implemented. Further details are included in section 2.4.5 of this report. Our programme of internal inspections has continued to ensure that we have focused consistently and firmly on maintaining high standards in our services and making further improvements going forward.

Until the end of quarter 2 of 2016/17, we were fully compliant with the "Monitor" targets set by our external regulator. From 1 October 2016, NHS Improvement (which replaced Monitor as our external regulator from 1 April 2016) introduced new stretching targets for NHS organisations and the Trust has struggled to achieve some of these. Most are within our gift to achieve and I am determined that we will improve our position in 2017/18.

Looking to the future

There is always opportunity for improvement. This is an exciting time for the Trust with the launch of our new Essex Partnership University NHS Foundation Trust from 1 April 2017. A significant amount of work was undertaken with NEP throughout 2016/17 to prepare for this merger and to ensure that the quality of services is maintained and continues to go from strength to strength. Section 2.2 of this report sets out the quality priorities we have agreed for the new organisation, based on the specific priorities within each of the predecessor organisations.

This merger brings significant opportunities to design and deliver new models of service. There will be no immediate changes to services. It will be "business as usual" for service users and carers for the foreseeable future. Clinicians from both Trusts are working together with commissioners and people with lived experience to develop a proposed new clinical model for Essex-wide mental health services. Any changes to current services proposed by this model are likely to be subject to formal consultation.

Funding challenges may mean sometimes standards of service delivery have to be redefined to be affordable. Our continuous focus on the quality of service provision, regardless of the complexity of the external environment, means that we, our commissioners and regulators can be confident about the quality of our existing service provision.

To support our development work, the Quality Academy established in SEPT will continue to act as a catalyst to improve quality across the organisation. We will do this by providing an opportunity to capture and sustain the commitment and enthusiasm of staff, supporting them and enabling them to drive forward changes which make a difference to the care we provide.

Our staff are our greatest asset

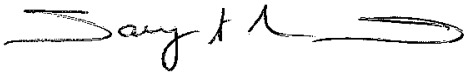
Our staff take pride in everything they do and provide consistently professional and high quality services. They work very hard to provide the highest quality care for our patients and I am immensely proud of them. Without each and every one of them, SEPT would not have been able to deliver the excellent services we and our patients expect.

We have a Staff Recognition Scheme and each month staff were nominated for In Tune Awards for their excellent customer service. On 1 February 2017 we held our annual SEPT Star Awards where more than 40 staff were recognised for their innovations and achievements with 26 proud winners taking home a trophy. Additionally, more than 400 staff were recognised for their excellent service throughout the year at our monthly Board Meetings.

After reading this Quality Report, I hope you will understand how seriously we all take quality and how hard we work to ensure that we continue to deliver services in a caring, dignified and respectful way. We believe that our patients, service users, carers, staff, volunteers and other stakeholders are the best people to tell us what constitutes the highest quality of service. We will continue to strive to meet their expectations and provide the highest standards of care by listening carefully to them and taking action promptly where necessary.

Statement of Accuracy

I confirm that to the best of my knowledge, the information in this document is accurate.



Sally Morris
SEPT Chief Executive 2016/17
Chief Executive of the Interim Board of Directors, EPUT from 1 April 2017

PART 2
OUR QUALITY PRIORITIES FOR IMPROVEMENT DURING 2017/18 AND STATEMENTS OF ASSURANCE FROM THE BOARD FOR 2016/17

Progress against the quality priorities for improvement for 2016/17, as set out in SEPT's 2015/16 Quality Report, is set out in Part 3 of this document.

What services did SEPT provide in 2016/17?

During 2016-2017, SEPT provided hospital and community-based mental health and learning disability services across South Essex as well as a small number of specialist mental health and learning disability secure services in Bedfordshire and Luton. SEPT also provided community health services in Bedfordshire, South East Essex and West Essex.

How have we prepared this Quality Report?

This Quality Report has been prepared in accordance with the national legislation / guidance relating to the preparation of Quality Reports and Quality Accounts in the NHS. From 1st April 2017, SEPT merged with North Essex Partnership University NHS Foundation Trust (NEP) to form Essex Partnership University NHS Foundation Trust (EPUT) and from this date responsibility for the finalisation of this Quality Report transferred to EPUT. The legislation / national guidance on Quality Reports and Accounts specifies mandatory information that must be reported within the Report and local information that the Trust can choose to include; as well as the process that Trusts must follow in terms of seeking comments from partner organisations (Clinical Commissioning Groups, Healthwatch organisations and Local Authority Health Overview and Scrutiny Committees) and the Council of Governors on their draft Quality Report and independent assurance from an external auditor.

This Quality Report has been collated from various sources and contains all the mandated information that is required nationally, as well as a significant amount of additional local information. It has been set out in three sections in accordance with the national legislation / guidance. The report was considered in draft form by the EPUT Quality Committee and the Board of Directors. The draft report was also sent to Clinical Commissioning Groups, Healthwatch organisations and Local Authority Health Overview and Scrutiny Committees in draft form and they were given 30 days in which to consider the draft and provide comment / a statement for publication in the final Quality Report. Clinical Commissioning Groups are required to provide a statement whereas the other partners are given the opportunity to provide a statement for inclusion should they wish to do so. The resulting statements are included at Annex A of this Quality Report *{to be inserted in final version prior to publication}.* The draft report was also sent to Local Authority Health and Wellbeing Boards for consideration and comment should they wish. The Lead Governor for SEPT also provided a statement, on behalf of the SEPT Council of Governors, which is included in Annexe A.

The report was sent in draft form to the Trust's external auditors in April 2017, in order to provide independent external assurance in accordance with national guidance. This process has been completed and the external auditor's report is included at Annexe C of this Quality Report. *{To be inserted in final version prior to publication}.*

The EPUT Board of Directors approved the final version of this Quality Report 2016/17 and their statement of responsibilities in this respect is included at Annexe B of this report. *{To be inserted in final version prior to publication}.*

2.1 Key actions to maintain and / or improve the quality of services delivered in 2017/18

How have we developed our priorities for the coming year?

As part of the preparation for the merger, SEPT and NEP established a joint planning process that led to the development of aligned strategic priorities and action to be taken to achieve these. Two joint stakeholder planning events for EPUT were held in December 2016. Those in attendance included commissioners, representatives from statutory and voluntary partners, staff, governors and service users and carers.

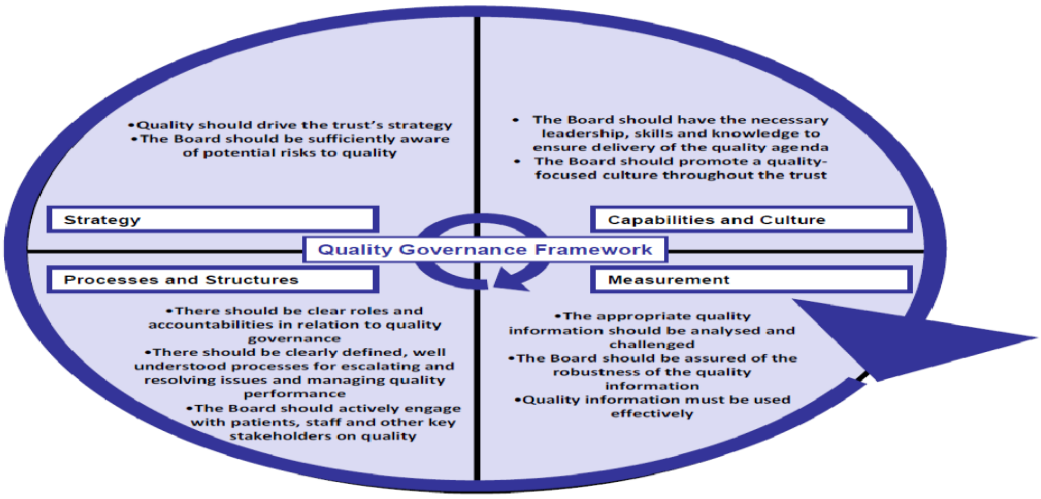
EPUT's vision commencing on 1st April 2017 is "working to improve lives". The priorities for quality for our new organisation have been produced with input from the Board, the Trust's Leadership Team, health economy partners and the Council of Governors. In addition, a number of economy wide discussions have been held with partners at Board and Executive level on the delivery of the Five Year Forward View and system wide Sustainability and Transformational Plans (STPs).

A safe transition from two organisations to one is clearly the key priority. A detailed "Post-Transaction Implementation Plan" (PTIP) was developed and scrutinised by NHS Improvement and by external auditors. A Quality Merger Workstream was put in place during 2016/17 and sub-workstreams established to oversee the review and harmonisation of systems, processes and policies associated with the management of quality in EPUT. Clear plans were put in place to establish harmonised processes required on day 1 of the new organisation (ie those most critical processes, for example adverse and serious incident reporting; complaints handling etc) and to understand those processes that could run in parallel until full harmonisation has taken place in a managed and safe way during the first 12 months post transaction.

In support of the above, harmonised written policies / procedures were developed for the critical processes for implementation on Day 1; and a prioritised plan is in place to harmonise remaining policies over the coming 12 month period.

EPUTs approach to quality will be firmly aligned to the quality governance framework principles.

Figure 1: The Quality Governance Framework



The Interim Board, put in place in November 2016 to prepare for the merger, identified that achieving the highest quality standards would be one of the key benefits of merger. EPUT's ambitions in respect of quality are to achieve a "good" CQC rating in the first comprehensive inspection post-merger; to achieve maximum autonomy in NHS Improvement segmentation ratings and to achieve top quartile ranking in the national transparency index.

Delivering quality services is one of the new Trust's four key strategic priorities, demonstrating that quality will drive the trust's strategy. The following overarching quality priorities have been identified as a result of the planning process put in place to develop the 2017/18 annual plans and articulate the key actions that will deliver EPUT's strategic vision for quality. These quality priorities have been identified as corporate objectives to ensure that they are integral to the delivery of the Trust's strategic and operational plans and are as follows:

*Implementation of a new mental health clinical model***:** the implementation of a new clinical model will be one of the key drivers and contributors to the strategic vision of the Trust in 2017/18. We aim to develop the proposed model and consult with stakeholders on it, with a view to implementation starting in 2018/19.

*Continued reduction in harm***:** both NEP and SEPT have taken action under the "Sign up to Safety" campaign to reduce harm. EPUT will align systems and processes and continue to reduce harm in the following areas**:**

- Pressure ulcers
- Avoidable falls
- Unexpected deaths
- Medication omission
- Physical health of mental health patients and early warning systems for deteriorating patients
- Restrictive practice

Record Keeping and Care Planning: both trusts experience on-going challenges associated with ensuring that high quality care records are maintained and that care plans are complete and personalised. Action will be taken to agree revised standards for record keeping and personalised care planning based on best practice and putting in place trust-wide training and practice development programmes to support excellence.

Mortality Review Processes: The CQC published the outcome of a comprehensive review of mortality review processes in December 2016. Both organisations have taken action in 2016 to establish local mortality review processes in response to the Southern Health report findings but these require review in light of CQC findings and recommendations (and the National Guidance on Learning from Deaths subsequently published by the National Quality Board in March 2017) and embedding in organisational systems and culture going forward.

*Using Technology***:** utilisation of new electronic systems and tools and maximising the use of those in place already will be required as part of changing culture and creating efficiencies required to deliver the agreed financial plan.

Standardisation and reducing variation: there are some excellent examples of leading practice and high quality services in both predecessor Trusts but neither could demonstrate consistently high standards across their entire portfolio. The new Trust will utilise the obvious internal opportunity to strengthen the use of benchmarking to identify clinical variation within mental health services provided in north and south Essex and action will be taken to agree a standardised approach to recording outcomes and the metrics in place to monitor them.

Creating a culture of quality improvement will be a high priority for EPUT. The Trust will develop and roll out a unique systematic approach to quality, building on the Quality Academy that was in place in SEPT and the Star Quality initiative in NEP. The EPUT approach to quality will support delivery of the agreed quality strategy; providing staff with the tools and training to support improvement activities and recognising and rewarding quality improvement as it takes place and makes a real difference to patient care.

The organisational development plan put in place to support merger identifies strong clinical leadership as integral to the trusts' aims. Within the workforce plan, a commitment has been made to develop a talent management programme to grow effective clinical leaders and managers within the organisation to support sustainable improvement.

2.2 Quality priorities for 2017/18

In setting the specific Quality Report / Account priorities for 2017/18, the EPUT Interim Board of Directors considered the strategic context, their knowledge of the predecessor Trusts and feedback from staff and stakeholders during the planning cycle. The Interim Board of Directors believe that the quality priorities outlined below will continue to deliver the improvements most often identified by our stakeholders and will lead to improved health outcomes for our patients and service users.

It is EPUTs intention to be ambitious with quality improvement and to set stretching targets. However, as a new organisation, it is the intention to undertake benchmarking and assessment of current position across the entirety of the new organisation in quarter 1 before setting appropriately ambitious and measurable improvement targets to be achieved through the remainder of the year. The priorities outlined below are therefore articulated to reflect this approach.

PRIORITY 1 - PATIENT SAFETY – Continued reduction in harm

NEP and SEPT have taken action under the "Sign up to Safety" campaign to reduce harm. EPUT will align systems and processes and continue to reduce harm.

Target: To continue to reduce harm across the organisation in the following key areas:

- **Pressure ulcers**
- **Avoidable falls**
- **Unexpected deaths**
- **Medication omissions**
- **Physical health of mental health patients and early warning systems for deteriorating patients**
- **Restrictive practice**

To achieve this, the Trust will deliver the following actions during 2017/18:

1) Pressure ulcers, avoidable falls, medication omissions and restrictive practice

- During Q1, the Trust will establish a baseline for the new organisation for each of the above areas and standardise processes and reporting where differences exist.
- At the end of Q1 when the baseline across EPUT has been established, the Trust will establish appropriate reduction targets for the remainder of the year.
- The Trust will monitor performance in each of the above categories during Q2 – Q4 and will have achieved an appropriate reduction against the new organisational baseline established in Q1 for:
    - The number of avoidable grade 3 and 4 pressure ulcers acquired in our care
    - The number of avoidable falls that result in moderate or severe harm
    - The number of omitted doses within services
    - The number of prone restraints
- The Trust will achieve above 95% harm free care from the "Safety Thermometer" every month throughout the year.

2) Unexpected deaths

- During Q1 the Trust will review the different suicide prevention training packages in place across the Trust and establish the organisational baseline for staff having completed suicide prevention training.
- At the end of Q1, the Trust will agree the training approach going forward and appropriate trajectories for completion of agreed suicide prevention training across the Trust.
- The Trust will monitor training completion during Q2 – Q4 and will have achieved the agreed completion rate by the end of Q4.

3) Physical health of mental health patients and early warning systems for deteriorating patients

- During Q1 the Trust will review the physical health monitoring tools in place across the Trust, standardise and deliver training on the agreed tool.
- During Q2, the Trust will undertake an audit of physical health and early warning systems for deteriorating patients and agree appropriate outcome measures to achieve by the end of Q4.
- At the end of Q4, the Trust will review performance against the agreed outcome measures.
- The Trust will consistently achieve the following targets in terms of patients with psychosis receiving a cardio metabolic assessment from Q1:
    - Inpatients 90%
    - Early Intervention in Psychosis patients 90%
    - Community patients on CPA
- The Trust will consider how to implement a sustainable process which ensures that all patients with psychosis receive a cardio metabolic assessment and will set stretch targets for the remainder of the year at the end of Q1.

PRIORITY 2 - CLINICAL EFFECTIVENESS – Record keeping and care planning

Both trusts experience on-going challenges associated with ensuring that high quality care records are maintained and that care plans are complete and personalised. Action will be taken to agree revised standards for record keeping and personalised care planning based on best practice and putting in place trust-wide training and practice development programmes to support excellence.

Target: To develop and implement revised standards for record keeping and achieve an improvement in the quality of record keeping between Q1 and Q4.

To achieve this, the Trust will deliver the following actions during 2017/18:

- During Q1, the Trust will undertake a record keeping baseline audit and develop and launch revised standards for record keeping.
- At the end of Q1, the Trust will agree appropriate improvement targets to be achieved by Q4 against the established baseline.
- The Trust will undertake a further record keeping audit in Q4 and will have achieved a percentage improvement in the quality of record keeping.

Target: To ensure that all patients identified as on an "end of life" care pathway have a personalised care plan in place.

To achieve this, the Trust will deliver the following actions during 2017/18:

- During Q1, the Trust will undertake an audit of the number of patients identified as on an "end of life" pathway who have a personalised care plan in place.
- During Q4, the Trust will undertake another audit of the number of patients identified as on an "end of life" pathway who have a personalised care plan in place and will have achieved an increase in the number.

PRIORITY 3 - CLINICAL EFFECTIVENESS – Mortality Review

The CQC published the outcome of a comprehensive review of mortality review processes in December 2016. Both organisations have taken action in 2016 to establish local mortality review processes in response to the Southern Health report findings but these require review in light of CQC findings and recommendations and newly issued National Quality Board's "Learning from Deaths" guidance (March 2017).

Target: To develop and implement organisational systems to deliver the National Quality Board's "Learning from Deaths" Guidance issued in March 2017.

To achieve this, the Trust will deliver the following actions during 2017/18:

- By September 2017, the Trust will have developed and approved an updated Mortality Review Policy in line with the "Learning from Deaths" national guidance.
- From Q3 onwards, the Trust will report mortality information on a quarterly (and annual) basis in line with the requirements of the "Learning from Deaths" national guidance (data to be published will be from April 2017 onwards). This will include the total number of the Trust's in-patient deaths and those deaths that the Trust has subjected to case record review; of the deaths subjected to review, an estimate of how many deaths were judged more likely than not to have been due to problems in care; and learning points.
- At the end of Q4, the Trust will undertake an audit of implementation of the Policy to assess whether processes have been embedded and are operating effectively.

PRIORITY 4 - PATIENT EXPERIENCE – Family and carer involvement in mortality review

The National Quality Board's "Learning from Deaths" Guidance (March 2017) highlights the importance of engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. As a starting point, the focus will be on all deaths which occur in in-patient services and those deaths occurring in a community setting which are classified as a "serious incident".

Target: To achieve high quality family and carer engagement and involvement after the death of an in-patient or the death of a patient in a community setting which is classified as a "serious incident" in line with the national guidance on learning from deaths.

To achieve this, the Trust will deliver the following actions during 2017/18:

- By September 2017, the Trust will have developed a Family and Carer Engagement and Involvement Policy which will include how families and carers are involved after the death of a patient who died in in-patient services or the death of a patient in a community setting which is classified as a "serious incident".
- By September 2017, the Trust will design appropriate mechanisms of seeking feedback from families and carers in terms of their engagement and involvement following the death of a patient in in-patient services or the death of a patient in a community setting which is classified as a "serious incident".
- The Trust will implement these mechanisms and undertake an audit through Q3 – 4 to establish the position in terms of the effectiveness of engagement and involvement, aiming to achieve a target of 100% of families / carers of patients whose death was in in-patient services or classified as a serious incident indicating that they were satisfied with their engagement and involvement after the death.
- The outcomes of the Q3 - Q4 audit will be assessed and actions agreed that could be taken to achieve improvement for on-going monitoring.

All of the above quality priorities will be monitored on a monthly basis by the Executive Directors of the Trust as part of the routine quality and performance report and the Board of Directors will be informed of any slippage against agreed targets. EPUT will report on progress against these priorities in their Quality Account for 2017/18.

2.3 Stretching goals for quality improvement – 2017/18 CQUIN Programme (C**ommissioning for **Qu**ality and **In**novation) **for EPUT

Commissioners have incentivised Essex Partnership University NHS Foundation Trust (EPUT) to undertake 57 CQUIN projects in 2017/18 which aim to improve quality of care and encourage collaborative working.

The value of the 2017/18 CQUIN scheme for EPUT is £6,534,062 which equates to 2.5% of Actual Annual Contract Value, as defined in the 2017/18 NHS Standard Contract. In contrast to previous years, all are national CQUIN schemes with the single exception of one which is a local scheme negotiated in South East Essex community services to continue an existing 2016/17 area wide transformation scheme.

The CQUIN programme content is markedly different in 2017/18 in line with national NHS England guidance which explains *"The CQUIN scheme has shifted focus from local CQUIN indicators to prioritising system wide Sustainability and Transformational Plans (STP) engagement and delivery of financial balance across local health economies. It is anticipated that that this approach will free up commissioner and provider time and resource to focus on delivering critical priorities locally."*

Given the financial and capacity challenges facing the NHS and the need to transform area-wide care pathways involving many service providers to effectively deliver care, the 2017/18 CQUIN programme contains 7 CQUIN themes (total 14 projects) that incentivise providers to collaborate and deliver quality and efficiency through transformation.

There are five CQUIN themes (22 projects) that enable the embedding of existing project work from 2016/17:

- Staff Health & Well-being (Year 2) – a 3-part CQUIN applicable to community and mental health contracts that incentivises provision of a well-rounded programme of physical and mental health initiatives to support and promote staff wellness.

- Physical Health (Year 4) – a 2-part CQUIN applicable to mental health contracts only that encourages physical health monitoring for patients with schizophrenia through consistent assessment and documenting of physical health and better partnership working with GP's.
- Neighbourhood Workforce Development (Year 2) – rollout of the 2 pilot neighbourhoods to the remaining 6 areas will embed the integration and transformation work initiated during 2016/17.
- Reducing Restrictive Practice (Year 2) – exploration of staff and service user experience of restrictive practice is developing initiatives that support least restrictive practice.
- Recovery College (Year 2) – successfully launched FRESH, our new Recovery College and objectives for this year will embed this initiative.

The commitment to rollout of national CQUIN programmes for a minimum of 2 years and 5 years in the case of Physical Health for people with Severe Mental Illness is very positive in our view. This acknowledges the length of time for real change to occur especially regarding change in health behaviour and supports embedding of change in practice.

In conclusion, the Trust is dedicated to continually improving services and teams have proven to be committed to and adept at managing resources to meet the stretching goals for quality improvement within the National CQUINs that have been set by commissioners in previous years. We are mindful of contextual events including transition within a newly merged organisation, and dependencies inherent in the progression of shared CQUIN schemes that may present risks but anticipate teams will ably meet the challenges for the coming year.

2.4 Statements of Assurance from the Board relating to SEPT 2016/17

2.4.1 Review of services

During 2016/17, SEPT provided and/or sub-contracted 156 relevant health services.

SEPT has reviewed all the data available to them on the quality of care in 156 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 96 per cent of the total income generated from the provision of relevant health services by SEPT for 2016/17.

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. During 2016/17 monthly data quality reports have been produced in a consistent format across all services. These reports monitor both timeliness of data entry and data completeness. The Trust has continued to make significant improvement in compliance throughout 2016/17. This has once again been achieved with the continuation of the reports introduced in 2014/15 and there has been excellent clinical engagement with a clear understanding of the importance of good data quality across the clinical areas. Further information in terms of data is included in section 2.4.6 below.

2.4.2 Participation in clinical audits and national confidential enquiries

Clinical audit is a quality improvement process undertaken by doctors, nurses, therapists and support staff that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE 2005). Robust programmes of national and local clinical audit that result in clear actions being implemented to improve services is a key method of ensuring high quality. Clinical audit is a tool to assist in improving services. The Trust participates in all relevant National Clinical Audit Patient Outcome Programme (NCAPOP) audit processes and additional national and locally defined clinical audits identified as being important to clinical outcomes of our service users.

During 2016/17 12 national clinical audits and 1 national confidential enquiry covered relevant health services that SEPT provides.

During that period SEPT participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SEPT was eligible to participate in during 2016/17 are as follows:

National clinical audits:

- *Sentinel Stroke National Audit Programme Round 4 (SNAP) 2016/17*
- *National Diabetes Foot Care Audit Round 2*
- *NHS National Benchmarking*
- *National Chronic Obstructive Pulmonary Disease (COPD) Audit* - Pulmonary Rehabilitation Workstream Round 2
- *National Audit Of Parkinsons Disease*
- *POMH uk Topic 15a Prescribing for Bipolar Disorder - (2015/16 project completed in 2016/17)*
- *POMH uk Topic 14b Prescribing for substance misuse and alcohol detoxification – (2015/16 project completed in 2016/17)*
- *POMH uk Topic 11c Prescribing antipsychotic medication for people with dementia*
- *POMH uk Topic 7e Monitoring of patients prescribed lithium*
- *POMH uk Topic 16a Rapid tranquilisation*
- *POMH uk Topic 1g &3d Prescribing high dose and combined antipsychotics on adult psychiatric wards –(data collection will complete in 2016/17)*
- *National Early Intervention in Psychosis services*

National confidential enquiries:

- *Suicide and homicide*

The national clinical audits and national confidential enquiries that SEPT participated in during 2016/17 are as above.

The national clinical audits and national confidential enquiries that SEPT participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit *(POMH = Prescribing Observatory for Mental Health)*	**Number of cases submitted as a percentage of the number of registered cases required by the terms of the audit / enquiry**
Sentinel Stroke National Audit Programme Round 4 (SSNAP) 2016/17	Data collection is on-going and continuous.
National Diabetes Foot Care Audit Round 2	Data collection is on-going and continuous.
National Audit Of Parkinson Disease	100% of relevant cases had information provided to national organisers.
POMHuk Topic 11c Prescribing antipsychotic medication for people with dementia	100% of required cases had information provided to national organisers.
National Early Intervention in Psychosis services	Organisational information provided to national organisers.

POMHuk Topic 7e- Monitoring of patients prescribed Lithium	100% of required cases had information provided to national organisers.
NHS National Benchmarking for: Community Services Community Hospitals Cardiac and respiratory Specialist Nursing	West Essex Community Services participation. All relevant cases included in the Benchmarking Process.
National Chronic Obstructive Pulmonary Disease (COPD) Audit - Pulmonary Rehabillitation Workstream Round 2	West Essex CHS 100% of relevant cases had information provided to national organisers.
POMHuk Topic 16a Rapid Tranquillisation	100% of required cases had information provided to national organisers.
POMHuk Topic 1g & 3d Prescribing high dose and combined anti-psychotics on adult psychiatric wards	100% of required cases had information provided to national organisers.
National Confidential Enquiry - Suicide and Homicide	100% of relevant cases were submitted with information to national organisers.

The reports of 6 national clinical audits were reviewed by SEPT in 2016/17 and we intend to take the following actions to improve the quality of healthcare provided (examples only are listed):

- A checklist (for prescriber and patient to sign off) regarding the risks posed during pregnancy using sodium valproate to be added to Section 3 Treatment of Bipolar Affective Disorder Mental Health Formulary and Prescribing Guidelines.
- Process put in place for patient leaflet (as identified in MHRA suite of resources from MHRA alert Jan 2015) to be issued to all relevant patients on sodium valproate.
- Letter template amended for GPs to be advised of risk factors for patient of child bearing age prescribed sodium valproate.
- Findings from national POMHuk Audits will be used by the Physical Health Implementation Group to identify key areas of concern for action planning and priorities.
- Following the audit into early intervention in psychosis the service is undergoing a review and resources are being negotiated to provide services as outlined in NICE QS80.
- Induction of Junior Doctors to include teaching on basic principles of taking a complete alcohol history when clerking patients.

(Note: All national clinical audit reports are presented to relevant Quality and Safety Groups at a local level for consideration of local action to be taken in response to the national findings.)

SEPT's priority clinical audit programme for 2016/17 was developed following consultation with senior mental health and community health service managers to focus on agendas required to provide assurance to the Trust and stakeholders that services being delivered are safe and of high quality. A centralised Clinical Audit Department oversee all priority clinical audits, facilitate clinicians to ensure high quality, robust audits and monitor and report on implementation of action plans post audit to ensure that, where necessary, work is undertaken to improve services. Learning from audits takes place internally via reports that are provided to individual senior and local managers, operational quality groups and centralised senior committees. The Trust also reports regularly to stakeholders such as Clinical Commissioning Groups about outcomes of audits relevant to services in their portfolios.

The reports of 36 local clinical audits were reviewed by SEPT in 2016/17 and we have or intend to take the following actions to improve the quality of healthcare provided (examples only are listed):

- New suicide prevention awareness and response training commissioned which includes safety planning and risk management planning.
- Small group training on the handling of Controlled Drugs to be provided to all wards not achieving compliance with the standards.
- Changes made to Mobius Electronic Patient Record system to highlight if patient has a carer, therefore making it easier to include them in care decisions.
- Following the falls audit, posters and presentations have been implemented. Handouts included in doctors induction packs.
- Improving complaints processes to ensure they are also child friendly.
- Ensure new doctors are made aware of DVT risk assessment form (including need to prescribe anti-VTE stockings) at induction.
- Introduced Distress Thermometer (Holistic Assessment Tool) within Oncology and Palliative Care.
- Consideration to piloting the use of tablet computers in hospital teams.

2.4.3 Clinical Research

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical Research' is defined as Health and social care research undertaken within the NHS and in NHS England this means research that has received Health Research Authority (HRA) approval. Information about clinical research involving patients is kept routinely as part of a patient's record.

For NHS research taking place in England there is a new process of approval via the HRA that brings together the assessment of governance and legal compliance, undertaken by dedicated HRA staff, with the independent Research Ethics Committee (REC) provided through the UK Health Departments' Research Ethics Service. HRA Approval replaces the need for local checks of legal compliance and related matters by each participating NHS organisation in England. This allows participating NHS organisations to focus their resources on assessing, arranging and confirming their capacity and capability to deliver a study.

As a demonstration of our commitment to research and development we continue to participate in studies funded by the National Institute for Health Research (NIHR) and this is very much our core research activity. We continue to work with our partner organisations to develop research and to support students undertaking research as part of further education courses.

The number of patients receiving relevant health services provided or sub-contracted by SEPT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 619.

2.4.4 Goals agreed with commissioners for 2016/17

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It continues to be an important lever, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed at Board level within and between organisations. It makes a proportion of the provider's income dependent on locally agreed quality and innovation goals.

A proportion of SEPT's income (2.5% of contract value) in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between SEPT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2016/17 and the following 12 month period are available electronically at:
http://www.eput.nhs.uk

The SEPT CQUIN programme for 2016/17 included 27 schemes negotiated with commissioners across the areas in which SEPT was commissioned to operate services. The CQUIN programme included a mix of local (1.5% of contract value) and national (1.00% of contract value) schemes and was valued at just under £4.4 million which represents 2.5% of contract value for the Trust. This compares to the 2015/16 CQUIN programme which again represented 2.5% of contract value equating to £4.87 million.

The current forecasted achievement is 96% (£4.2 million income), reflecting strong operational performance within each of the five services in achieving a complex programme and challenging expectations of Commissioners. Given the financial and operational challenges facing the NHS in 2016/17 overall we are pleased that collaboration to deliver shared CQUINs is helping to strengthen links with partners. There is clear evidence of improving quality for patients across the breadth of community, mental health and specially commissioned services run by SEPT over the last 12 months.

The Trust's CQUIN programme included the two national CQUINs applicable for Community Health Services and/or Mental Health Services. These are:

- Staff Health & Well-being – a new 3-part CQUIN applicable to South East Essex and West Essex community and South Essex mental health contracts.
- Physical Health (Year 3 Cardio-metabolic Assessment) - a 2-part CQUIN applicable to South Essex mental health contract only.

We implemented a total of 11 CQUIN schemes across the organisation under the above three national schemes. The remaining 16 out of the total of 27 CQUIN schemes were set locally in discussion with the Clinical Commissioning Groups based on local priorities.

Several locally negotiated CQUINs e.g. Workforce Development and Motivational Interviewing in West Essex and Care Packages and Pathways in South Essex were continued from 2015/16. Year 2 schemes ensured an opportunity to consolidate and embed earlier work.

Notable schemes in which Commissioners have given very positive feedback include:

- Payment by Results CQUIN – staff from SEPT including the CQUIN project lead, operational leads in Mental Health Services (MHS) and Performance worked closely with commissioners in South Essex developing a collaborative approach to review care pathways, cost care delivery and select appropriate outcome measures to evidence efficacy.
- Palliative Care Support (PCS) Register CQUIN – the PCS team and Modern matrons in South East Essex Community Health Services (CHS) trialled attending hospital based Multi-Disciplinary Team meetings aiming to identify patients and support hospital staff to be more confident in making referrals. They are now focussing on support for care home staff to increase referrals and support a greater number of patients to plan care at the end of their life and avoid unnecessary hospital admissions.
- The Care Home Multi-Disciplinary Team (MDT) CQUIN in West Essex Community Health Services (CHS) supported GP's to launch and embed new care home MDT's in order to encourage effective partnership working. The aim was to reduce the number of unplanned avoidable admissions from care homes into acute care in comparison to 2015/16 activity.
- The second year of the Workforce Development CQUIN in West Essex CHS successfully supported integrated working across West Essex through joint inductions, joint training and shadowing opportunities.
- The Nursing Home CQUIN in Bedfordshire Community Health Services provided an opportunity for the SEPT community health services to work collaboratively with nursing home staff aiming to improve skills and knowledge regarding the wound care formulary, SSKIN bundle for managing pressure ulcer risk and the diabetic foot attack pathway.

- There are 3 notable CQUINs in Specialist Services that launched during the year - a new carers evening for parents and carers in Child and Adolescent Mental Health Services (CAMHS); a Recovery College for adult inpatients in 3 locations within secure mental health services; and an initiative to understand and reduce restrictive practices through staff and service user involvement in secure mental health services.

In conclusion, the Trust has continued to be dedicated to continually improving services and teams have proven to be committed to and adept at managing resources to meet the stretching goals for quality improvement within the National CQUINs that have been set by commissioners in previous years as well as locally negotiated schemes. We anticipate teams will continue to ably meet the challenges for the coming year.

2.4.5 What others say about the provider?

SEPT is required to register with the Care Quality Commission and during 2016/17 its registration status was 'Registered Without Conditions'. *Please note that SEPT was de-registered with the Care Quality Commission on 31st March 2017 and the services were re-registered by EPUT on 1st April 2017.*

The Care Quality Commission has not taken enforcement action against SEPT during 2016/17.

SEPT has participated in special reviews or investigations by the Care Quality Commission (CQC) relating to the following areas during 2016/17:

Safeguarding Children's Inspection for Southend (July 2016)

We intend to take the following action to address the conclusions or requirements reported by the CQC:

- Develop a Think Family approach in Mental Health and Sexual Health Services.
- Standardise the utilisation of alerts on mental health electronic systems.
- Establish operational governance and quality assurance to support mental health staff delivering best safeguarding practice.
- Develop liaison and communication pathways between Mental Health and STaRs.
- Expedite transition to single electronic patient record system in sexual health services.
- Ensure training, supervision and record keeping in sexual health services reflects national guidance.
- Work with Commissioners to increase visibility of sexual health services into wider safeguarding networks.
- Strengthen liaison between health visiting, school nursing and midwifery.

SEPT has made the following progress by 31st March 2017 in taking such action:

- Action plan in place and progress reported to Clinical Commissioning Group quarterly. There are no concerns in terms of the ability to complete the actions in accordance with the plan.

Please note, the Trust has completed all actions arising from the Inspections undertaken in 2015/16 reported in last year's Quality Report.

The most recent Care Quality Commission (CQC) Inspection of SEPT was the Comprehensive Inspection of all Trust Services in June / July 2015 undertaken as part of its on-going comprehensive health inspection programme. This reviewed compliance against the Fundamental Standards and Key Lines of Enquiry (KLOE's). The feedback reports published by the CQC in November 2015 confirmed that the Trust had received an overall rating of "Good". The Trust received 16 reports which confirmed the overall rating for the Trust and a rating for each core service (as defined by the CQC) as at the point of Inspection in 2015 – these were as follows:

Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

	Safe	Effective	Caring	Responsive	Well led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Requires improvement	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Requires improvement	Good	Good

	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community dental services	Good	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good

As a result of this Inspection, the CQC identified 4 “Must Do” and a number of “Should Do” recommendations. Following the receipt of the final feedback reports in November 2015, the Trust developed a detailed action plan aimed at addressing the recommendations made by the CQC and bringing about real improvement within Trust services. The action plan was taken forward by a series of Task and Finish Groups, overseen by an Executive Task and Finish Group.

The Trust recognised that simply reporting progress with the agreed actions may not have provided sufficient assurance that there had been learning from the inspection and that actions taken had actually engendered change / improvement. It was agreed therefore that a robust compliance process would be implemented in order to provide the Executive Team, Quality Committee and ultimately the Board of Directors with the necessary assurance in respect of the position reported in September 2016.

The Compliance process implemented consisted of two separate assurance "tests" carried out on each recommendation.

- **Test 1 Have the actions been completed as reported?** This was undertaken as a desktop audit to check the actions reported as being completed had in fact been completed. The audit involved checking every action identified and collating evidence of the action reported.
- **Test 2 Is there evidence that the action taken has engendered change / improvement?** A comprehensive programme of audit was undertaken by the Compliance Team to determine whether the recommendations made by the CQC had been addressed and if any improvement had been made as a result. The audits included data gathering, speaking with patients and staff, reviewing patient notes, undertaking observations and reviewing the environment.

The Trust Compliance Team collated and analysed the results of both tests and presented these to the Executive Task and Finish Group. Further discussions were held collectively and individually with Executive Directors in order to agree the final position to be reported to the CQC.

The Trust reflected on the outcome of both Test 1 and Test 2 in order to agree the recommendation position overall for each CQC recommendation as at September 2016. The Trust concluded that there was sufficient assurance available to recommend closure of all but ONE CQC recommendation taking into account the action taken and the assurance available on the difference it had made.

The recommendation that it was felt could not be closed as a result of this process required the Trust to "ensure that all relevant patients have easy access to psychological therapies". The Trust was satisfied that some action had been taken but was not satisfied that this had led to change or improvement. The Director of Mental Health was therefore requested to take this action forward to improve the current provision and in March 2017 the Quality Committee received assurance that good progress was being made to improve the service and this will continue in 2017/18.

In drawing its conclusions, the Trust was clear the action plan submission to the CQC was not the end of the follow-up and implementation of the CQC recommendations. Where there was not full assurance that action taken had resulted in change / improvement, on-going action and appropriate monitoring arrangements were established. Sustainability / monitoring arrangements for 2017/18 will also be implemented to minimise the risk of issues identified by the CQC in 2015 being identified in any future inspection.

2.4.6 Data Quality

The ability of the Trust to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for the Trust to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows the Trust to undertake meaningful planning and enables services to be alerted of deviation from expected trends.

2016/17 has been a challenging year within the Trust with the implementation of a new information system for Mental Health services. The new system provides a unified patient summary database which houses all key inpatient and community Mental Health and Learning Disability information. This will ensure more robust information capture and reporting and provides facilities to respond to ever growing information requirements (both nationally and locally). The introduction of the new system has led to a change in a number of operational procedures for both inputting information and extracting information from the system. Due to the system change over, there were periods of time in 2016/17 where information was not available to support contractual and national reporting. Considerable work has been undertaken training staff and there has been ongoing data validation. An in-depth data quality audit was undertaken at the end of the financial year looking at data provided for 10 Key Performance Indicators, this involved the audit of over 750 records. Substantial Assurance was achieved.

In addition to the system change the following key developments have been made:

- Undertaking of an increased number of Data Quality Audits by internal audit to continue the focus on data quality in year.
- Presentation of a regular Data Quality Reports to the Information Governance Steering Sub Committee.
- Successful submission of the new Children and Younger Persons Dataset (CYDS) focusing on the high level of data quality and which showed the trust to be one of the highest for data quality.
- Continued production of Routine Data Quality Reports available via the Trust's Intranet - these reports highlight missing and out of date data fields.

SEPT did not submit records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. *Note: This was due to significant system upgrade running over 2016/17 with submission due to re-commence with month 12 data which will be provided in April 2017.*

The projected percentage of records in the published data:

1) which included the patient's valid NHS Number was:

- *99.15% for admitted patient care;*
- *99.96% for outpatient care; and*
- *Accident and emergency care – Not applicable*

2) which included the patient's valid General Medical Practice Code was:

- *98.96% for admitted patient care;*
- *99.89% for outpatient care; and*
- *Accident and emergency care – Not applicable*

SEPT's Information Governance Assessment Report overall score for 2016/17 was 74% and was graded Green (Level 2 or above (Satisfactory)).

SEPT was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

We will be taking the following actions to improve data quality:

- Submission of additional fields within the MHSDS (Mental Health Services Dataset). As part of the implementation of new National Datasets the Trust is undertaking intensive analysis and monitoring of all the data fields to ensure a high level of data quality is achieved; and
- Increased number of Data Quality Audits to be undertaken by the Internal Audit function.

2.5 National Mandated Indicators of Quality

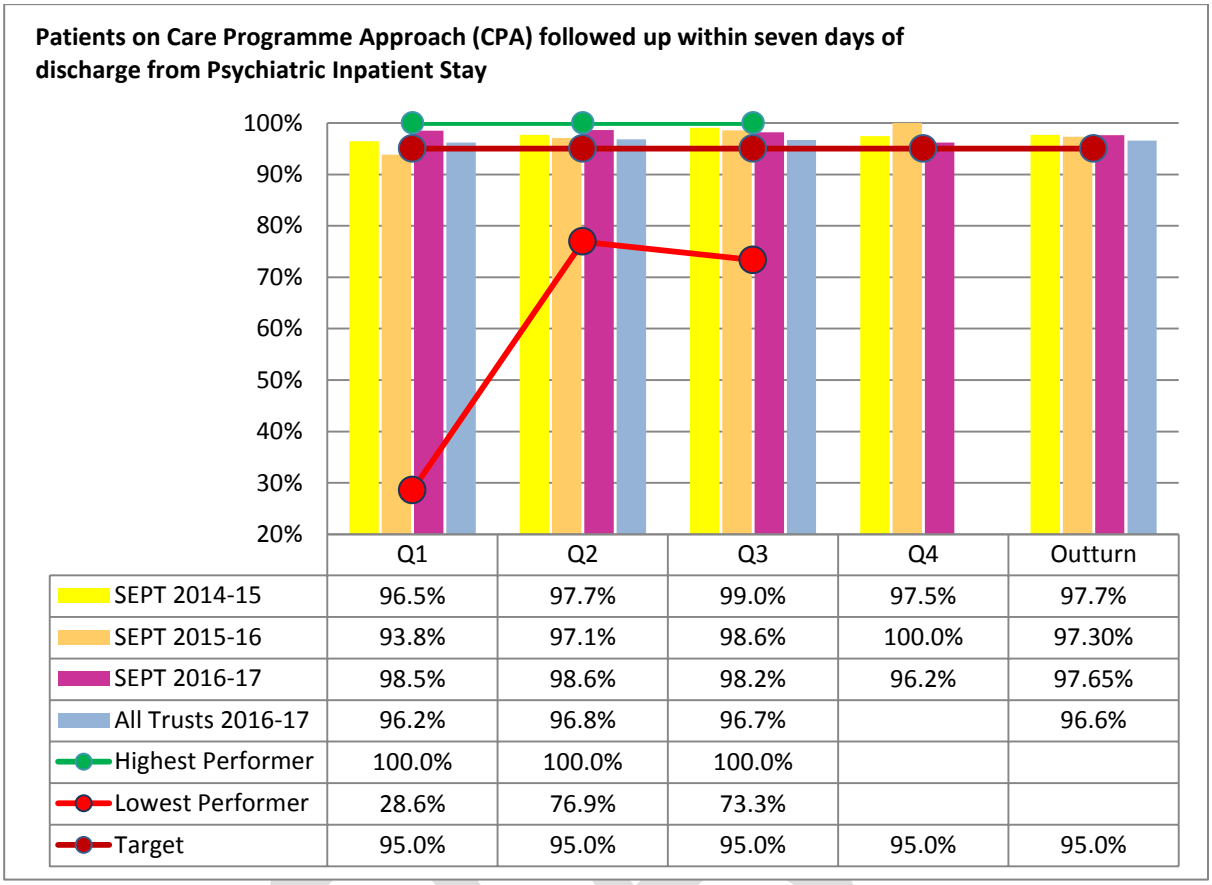
A letter from NHS England dated 6th January 2017 and guidance from NHS Improvement (previously Monitor) published in February 2017 outlined the reporting and recommended audit arrangements for Quality Accounts / Reports for 2016/17. The National Health Service (Quality Accounts) Regulations 2010 had been previously amended to include changes of the mandatory reporting of a core set of quality indicators. Those indicators relevant to the services SEPT provided during 2016/17 are detailed below, including a comparison of SEPT's performance with the national average and also the lowest and highest performers. The information presented for the mandated indicators has been extracted from nationally specified datasets, and as a result, is only available at a Trust-wide level.

The provision of mental health services in Bedfordshire and Luton transferred to a new provider from 1st April 2015. Historical data (ie up to 31st March 2015) for this service has only been retained in this section where it has not proved possible to disaggregate the SEPT figures and such indicators are marked clearly.

Please note, we have reported the latest actual position on the graphs in the section below and have included details of the figure reported at quarter end to NHS Improvement (formerly Monitor) via the Health and Social Care Information Centre (and to the Board of Directors) where this is different in the associating narrative. Such differences in the quarterly figures will occur in some instances due to information / data being received after the national submission / report to the Board of Directors.

The letter from NHS England dated 6th January 2017 asked NHS Trusts to consider including in Quality Reports/Accounts again this year the results from the NHS Staff Survey indicators relating to the "percentage of staff experiencing harassment, bullying or abuse from staff" and the "percentage of staff believing their Trust provides equal opportunities for career progression and promotion". The results of these indicators are therefore included at the end of this section.

Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay



	Q1	Q2	Q3	Q4	Outturn
SEPT 2014-15	96.5%	97.7%	99.0%	97.5%	97.7%
SEPT 2015-16	93.8%	97.1%	98.6%	100.0%	97.30%
SEPT 2016-17	98.5%	98.6%	98.2%	96.2%	97.65%
All Trusts 2016-17	96.2%	96.8%	96.7%		96.6%
Highest Performer	100.0%	100.0%	100.0%		
Lowest Performer	28.6%	76.9%	73.3%		
Target	95.0%	95.0%	95.0%	95.0%	95.0%

This indicator measures the percentage of patients that were followed up (either face to face or by telephone) within seven days of their discharge from a psychiatric inpatient unit.

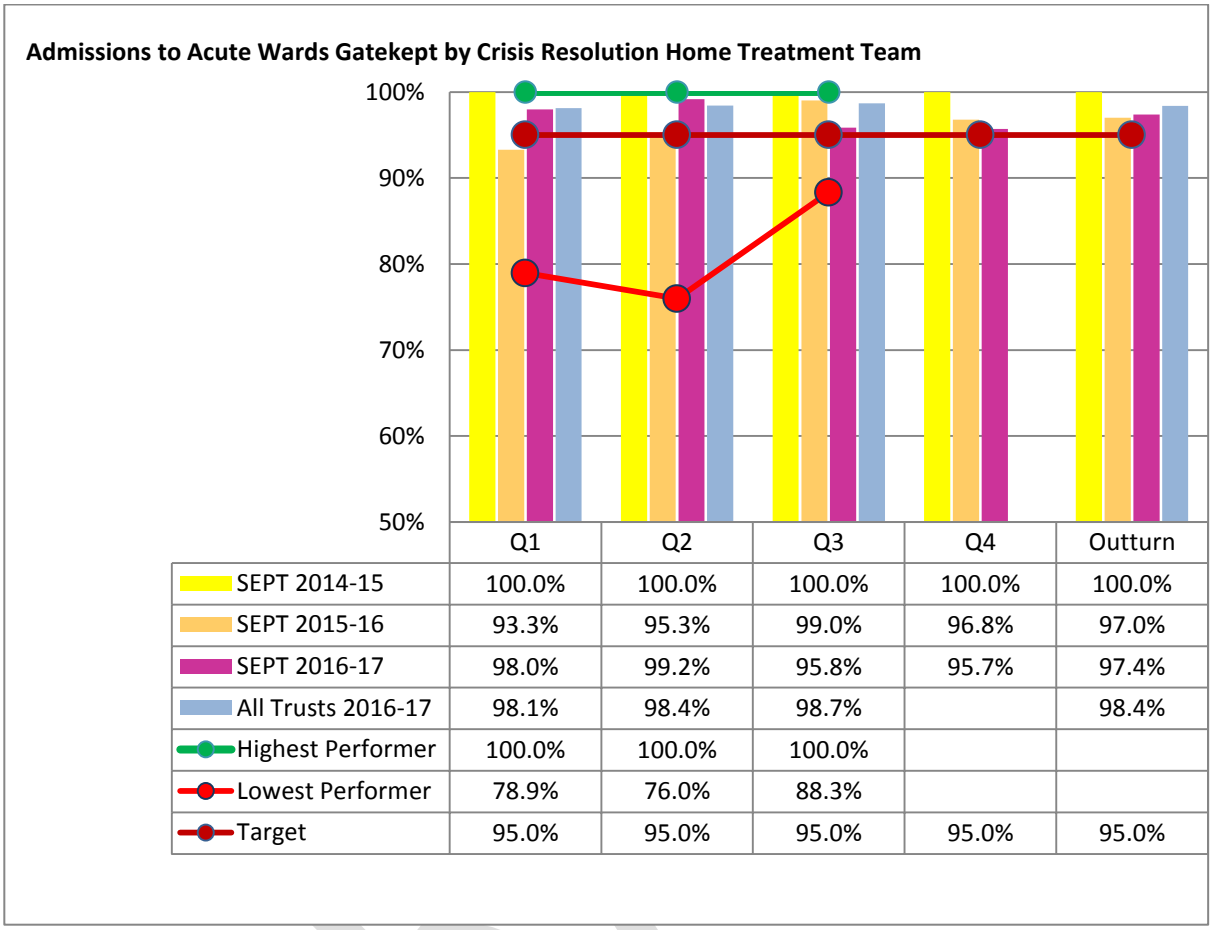
This target has been met consistently each quarter during 2016/17 and for the year as a whole.

In order to improve this percentage and thus the quality of its services, SEPT has been routinely monitoring compliance with this indicator on a monthly basis and identifying the reasons for any patients not being followed up within seven days of their discharge. Any identified learning is then disseminated across relevant services.

Please note, at the time of preparing this draft, Q4 figures (and refreshed Q1 – 3 figures) are still to be published nationally and figures may subsequently change in the final published Quality Report.

Data Source : DoH Unify2 Data Collection – MHPrvCom
National Definition applied: Yes

Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team



	Q1	Q2	Q3	Q4	Outturn
SEPT 2014-15	100.0%	100.0%	100.0%	100.0%	100.0%
SEPT 2015-16	93.3%	95.3%	99.0%	96.8%	97.0%
SEPT 2016-17	98.0%	99.2%	95.8%	95.7%	97.4%
All Trusts 2016-17	98.1%	98.4%	98.7%		98.4%
Highest Performer	100.0%	100.0%	100.0%		
Lowest Performer	78.9%	76.0%	88.3%		
Target	95.0%	95.0%	95.0%	95.0%	95.0%

This indicator measures the percentage of adult admissions which are gatekept by a crisis resolution / home treatment team.

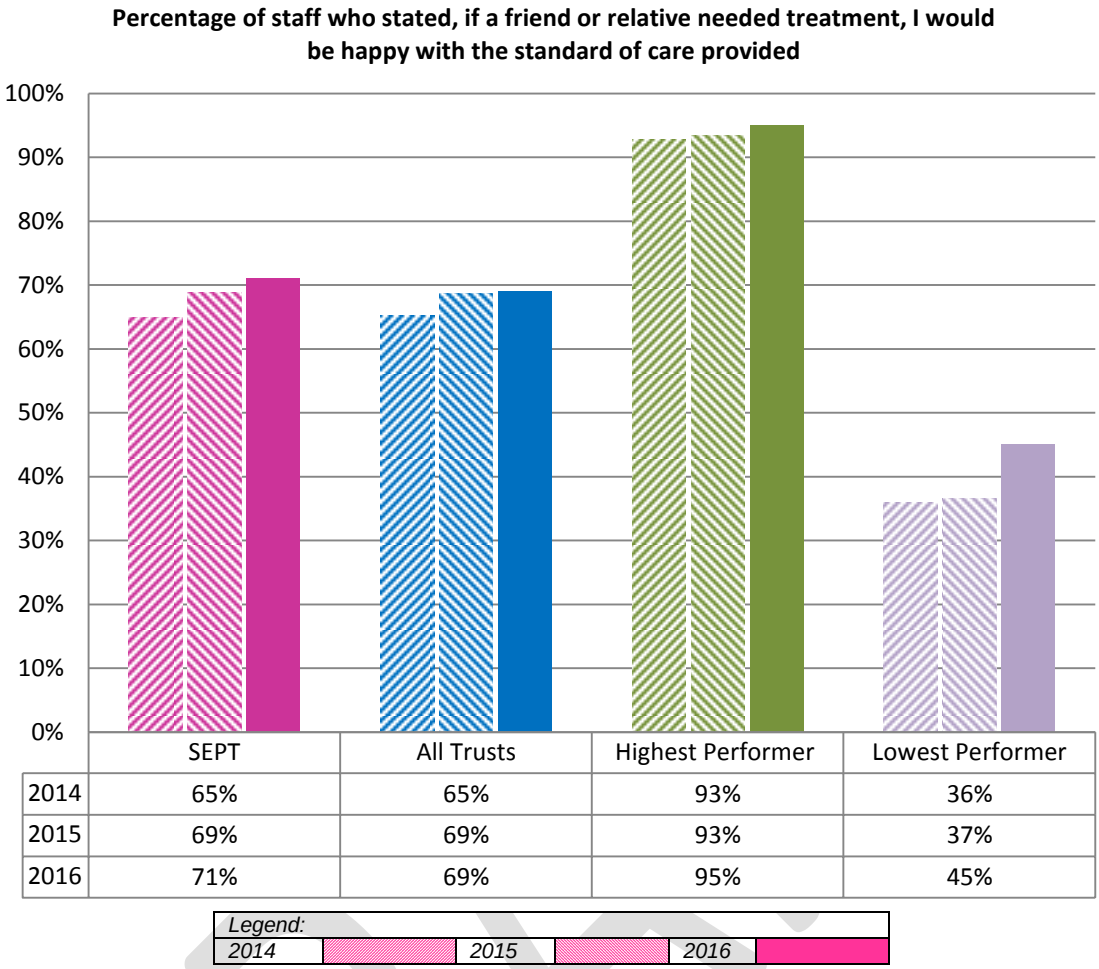
This target has been met consistently each quarter during 2016/17 and for the year as a whole.

In order to improve this percentage and thus the quality of services delivered, the senior operational staff in each locality responsible for the delivery of mental health services review the causes of any breaches each month to ensure that no common themes or trends are developing.

Please note, at the time of preparing this draft, Q4 figures (and refreshed Q1 – 3 figures) are still to be published nationally and figures may subsequently change in the final published Quality Report.

Data Source : DoH Unify2 Data Collection – MHPrvCom
National Definition applied: Yes

Staff who would recommend the Trust to their family or friends



	SEPT	All Trusts	Highest Performer	Lowest Performer
2014	65%	65%	93%	36%
2015	69%	69%	93%	37%
2016	71%	69%	95%	45%

SEPT participates on an annual basis in the national staff survey for NHS organisations. Within the survey staff are asked to answer the question "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation".

This year ALL staff received a survey – instead of just a sample size as per previous years. 1800 surveys were returned giving a response rate of 43%. This is an excellent response rate and carrying out a full census survey means we are able to get a truer picture of the levels of engagement within the organisation.

Our response rate remains in line with other combined mental health / learning disability and community trusts in England.

It is pleasing to note that the percentage of staff who stated that they would be happy with the standard of care provided if a friend or relative needed treatment continues to increase. Our level of satisfaction on this question is now above average nationally.

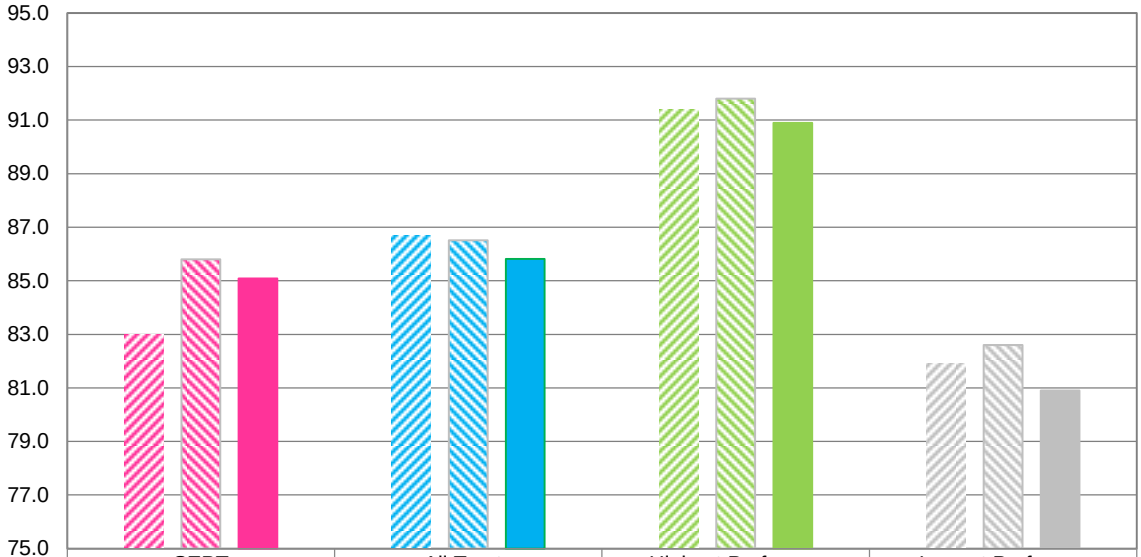
A full action plan to address the results of the staff survey is being implemented in order to ensure that the Trust continues to achieve positive results in this area. This will focus on our lowest performing areas of the survey and those questions where we were below the national average (only five out of a total of 32 questions).

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

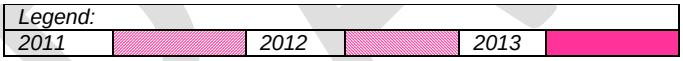
Data Source: National NHS Staff Survey Co-ordination Centre/ NHS Staff Surveys 2014, 2015, & 2016
National Definition applied: Yes

Patient experience of community mental health services

The Trust's 'Patient experience of community mental health services' indicator score reflects patients' experience of contact with a health or social care worker. The score was calculated as a weighted average of the responses to four distinct questions.

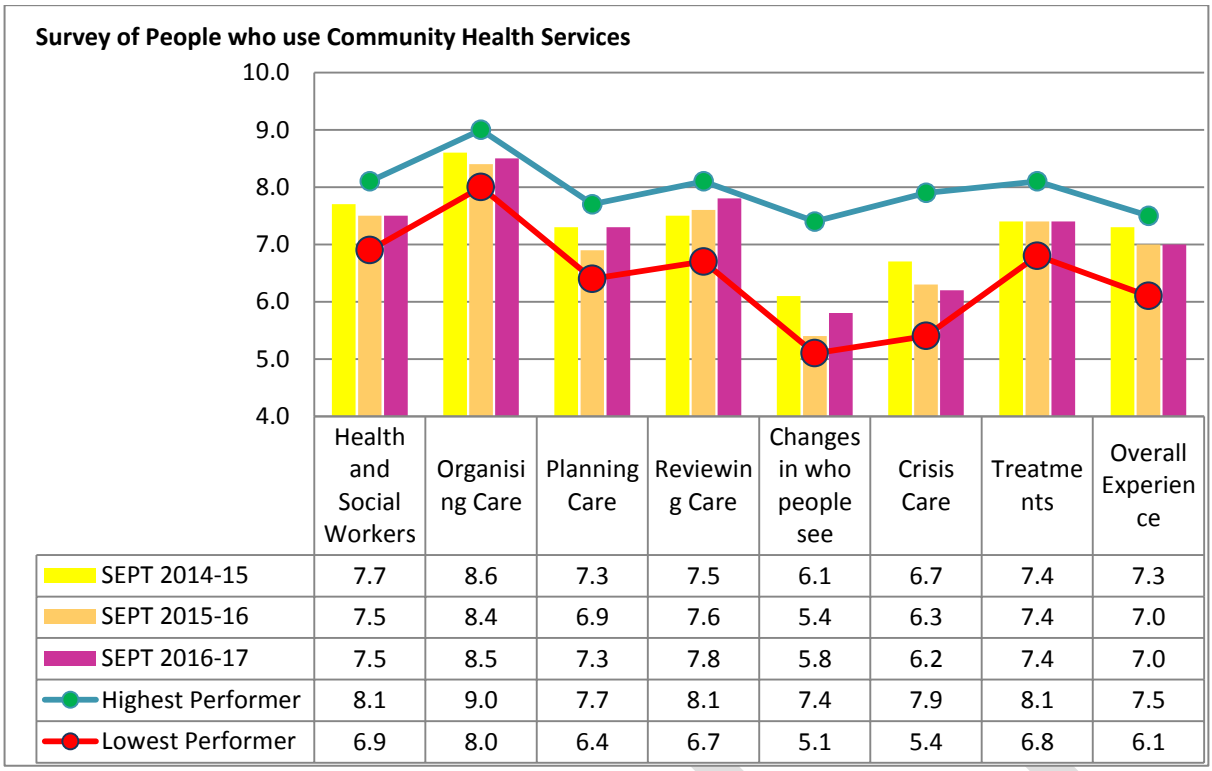


	SEPT	All Trusts	Highest Performer	Lowest Performer
2011	83.0	86.7	91.4	81.9
2012	85.8	86.5	91.8	82.6
2013	85.1	85.8	90.9	80.9



Please Note: Although the Trust has been mandated to provide this indicator in its Quality Account, due to a change in the national patient survey questions in 2014, the Health and Social Care Information Centre are no longer able to use the same questions to calculate an overall measure of patient experience for Trusts as they had done in previous years (and as reported above). Therefore, please find following a summary of the key section results of the Survey for 2014, 2015 and 2016 for information. The outcomes of all the community mental health surveys nationally can be found at http://www.cqc.org.uk/content/community-mental-health-survey .

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.



	Health and Social Workers	Organising Care	Planning Care	Reviewing Care	Changes in who people see	Crisis Care	Treatments	Overall Experience
SEPT 2014-15	7.7	8.6	7.3	7.5	6.1	6.7	7.4	7.3
SEPT 2015-16	7.5	8.4	6.9	7.6	5.4	6.3	7.4	7.0
SEPT 2016-17	7.5	8.5	7.3	7.8	5.8	6.2	7.4	7.0
Highest Performer	8.1	9.0	7.7	8.1	7.4	7.9	8.1	7.5
Lowest Performer	6.9	8.0	6.4	6.7	5.1	5.4	6.8	6.1

The results of the 2016/17 community mental health patient survey show that SEPT has scored “About the Same” as the England average and our score is within the expected range of results.

The results of the 2016/17 are compared in the graph above to the two previous years by section score. Across the eight section scores, SEPT is showing improvement in four sections, remaining the same as last year in three sections. However patient experience of crisis care has deteriorated slightly from 6.3/10 in 2015-16 to 6.2/10 in 2016-17

The Trust has developed an action plan to address the outcomes of the National Survey, ensuring that targeted action is taken to improve the quality of services. Its implementation is being overseen by the Senior Management Team, led by the Executive Director responsible for Mental Health Services.

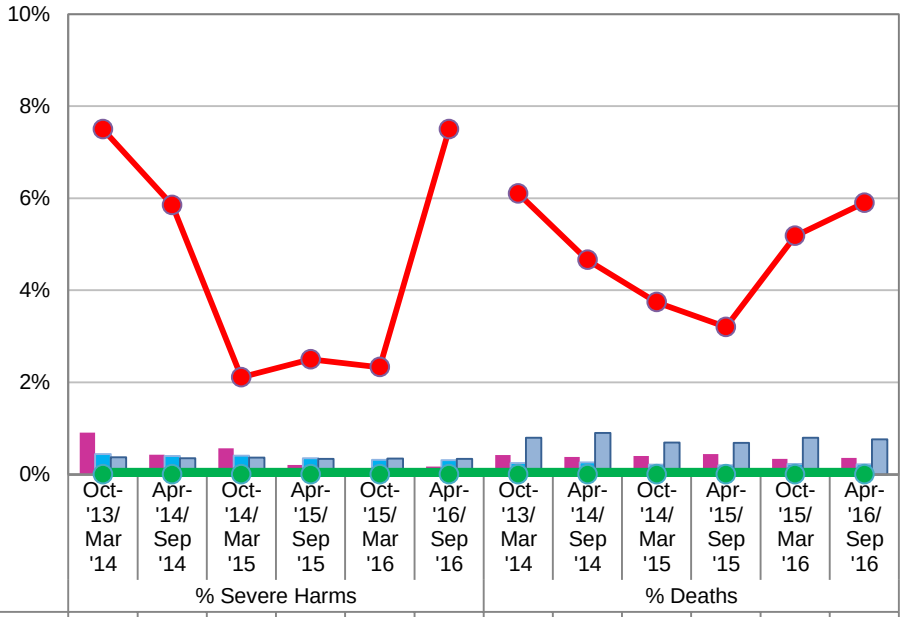
Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

Data Source: HSCIC/Community Mental Health Services Surveys
National Definition applied: Yes

Patient safety incidents and the percentage that resulted in severe harm or death

Reported Dates	1st October 2015 – 31st March 2016			1st April 2016 - 30th September 2016		
Organisation	All incidents	Severe harm	Deaths	All incidents	Severe harm	Deaths
All UK & Wales	906202	2875	2121	938314	2893	2032
SEPT	3807	2	13	3581	6	13

The graphs below shows the percentage of all incidents reported by SEPT to the NRLS that resulted in severe harm and those which resulted in death, compared to the rates of all UK & Wales NHS trusts, all Mental Health Trusts, and also includes the highest and lowest reported rates of all UK & Wales NHS trusts.



	% Severe Harms						% Deaths					
	Oct-'13/ Mar '14	Apr-'14/ Sep '14	Oct-'14/ Mar '15	Apr-'15/ Sep '15	Oct-'15/ Mar '16	Apr-'16/ Sep '16	Oct-'13/ Mar '14	Apr-'14/ Sep '14	Oct-'14/ Mar '15	Apr-'15/ Sep '15	Oct-'15/ Mar '16	Apr-'16/ Sep '16
SEPT	0.91%	0.43%	0.57%	0.21%	0.05%	0.17%	0.42%	0.38%	0.40%	0.44%	0.34%	0.36%
All Trusts	0.44%	0.40%	0.41%	0.35%	0.32%	0.31%	0.25%	0.26%	0.21%	0.20%	0.23%	0.22%
All Mental Health Trusts	0.37%	0.35%	0.37%	0.34%	0.34%	0.34%	0.80%	0.90%	0.69%	0.68%	0.80%	0.76%
Highest Reported	7.50%	5.85%	2.11%	2.50%	2.33%	7.50%	6.10%	4.66%	3.74%	3.20%	5.18%	5.90%
Lowest Reported	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Patient safety data for period 1st October 2015 to 31st March 2016 was published in September 2016. The report for the next 6 month period, ending 30th September was published in March 2017. The national collection of patient safety incident data for period 1st October 2016 to 31st March 2017 is due to be completed by the end of May 2017 and publication of reports is anticipated to be around September 2017.

The rate of incidents resulting in severe harm (detailed on the left-hand side of the above table/graph) which had previously shown a downward trend has increased in the final 6 months reported. These figures for the most recent period where national data is available show SEPT's % of severe harm (0.17%) remains below the national average for All Trusts (0.31%) and for All Mental Health Trusts (0.34%). The rate of incidents reported as resulting in death (detailed on the right-hand side of the above table/graph) is 0.36% for SEPT for the latest reported period. Whilst higher than the national average for All Trusts (0.22%), this compares favourably with the national average of All Mental Health Trusts (0.76%) and the highest reported rates of death (5.90%).

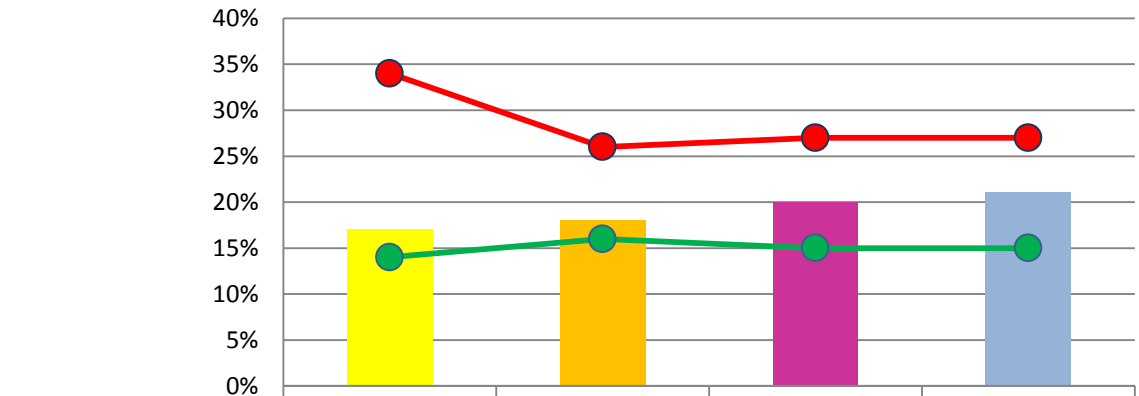
Significant work has been and continues to be taken forward across the Trust to reduce harm and details of some of this work are included throughout this report. A number of the quality priorities for the coming year outlined in section 2.2 are specifically intended to reduce incidents resulting in harm; and work in this area will continue to be monitored closely by the Trust.

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

Data source: NRLS NPSA Submissions
National Definition applied: Yes

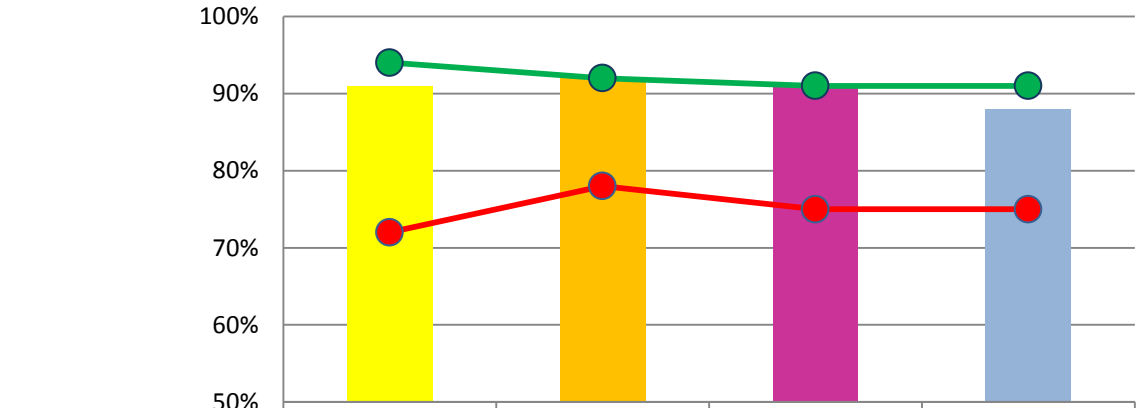
Workforce Race Equality Standard

KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



	2014 SEPT	2015 SEPT	2016 SEPT	All Trusts 2016
% SEPT Score	17%	18%	20%	21%
Highest Performer	34%	26%	27%	27%
Lowest Performer	14%	16%	15%	15%

KF21 Percentage of staff believing that trust provides equal opportunities for career progression or promotion



	2014 SEPT	2015 SEPT	2016 SEPT	All Trusts 2016
% SEPT Score	91%	92%	91%	88%
Highest Performer	94%	92%	91%	91%
Lowest Performer	72%	78%	75%	75%

Even though we remain under the highest levels nationally, this year shows a steady increase in the proportion of respondents that have experienced some form of harassment or bullying at work. A specific bullying and harassment action plan has therefore been developed to address this over the financial year 2017/18 and progress in implementation will be monitored.

We are very pleased at the level of perception that there are career opportunities and our scores in this area are within the top scoring bracket for trusts of our type.

The work to improve the experience of our black, asian and minority ethnic workforce will be contained within its own Workforce Race Equality Standard (WRES) action plan which will be published with our full staff survey results in July 2017.

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

Data Source: National NHS Staff Survey Co-ordination Centre/ NHS Staff Surveys 2014, 2015, & 2016

National Definition applied: Yes

2.6 Implementing the Duty of Candour and "Sign up to Safety"

This year, NHS England have again asked Trusts to consider including information in their Quality Reports relating to the implementation of the Duty of Candour and of the national Sign Up To Safety (SUTS) campaign. The following sections therefore outline the progress made by SEPT in 2016/17.

Implementing the Duty of Candour

The *Duty of Candour* is the requirement for all clinicians, managers and healthcare staff to inform patients/relatives of any actions which have resulted in harm. It actively encourages transparency and openness and the Trust has a legal and contractual obligation to ensure compliance with the standard. SEPT has considered such openness and transparency to be vital in ensuring the safety and quality of services; and has continued to drive forward work in this area.

Work undertaken in 2016/17 has included:

- Mandatory online training courses for staff as follows:
  - Short overview course for all clinical staff
  - Detailed course for managers/team leads and senior staff.
- Duty of Candor and Being Open session included within Trust induction.
- The identification of a Family Liaison Officer / Duty of Candour lead for all serious incidents and weekly reporting to the Executive Team.
- Information and evidence in terms of meeting Duty of Candour requirements collated within Datix system.
- Weekly review of all moderate incidents to assess if the Duty of Candour is applicable and ensuring that necessary actions are taken.
- The addition of Duty of Candour sections to root cause analyses reports and the Decision Monitoring Tool for Serious Incidents to ensure it is addressed for all incidents.
- The introduction of monthly reporting in the Trust's Performance Report of relevant incidents, with weekly progress chaser / situation reports sent to Directors and senior managers.

The Trust is confident that the ongoing work being taken is contributing to the on-going development of a culture which is open and transparent.

Implementing "Sign up to Safety" (SUTS)

The Trust has been committed to "Sign Up To Safety" (SUTS), a national safety campaign, since its launch in June 2014. The mission of the national campaign is to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. A Safety Improvement Plan was developed by the Trust and submitted to NHS England. The Plan covers six priorities aligned with the Quality Strategy as follows:

- Early detection of deteriorating patient
- Avoidable pressure ulcers
- Avoidable falls
- Avoidable unexpected deaths
- Reduction in use of restraint
- Reduction in omitted doses of medication

These align with the six Quality Priorities SEPT set for 2016/17 (progress reported in section 3.1 of this report) and with Quality Priority 1 set for the new merged Trust (EPUT) for 2017/18 detailed in section 2.2.

Leads have been assigned to each of the "Sign up to Safety" workstreams to ensure the Safety Improvement Plan actions are taken forward and monthly meetings have been held with these workstream leads

throughout the year to review progress. A regular update on each workstream is presented to the Quality Committee. Key actions delivered this year include:

- Recruitment to Practice Educator posts with a focus on supporting staff with physical health skills.
- Review of the early warning scoring system chart (MEWS) and incorporation of a hydration status and Glasgow Coma Scoring chart to encourage an integrated approach when monitoring vital signs.
- Review of mandatory falls prevention training and implementation of a training package based on the national “Fallsafe” project.
- Development and recruitment to a new post of Falls Co-ordinator with responsibility for the provision of support to nursing, therapy and medical staff to provide a systematic approach to falls prevention and management.
- Investment in a wide range of falls prevention assistive technology and a digital reminiscence therapy system for older people’s wards that helps clinical staff in the delivery of better care by tailoring meaningful activities for their patients.

The leads have continued to work with the national team to ensure best practice is implemented in the Trust and have also made links with a number of other organisations involved in the initiative with the aim of sharing best practice and learning. Work has taken place to align NEP and SEPT SUTS workstreams and actions; and a new SUTS action plan is to be developed for EPUT in 2017/18.

PART 3:
REVIEW OF SEPT QUALITY PERFORMANCE DURING 2016/17

This section of the Quality Report outlines the Trusts performance over the past year in terms of delivering on the quality priorities set out in the SEPT Quality Report 2015/16. It also details performance against some key indicators of quality service which have been reported on in previous years. The tables include previous year's results too as this gives an indication of whether the Trust is getting better at quality or if there are areas where action needs to be taken to improve. Where this is the case, we have detailed the actions we intend to take.

This part of the Quality Report is divided into five sections, as follows:

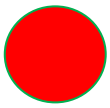
Section	Content	Page
3.1	Progress against our quality priorities for 2016/17 (which were outlined in our Quality Report 2015/16) – we have included historic and benchmarking data, where this is available, to enable identification of whether performance is improving	**34**
3.2	Some examples of local service quality improvements and Trust workforce development initiatives delivered during 2016/17	**46**
3.3	Performance against SEPT Trust wide and service specific quality indicators • Trust wide quality indicators • Community Health Services quality indicators • Mental Health Services quality indicator	**54** **62** **65**
3.4	Performance against key national indicators and thresholds mandated nationally which are relevant to SEPT from the NHS Improvement Single Oversight Framework (as specified in the NHS Improvement Quality Reports Guidance for 2016/17)	**67**
3.5	Listening to our patients / service users. This section details some of the work the Trust has undertaken to capture patient experience and use this to help improve the quality of services	**71**

To enable readers to get an understanding of the Trust's performance in local areas, performance against indicators is detailed by locality area where it is possible to do so.

Section 3.1: Progress against the quality priorities we set for 2016/17

The SEPT Board of Directors considered the strategic context, their knowledge of the Trust and the feedback from staff and stakeholders during the planning cycle and identified six Quality Priorities for 2016/17. These built on our quality priorities for 2015/16 and are linked with the national 'Sign up to Safety' Campaign.

RAG (**R**ed **A**mber **G**reen) ratings have been applied to provide an accessible method of understanding the levels of performance. RAG ratings should be used in conjunction with the actual levels of performance which are also quantified in the charts that follow.



RAG rated **RED** to indicate that performance has not met the target by more than 10%
(Avoidable Falls employs a 20% threshold due to small numbers)

R**A**G rated **AMBER** to indicate that performance has met the target by +/- 10%.
(Avoidable Falls employs a 20% threshold due to small numbers)

RA**G** rated **GREEN** to indicate that performance has exceeded the target by more than 10%.
(Avoidable Falls employs a 20% threshold due to small numbers)

The provision of mental health services in Bedfordshire and Luton was transferred to a new provider from 1st April 2015. Data for these services has therefore been extracted for the purposes of the historical data presented in this section so that it is possible to make meaningful year-on-year comparisons of the data presented.

Quality priority: To reduce the number of restrictive practices undertaken across the Trust

TARGET: *We said we would have less prone restraints in 2016/17 compared to 2015/16 (266 prone restraints)*

Data source: Datix
National Definition applied: Yes

Why did we set this priority?

Across health and social care services, people who present with behaviour that challenges are at higher risk of being subjected to restrictive interventions. These can include physical restraint, seclusion and segregation. Many restrictive interventions place people who use services, and to a lesser degree staff and those who provide support, at risk of physical and/or emotional harm. Increasing concerns about the inappropriate use of restrictive interventions across health and care settings led to guidance being developed.

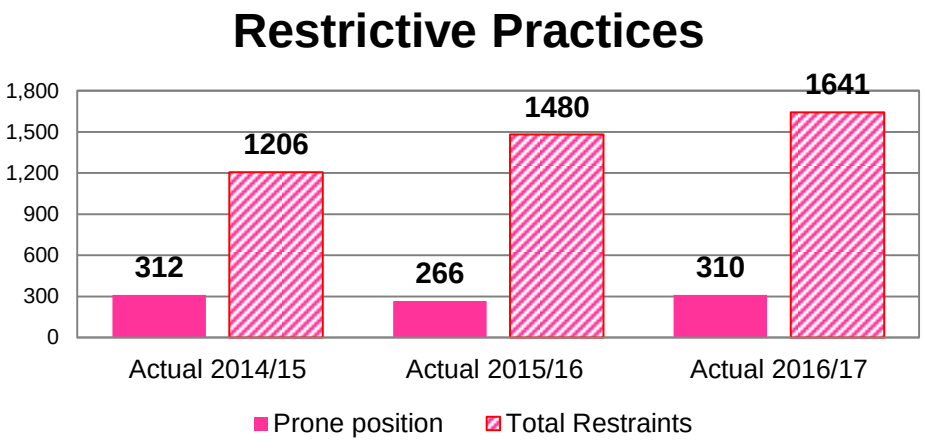
During 2016/17 we have taken the following actions:

- Worked to NICE guidance of Management of Violence and Aggression.
- Reviewed and updated training programmes.
- Built on existing networks across health to support best practice and learned from other trusts.

Has the target been achieved?

The Trust has not achieved this target. During 2016/17 the number of prone restraints was 310, which is an increase on the 266 reported in 2015/16. The table below also illustrates an increase in total reported restraints (from 1480 to 1641). These increases are considered likely to be the result of increased awareness and reporting of restrictive practices due to the focused work in this area and also a rise in the number of patients who presented particularly challenging behaviours. Following the publication of the DOH benchmarking report on the use of restraints, further analysis of the use of restraints has been undertaken. The figures show that using the DOH benchmark of restraints per 10 beds, SEPT has a monthly average of 2.85 uses of restraint per 10 beds over the year to date. This is higher than the national average of 2.80.

Reduction in the number of restraints in in-patient areas has again been set as a quality priority for 2017/18 and monitoring processes are in place. A programme of work is in place with the aim of achieving a reduction; implementation progress and numbers of restrictive practices will be closely monitored through 2017/18. The Restrictive Practice Steering Group has also set a target for zero avoidable restraint which will be monitored.



.

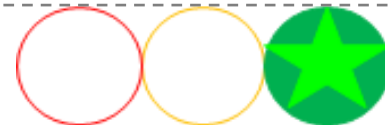
3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

Quality priority: To further reduce the number of avoidable grade 3 and 4 Pressure Ulcers acquired in our care.

TARGET: *We said we would have less avoidable grade 3 and 4 pressure ulcers acquired in our care in 2016/17 compared to 2015/16.*

A total of 17 avoidable pressure ulcers were identified following RCAs for 2015/16.

Data source: Datix
National Definition applied: Yes



Why did we set this priority?
Avoidable pressure ulcers are seen as a key indicator of the quality of nursing care and preventing them happening will improve all care for vulnerable patients. Within SEPT over the past 3 years, we have had an ambition for 'no avoidable pressure ulcers' and a number of areas of work had been taken forward with significant progress, but this work needed to be sustained to meet our ambition.

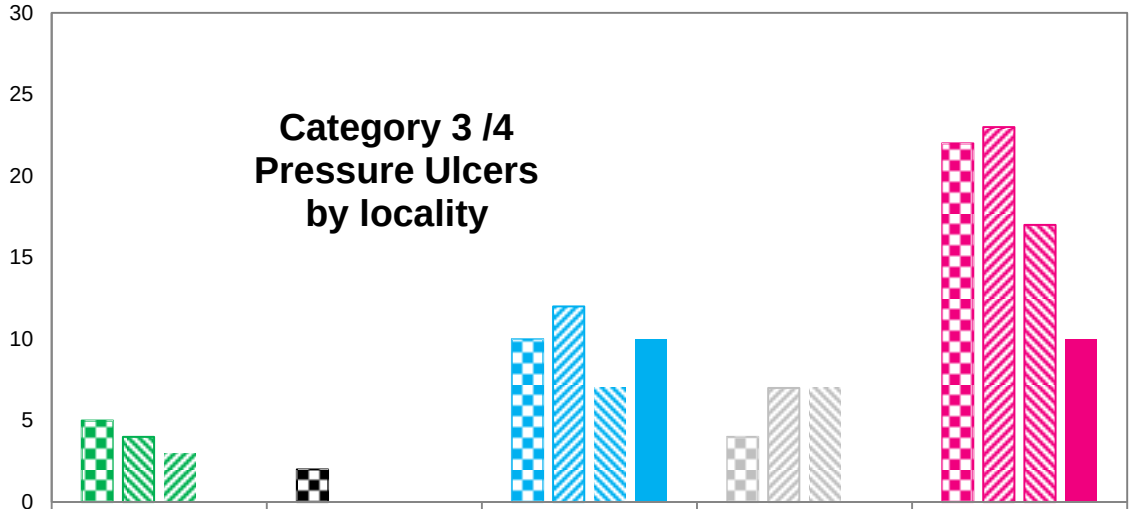
During 2016/17 we have taken the following actions:

- Continuation of Skin Matters groups within each community service.
- Facilitated an independent review of Skin Matters panels to ensure robust procedures/scrutiny continue, and that learning identified during the review process is taken forward.
- Learning from RCAs undertaken for category 3 and 4 pressure ulcers shared with teams.
- Review of policy and procedures to ensure compliance with NICE Guidance and European Pressure Ulcer Advisory Panel (EPUAP) guidance.
- Developed and embedded a process for reporting and managing Suspected Deep Tissue Injuries (SDTIs).
- Celebrating World Stop the Pressure Day with events held to engage with the public over supporting themselves and relatives to understand the risks and how to avoid pressure ulcer development.
- Tissue Viability Nurse attendance at regional networking meetings, national and international conferences to ensure awareness of best practice developments and innovations are considered and implemented where appropriate.
- Review of National Sign Up To Safety work streams regarding pressure ulcers.
- Formulary reviews with pharmacy and wound management colleagues to ensure prescribing guidelines and product availability are in line with best practice.
- Initiated a review of diabetic foot ulcer prevalence in South East Essex to consider the next steps in taking forward a work stream relating to this issue.
- Confirmed our commitment to the NHSI relaunch of the ambition to reduce/eliminate avoidable pressure ulcers.
- Formalised a reporting process for poor discharges for patients from acute trusts (in the context that pressure ulcer management has featured in a percentage of poor discharges).

Has the target been achieved?

The Trust has achieved this target. During 2016/17 the Trust has identified 10 avoidable grade 3 / 4 pressure ulcers, which is seven fewer than in 2015/16. In addition, it is very positive to note that two out of the three community health services have achieved zero avoidable pressure ulcers.

The variation in the number of pressure ulcers in South East Essex compared to other localities is attributed to different SEPT services being commissioned in each area, together with different operating practices within these services. The Trust has commissioned an analysis of the reporting of avoidable grade 3 /4 pressure ulcers across localities to determine the root cause of the variation. In addition, the Skin Matters process has identified areas of learning required within the community teams and these are being addressed through formal and informal education sessions, enhanced supervision for staff (including reflective practice) and review of pathways for equipment provision to ensure they are clear and comprehensive.



	Bedfordshire CHS	South Essex MH	South East Essex CHS	West Essex CHS	SEPT
2013/14	5	2	10	4	22
2014/15	4	0	12	7	23
2015/16	3	0	7	7	17
2016/17	0	0	10	0	10

Please note, one additional avoidable pressure ulcer identified in SEECHS in 2015/16 after publication of the Quality Report 2015/16 as a result of RCAs completed after preparation of the document.

The Trust also has 45 Root Cause Analyses underway at the end of 2016/17 and there is the potential for some of these to be classified as avoidable grade 3 / 4 pressure ulcers when the investigations are complete. As a comparator, last year the Trust had 115 Root Cause Analyses underway at the end of 2015/16 and only one additional avoidable grade 3 / 4 pressure ulcer was identified when the investigations were complete.

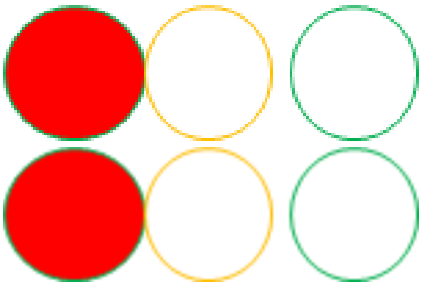
3.1.1 Safety 3.1.2 Experience 3.1.3 Effectiveness

Quality priority: Reduction in avoidable falls that result in moderate or severe harm within inpatient areas

TARGETS:

1. We said we would have less avoidable falls that result in moderate or severe harm in 2016/17 compared to 2015/16.

2.We said we would have a reduction in the number of patients who experience more than one fall in 2016/17 compared to 2015/16 (203).



Data source: DATIX
National Definition applied: Yes

Why did we set this priority?

Across England and Wales, over 36,000 falls are reported from mental health units and 28,000 from community hospitals. Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. Hip fracture is the most common serious injury related to falls in older people, resulting in an annual cost to the NHS of around £1.7 billion for England. Of this, 45% of the cost is for acute care, 50% for social care and long term hospitalisation, and 5% for drugs and follow up.

The causes of falls are multifaceted. People aged 65 years and older have the highest risk of falling, with 30% of the population over 65 years and 50% of those older than 80 years falling at least once a year. People admitted to hospital are extremely vulnerable as a result of their medical condition, as are those with dementia. Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in those over the age of 75 years. Prevention of falls is a vitally important patient safety challenge as the human cost includes distress, pain, injury, loss of confidence and independence and, in some cases, death. Since 2013/14, the trust has had a priority to reduce the level of avoidable falls, and again a number of areas of work had been taken forward with significant progress, but this work needed to be sustained to meet our ambition.

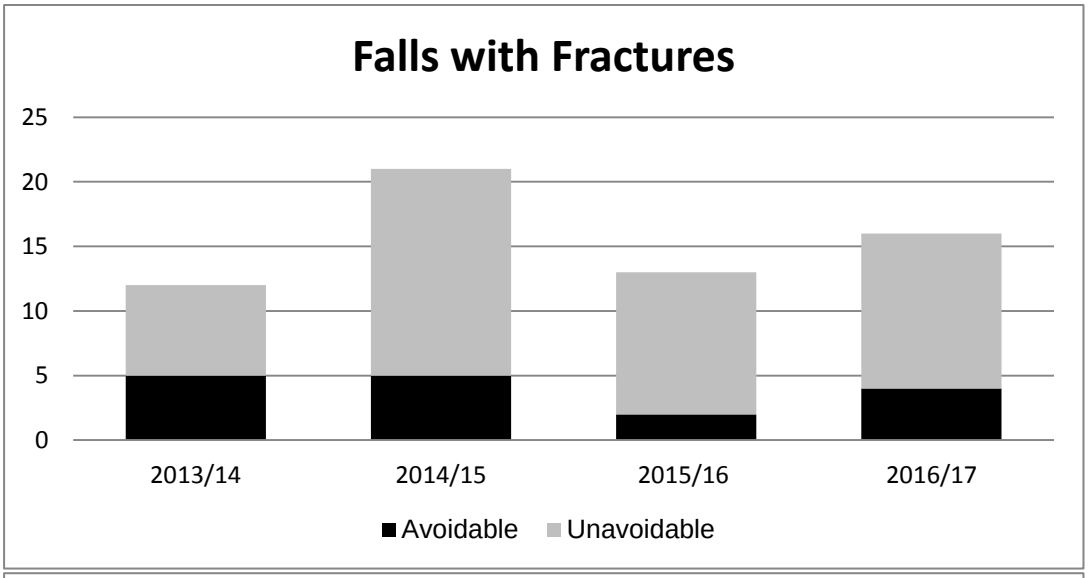
During 2016/17 we have taken the following actions:

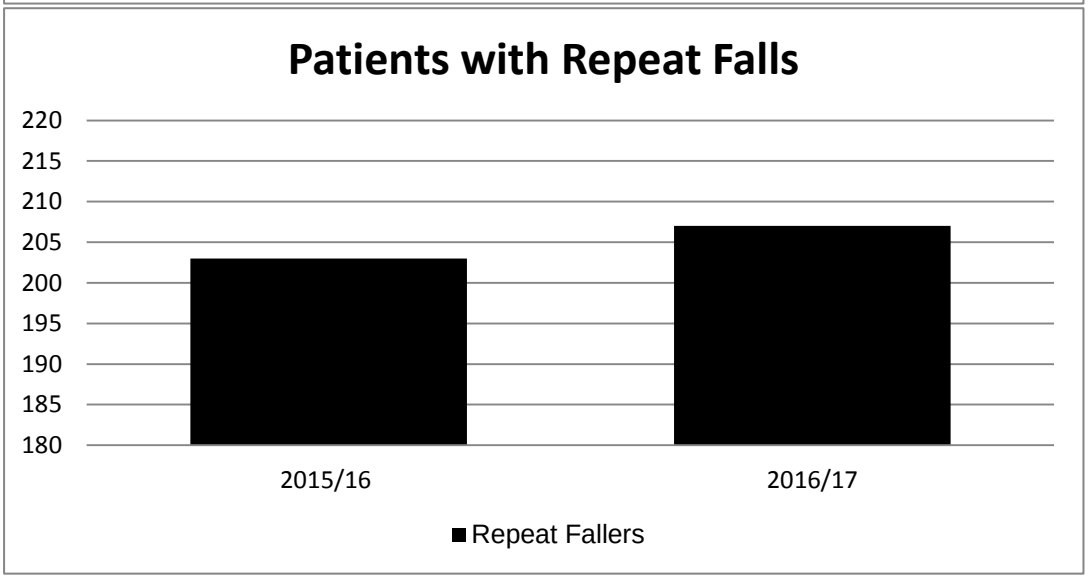
- Continuation of the Trust wide Falls Group with strengthened multi-disciplinary membership.
- Introduced a training package for registered staff on older people's wards based on the national Fallsafe Project. This includes patient risk factors, environmental risk factors, the use of specialist equipment and actions to be taken following a fall.
- Face to face training has also been delivered on olders people's inpatient units.
- Further reviewed the Trust wide Risk Assessment tool to ensure that the complex nature and causes of falls were captured and to support clinical decision making in the prevention and management of falls.
- Refinement of the Root Cause Analysis tool.
- Recruitment to a new post of Falls Co-ordinator – a physiotherapist with responsibility for taking a primary role in providing support to staff around falls prevention and management.
- Purchase of a digital reminiscence therapy system for older people's wards.

Have the targets been achieved?

The target to have fewer avoidable falls has not been met. During 2016/17 there was a total of 4 avoidable falls (out of a total of 16 falls classified as serious incidents). This is an increase of 2 against the total of 2 avoidable falls in 2015/16. However, this figure still represents a significant decrease from the baseline of 14 avoidable falls when falls work started in 2013/14 and the number of falls classified as serious incidents has decreased from 21 in 2014/15 to 16 in 2016/17.

The target to reduce the number of patients who experience more than one fall has not been met. During 2016/17 there was a total of 207 patients who experienced more than one fall compared to 203 for 2015/16. This represents an increase of 2%. It is possible that increased awareness of repeat fallers and a concurrent improvement in reporting rates have contributed to the increase in the number of repeat fallers identified.





We continue with our commitment to provide a safe and therapeutic environment for all patients in our care. The trust is one of nineteen in the country to be part of the NHSI Falls Collaborative, of which only three are mental health/integrated mental health and community health trusts. Participation in this important initiative will provide staff with vital quality improvement skills and create a system devoted to continuous learning and improvement.

We will continue work in this area through our Sign Up To Safety workstream. Further work will include targeted support to those areas where patients experience the greatest number of falls. This will include the introduction of Falls Care Bundles which are a set of interventions that, when used together, significantly improve patient outcomes.

3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

Quality priority: To embed system of early detection of deteriorating patient and preventative actions

TARGET 1: *We said we would increase the % of Modified Early Warning System (MEWS) scores recorded during 2016/17 from the baseline established in 2015/16 (70%).*

TARGET 2: *We said we would increase the % of MEWS scores greater than 4 (or a single score of 3) that are escalated appropriately (57%).*

Data source: Audit
National Definition applied: Yes

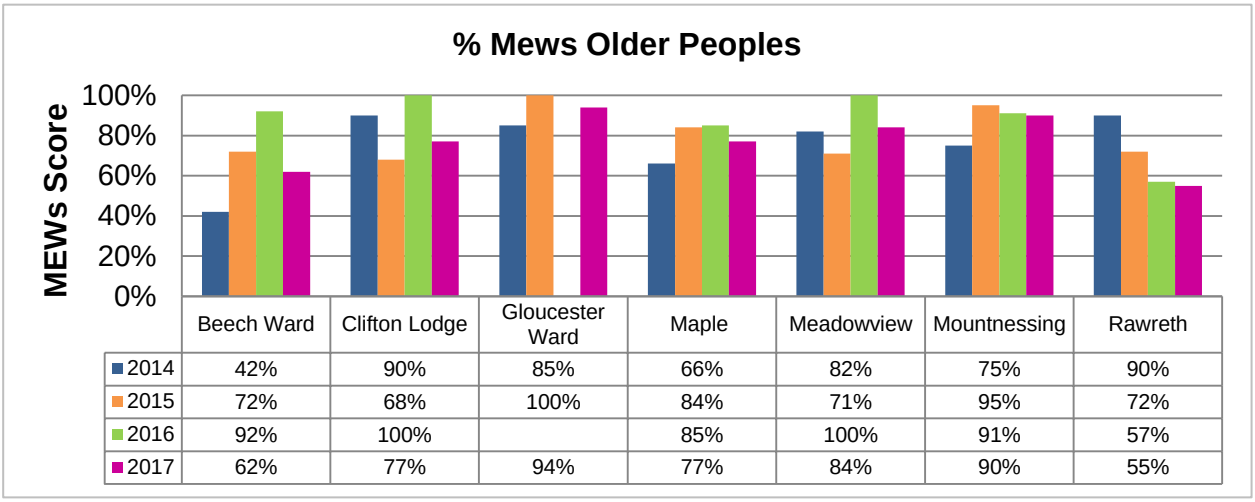
Why did we set this priority?
People with mental illness today have life expectancies as low as that of the general population of the UK in the 1950s and they account for more than a third of the 100,000 annual avoidable deaths from physical illnesses in the UK each year. They have three times the risk than the general UK population of dying from preventable coronary artery disease and are more likely than the general UK population to develop preventable and treatable long term physical health conditions (such as type 2 diabetes and hypertension) which, if unmanaged, are key causes of early preventable death. Physical healthcare assessment is a vital part of the holistic assessment and supports early detection of deteriorating patients. Current evidence suggests that early detection, timeliness of response and competency of the staff involved are vital to defining positive clinical outcomes.

During 2016/17 we have taken the following actions:

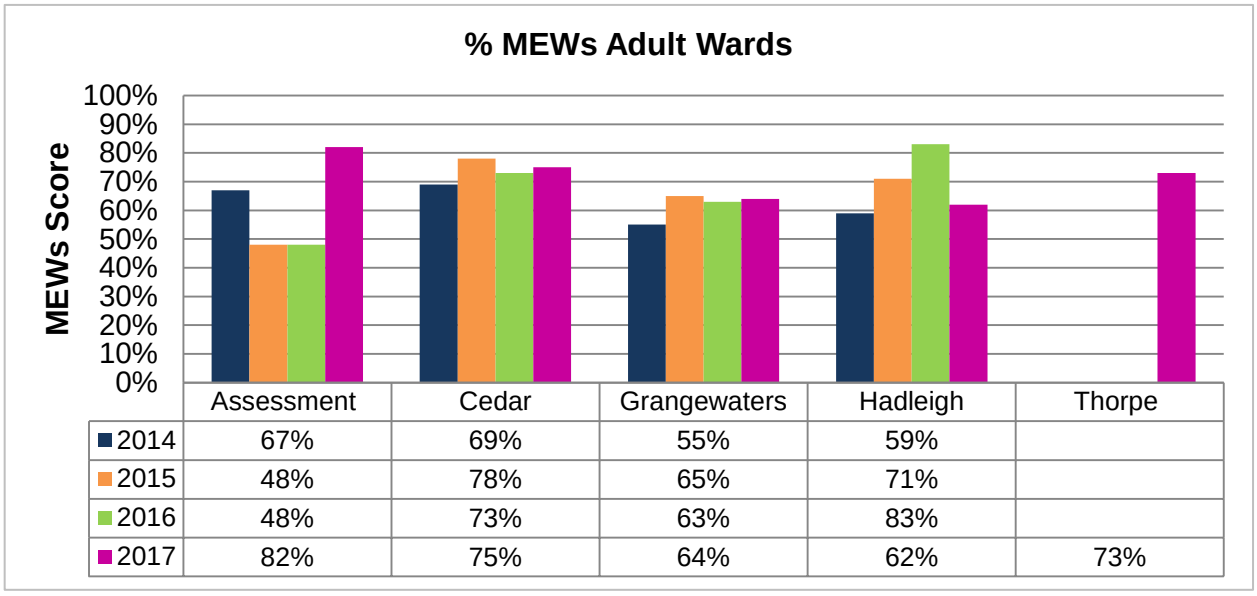
- The observation chart used to monitor patients' physical vital signs and act as an early warning system (MEWS) has been reviewed and revised to support more effective reporting. The aim of the scoring system is to standardise assessment of the severity of acute physical illness so that patients who are deteriorating physically or at risk of deteriorating are identified and managed consistently.
- The trust recruited to two fixed term Practice Educator posts with a focus on supporting staff with physical health skills and in particular how to identify patients who are or may becoming acutely physically unwell.
- Training in vital signs monitoring, interpretation and escalation of concerns continued and in order to maximise uptake, was delivered through a number of routes including being added to existing mandatory training. Additionally staff were supported with training in the clinical environment using scenario based situations on detecting patients who were becoming acutely physically unwell.
- The audit on use of MEWS has been expanded to include a review of patients with a raised MEWS score who are escalated appropriately.

Has the target been achieved?

The target to increase the % of MEWS scores recorded has not been achieved. Audits have been undertaken during 2016/17 which have resulted in an overall figure of 70% of MEWS scores being recorded. This is the same as the baseline figure of 70% for 2015/16. Two audits are undertaken per year and it is disappointing to note that the improved results of the first audit in 2016/17 were not maintained throughout the financial year and evidenced in the final audit result of 70%. The graphs below demonstrate baseline findings and use of MEWS from the recent audit on both older peoples and adult wards.



	Beech Ward	Clifton Lodge	Gloucester Ward	Maple	Meadowview	Mountnessing	Rawreth
2014	42%	90%	85%	66%	82%	75%	90%
2015	72%	68%	100%	84%	71%	95%	72%
2016	92%	100%		85%	100%	91%	57%
2017	62%	77%	94%	77%	84%	90%	55%



	Assessment	Cedar	Grangewaters	Hadleigh	Thorpe
2014	67%	69%	55%	59%	
2015	48%	78%	65%	71%	
2016	48%	73%	63%	83%	
2017	82%	75%	64%	62%	73%

The target to increase the % of patients with a MEWS score greater than 4 (or a single score of 3) that are escalated appropriately has not been met. In 2016/17 the Trust escalated 22%, compared to the 2015/16 baseline of 57%. Inpatient staff have confirmed that they escalate following indications of deterioration and action is taken and discussions take place during handover. We will continue to ensure that our patients receive the safest and most effective care. This will be achieved through supporting staff working in mental health in the development of quality improvement skills and the knowledge and understanding required to recognise and respond to physical health deterioration. An action plan is being developed to address the decrease in escalation. Further work is underway to introduce the principles of the deteriorating patient to the annual mandatory Enhanced Emergency Skills training to increase coverage of training. In addition, on-site training has been delivered to the wards.

3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

Quality priority: Reduction in unexpected deaths (suicides)

TARGET: *We said we would implement a bespoke training package for suicide intervention and train 50% of relevant mental health front line staff during 2016/17.*

Why did we set this priority?
Around 4,400 people end their own lives in England each year, that is one death every two hours and at least 10 times that number attempt suicide. People with a diagnosed mental health condition are at particular risk and around 90% of suicide victims diagnosed with a mental illness suffer from a psychiatric disorder at the time of their death, although three-quarters of all people who end their own lives are not in contact with mental health services. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

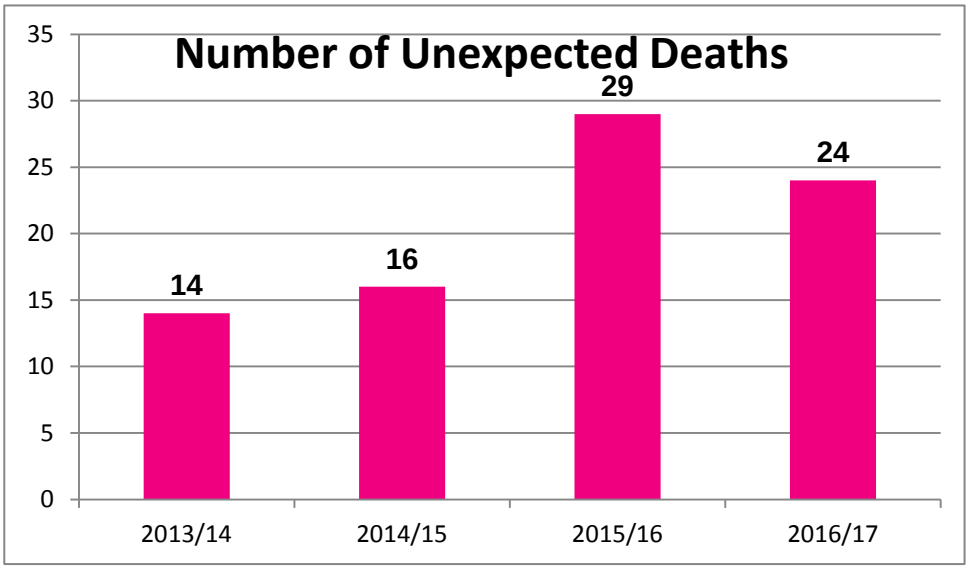
During 2016/17 we have taken the following actions:

- Reviewed the training programme and implemented a bespoke training programme targeted at equipping staff with the knowledge and skills to deliver appropriate interventions with the aim of preventing suicide.
- Purchased the "Connecting with People" suicide prevention training package consisting of three distinct modules. Seven clinicians have been trained to deliver the modules.
- In January 2017 it was recognised that more trainers were required to roll out the training and the Trust has therefore commissioned further "train the trainer" training for 8 more clinicians.
- Training was initially targeted at CRHT, First Response and the Mental Health Assessment Unit staff, but any available places have been utilised for other clinical staff.
- Engaged further with all members of the multi-disciplinary team to deliver suicide prevention culture across the Trust.
- Undertaken baseline audits of current practice in the detection and prevention of suicide, identify actions to be taken forward and repeat audits at agreed timeframes to monitor improvements.
- Raised public awareness.
- Purchased a range of self-help leaflets which complement the training and allow clinicians to make emergency safety plans with people in distress.

Has the target been achieved?

Training commenced at the end of quarter three and, as at the end of quarter four, 58 staff had been trained. This is below the target of 50% of frontline staff set. However, the requirement for additional trainer capacity to achieve the required roll out was identified in January 2017 and an additional 8 trainers are to be trained which will improve the capacity to roll out training to front line staff. The training will be reviewed with colleagues from North Essex who have also been providing training as part of the NEP Sign up to Safety Suicide Prevention work-stream, with a view to agreeing the training approach to be adopted by EPUT into the future.

Although the training target has not been achieved, the graph below indicates that an overall reduction in the number of unexpected deaths from 29 in 2015/16 to 24 in 2016/17 has been achieved.



3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

Quality priority: To reduce the number of medication omissions across the Trust and to reduce the number of medication omissions where no reason code is annotated.

TARGET: *We said we would reduce the number of omitted doses within services in 2016/17, compared to 2015/16.*

Data source: Audit
National Definition applied: Yes

Why did we set this priority?
Care Quality Commission standards require that people who use services will have their medicines at the time they need them and in a safe way. Between 2005 and 2010 more than 82,000 incidents involving omitted and delayed medicines were reported nationally to the National Reporting and Learning System (NRLS). 'Omitted and delayed medicines' was the most commonly reported category, accounting for nearly 16% of all medication incidents.

For some medicines such as antibiotics, anticoagulants and insulin, a missed dose can have serious or even fatal consequences. In some conditions it may lead to slower recovery or loss of function.

Doses of medicines may be omitted for a variety of reasons. Causes include:
- a valid clinical reason for not giving the medicine;
- the intention to prescribe a new or regular medicine is not carried through;
- the medicine is not available on the ward / in the patient's home;
- the route of administration is not available (i.e. nil by mouth, IV line tissued);
- the patient is away from the ward or out when visited at home;
- poor communication between or within teams about the patient's needs;
- the patient refuses the medication.

During 2016/17 we have taken the following actions:
- Continued with Medicines Task and Finish Group as part of the Sign up to Safety campaign;
- Improved the reporting of omitted doses of medicines which occur within Community Health Services, especially community-based services; and
- Reviewed omitted medicines incidents as part of quarterly review of medication-related incidents at both Medicines Management Groups.

Has the target been achieved?
The Trust has not achieved the target to reduce the incidence of omitted doses.

	Total doses to be administered during period	Total doses omitted	% Omitted Doses	% Omitted Doses adjusted for clinical omissions (inc patient refusal)
MH & LD	29,665	1,215	4.1%	0.8%
CHS	7,515	324	4.3%	1.3%
Total	**37,177**	**1,539**	**4.1%**	**0.9%**

The 2017 audit demonstrated a slight deterioration over the 2016 results (0.9% compared with 0.8% in 2016), but overall this regular audit demonstrates an improving trend over the previous six years (2016 0.8%, 2014 1.3%; 2013 1.5%; 2011 1.9%).

In *Mental Health Services,* 29,665 doses of medication were due to be administered during the audit period. 0.8% of doses were omitted without a valid clinical reason (including patient refusal) against 1.2% in the audit undertaken in 2015/16.

In *Community Health Services*, 7.512 doses of medication were due to be administered during the audit period. 1.3% of doses were omitted without a valid clinical reason (including patient refusal) against 0.4% in the audit undertaken in 2016.

The Trust has developed a Safety Improvement Plan to support its commitment to the national Sign up to Safety campaign. The Sign up to Safety launch was used as an opportunity for front-line staff to volunteer or be nominated to participate in the future work of this workstream. Further actions identified at present include:

- Establishing the primary and secondary drivers for reducing the number of omitted doses which there is no clinically valid reason.
- Continue DATIX reporting and identify any areas to link with further improvements.
- Improving reporting of omitted doses of medicines which occur within Community Health Services, especially community-based services.
- Develop a mechanism for providing feedback to teams & services on reported incidents.
- Explore the use of a regular reporting tool, such as the NHS Medication Safety Thermometer to promote ownership at ward/team level.
- Explore potential training and resources within mental health and learning disabilities services to improve understanding of the risks associated with omitted doses of medication for physical health conditions.
- Explore whether advice is needed on how to approach patients who refuse medication.

Section 3.2: Examples of local service quality improvements and Trust Workforce Developments during 2016/17

Outlined below are some examples of quality improvements that have been achieved by SEPT services during 2016/17 to provide a flavour of the diversity of initiatives we are working on and the progress we are making in improving the quality of care we provide to our patients and users. Due to the diversity and volume of services we provide, we only have room to include very brief details in this report - please do get in touch with us (contact details are at the end of this report) if you would like further details about any of the initiatives listed.

Bedfordshire Community Health Services (Adults)

- Adult services are working with Local Authority colleagues to discuss the **development of improved integrated discharge planning** and develop more robust communication and monitoring systems.
- **Health Care Assistants** working with Community Nursing teams are now **delivering Low Molecular Heparin injections** to increase registered nursing time available for other responsibilities.
- Palliative Care nurses have introduced **Advanced Care Planning** and are implementing an **Outcome Assessment Complexity and Collaboration (OACC) pilot**. Discharge planning support packs have been distributed to 5 local acute trust providers to improve discharge planning processes and to aim to reduce unsafe discharges.
- All specialist nursing services are now using **Peer Review processes to review patient documentation** in order to improve record keeping and care planning standards.
- **Community Matron caseload is now shared with both acute trusts weekly** to improve communication routes and provide the opportunity for patients to be turned around in emergency departments back into community services if appropriate.

Bedfordshire Community Health Services (Childrens)

- Collaboration to implement the **Asthma Friendly Schools** programme: all early years settings and schools staff have received training to manage emergency action on Asthma. School nurses are supporting the co-ordination of asthma champions in every school in Bedfordshire.
- **Future in Mind Schools project** is now in place where School Nurses offer emotional wellbeing support to young people and collaborate with Child and Adolescent Mental Health Service workers based in upper schools across Bedfordshire.
- Development of 11 **Perinatal and Infant mental health champions** across the 0-19 service who will train all partner agencies in detection and support of mothers with postnatal depression.
- Collaboration with ELFT to deliver the **Mums Matter's programme** for parents with perinatal mental health needs.
- Successful delivery of **25,263 vaccines** to school age children across Bedfordshire.
- Redesign of the **websites for both Health Visiting and School Nursing** to improve accessibility and information provision for families with children 0-19 years.
- Development and cascade of **Working Agreements** between Health Visiting and GP's and School Nurses and schools to enhance communication, relationships and working together.
- Development of the **Nurse Led Continence Pathway** including workshops for parents with children with complex needs.
- Roll out of **Health Passports** to improve communication between partners who work with children with complex needs.
- Development of an **Integrated Autism Pathway** including Nurse led clinics for post diagnosis follow up.

Bedfordshire Community Health Services (Specialist)

- The Nutrition and Dietetic Service undertook an **audit of obesity referrals** in to the service for Luton which they have presented to Luton Borough Council as part of obesity pathway redesign to influence future commissioning and service design for childhood obesity.

- The Nutrition and Dietetic adult services completed a service review following which **internal processes have been redesigned to create capacity and increase flexibility** within the service to meet unpredictable and fluctuating demands.
- Introduction of an **eligibility assessment telephone appointment** before booking a dietitian home visit (for both home visit referrals and home-enterally fed patients) in order to eliminate unnecessary home visits, therefore creating capacity to help cope with rising demands and complexity of referrals.
- **Redesign of nutrition and dietetic clinics** by amending sessions, timings of appointment slots, method of booking appointments and creation of letter writing guidelines within the department. This has led to a decrease in admin time for dietitians and administrative staff, decreased DNA rates and decreased waiting times from 12-14 weeks to 8-9 weeks for adults. In addition, paediatrics have reduced 18 week breaches by 80% despite a rising number of referrals.
- **Streamlining of triaging/coding of referral processes** including creation of standard letters within the nutrition and dietetic department. This has resulted in reduced dietitian administrative time as referrals can be processed more quickly therefore patients are waiting less time to receive referral acknowledgment.
- The Food First team have developed **referral criteria and a new referral form for older people care homes** to use. In addition, referrals which are declined are evaluated to ensure appropriateness and safety of the criteria.
- The Food First team have updated their **care home audit standards** to ensure a more objective and consistent approach when awarding a Food First Care Home Certificate.
- The Food First team have employed a **Data Analyst** to free up dietetic time for other responsibilities and have employed a **Specialist Paediatric Dietitian** to support appropriate prescribing of infant formulas at primary care level.
- The Food First team have **designed and updated the Luton oral nutritional supplement prescribing guidelines.**
- The Food First team **presented at national events** - Food Matters Live and British Dietetic Association's BDA Vision.
- Paediatric Occupational Therapy has delivered **parent, carer and professionals workshops** for understanding sensory issues in children and young people.
- Development of a pilot project for the **prevention of foot ulcer in diabetic patients.** The project is designed to determine the efficacy of insoles, in deflecting the pressures from the vulnerable areas in diabetic feet and preventing plantar ulcers occurrences or relapse. This is an ongoing project and the records will be finalised by the end of November 2017.

Children's Services – South East and West Essex

- **FNP Adapt -** As part of the Southend 'A Better Start' programme we have been working with the Family Nurse Partnership (FNP) National Unit on FNP Adapt, which involves testing personalisation of the FNP programme. As part of this work we are extending the criteria for entry to the programme to ensure all the most vulnerable clients can access the service whilst enabling us to flex programme delivery to clients in order for us to meet their individual needs.
- **Partnership working with the Third Sector in Sexual Health Services -** We are working in partnership with Brook, a Third organisation, who specialise in the delivery of sexual health services for young people with very positive outcomes. Brook have been delivering the My Life, My Way programme to young people in Southend. This is a programme that was co-produced with young people which enables individuals and groups of young people to 'take charge' in order to improve their own health and well-being by exploring skills, goal setting and becoming more emotionally resilient.
- **Launch of the Children, Young People & Families Strategy (2016-19) -** The Trust wide Children, Young People & Families strategy was launched June 2016. This has been well received as it sets out a clear direction amongst the highly complex and changing environment of services for children, young people and families.
- **Development of Quality Champions and increasing the use of technology -** Given the client group it was felt that the use of technology was potentially a missed opportunity to engage with our target client groups using ways that are popular, easily accessible and most likely to be preferred by children and young people. We have had two Quality Champions (one from Health Visiting and one from Paediatric Speech & Language Therapy) who have been working on a project in relation to the use of communication technology within children's services. A West Essex Community Health Visiting Face book site is now active with followers beginning to sign up. The site contains information in relation to

the local Health visiting service including well child clinic provision, group & health promotion activities and contact details for local teams. We also hope to post health promotion messages linking into national campaigns. Followers can post a message for routine enquiries and will receive a response from one of the dedicated team within 3 working days. For any urgent enquires they are signposted to their GP or other local services. The local children centres are promoting the site within their settings to increase awareness which is positive. A dedicated team of staff in each locality lead by one of the clinical leads is monitoring activity on the site and moving forward will ensure its content is kept current and relevant for our service users within West Essex.

- **Parent Talk Essex project -** Over the last two years Health Visitors in West Essex have continued to work with Essex County Council, FutureGov researchers and clients to develop an interactive app which can enable antenatal and new parents to engage with each other and services in a unique and supportive way. This project has now advanced to the level of piloting the app with a group of antenatal women in the West Essex area. The app is named "Everymum"-meet other local mums to be. The development of this tool has been a true joint venture with clinicians, researchers, local authority and most importantly the women who will be using it and is based on what they valued in the current services and what would make services better for them.
- **Relationship Matters project -** Children's Services in West Essex have been supporting the relationship matters project being sponsored by Essex County Council focussed on the Waltham Abbey locality. One Plus One worked with frontline practitioners from Children's Centres, Health Visiting, Midwifery, Speech and Language Therapy and Family Solutions to test a professional development offer aimed at enhancing 'relational capability' through a mixture of activities and learning styles which included practitioner observations, specialist coaching, group learning and reflection. Alongside this they carried out research with families and professionals in Essex to gain a better understanding of why and how relationships matter, and what can hinder the development of trusting relationships. The results of this work have confirmed much of the hypothesis and Identified 10 key steps to improve and develop relational working.

South East Essex Adult and Older People's Community Health Services

- The **Care Co-ordination Service for Castle Point & Rochford** was initially set up as a 12 month pilot in 2016/17 and will now be commissioned as a core service in 2017/18 and onwards. An independent assessment of the team's work carried out by CP&R CCG demonstrated a positive impact on acute activity reduction, a positive experience for patients and their carers, a saving on the prescribing spend and that more people had been supported to remain independent in their own homes. The core aim of the service is to identify frail patients at risk of decline and intervene at an early stage to assess patients, plan their care and provide support to ensure that they can remain healthy, independent and out of hospital for as long as possible.
- The **Complex Care Coordination service for Southend** was launched as an 18 month pilot in January 2017 and is a proactive service improvement aimed at enhancing the user's quality of care and health and social wellbeing outcomes. The service focusses on appropriate case management with an emphasis on pre-empting the escalation of the user's health and social care needs to prevent or delay deterioration. The service has been commissioned by NHS Southend Clinical Commissioning Group (CCG) and will see health and social care staff from a number of agencies working side-by-side including local GP practices, social care and housing, community physical and mental health and substance misuse.
- South East Essex Diabetes Specialist Nurses and Podiatrists became part of the **Integrated Diabetes Service**, led by Southend University Hospital NHS Foundation Trust in September 2017, working alongside acute physicians and nurses and increasing the team to include Dietitians and Psychologists. The new Service is designed to deliver a streamlined, cohesive and patient focused pathway that enables rapid access, when appropriate, to a comprehensive diabetes skilled team. A key component of the new service is strong multi-disciplinary working with weekly outpatients for patients in a community setting. The Integrated Diabetes Service covers both Southend and Castle Point CCG areas and will triage all referrals, determining appropriate clinical pathways, and provide specialist advice where requested or noted as clinically appropriate within 72 hours. The implementation of a pump service in the area will allow eventual repatriation of patients who are currently treated out of area.
- The **Community TB (Tuberculosis) Service** expanded in 2016/17 in respect of a further contract with Mid Essex providing risk assessments, TB screening, contact tracing and management along with patient education. This is for a resident population of 383,600 (covering Chelmsford, Braintree,

Halstead and Maldon). The team already provide similar services to West Essex and South East Essex residents.

- From January 2017, a new proactive care model for **Neighbourhoods/Localities** went live on Canvey Island. Weekly proactive care MDTs take place, identifying and care co-ordinating people with moderate needs to prevent or delay a crisis or the need for more intensive health and social care services. This model of care is already demonstrating improvement in efficiency (e.g. quicker direct referrals) and improved individual outcomes (e.g. increased independence). We are also scoping co-location of health, social and third sector staff within the neighbourhood to further develop integrated working and maximise benefits. Our neighbourhood model is a blueprint which can be adapted to every area with local demographic tweaks. For example we have seen wholesale acceptance of this model in Southend. This will form the basis of future integrated models of care to be utilised within south east Essex, and aligns to the principles being applied as part of the Mid and South Essex Success Regime of building resilient Out of Hospital models of care.
- The **Adult Speech and Language Therapy Service** developed an integrated process across Southend and Castle Point & Rochford for the management of assistive technology devices communication aids. This included improved access to devices and streamlined processes for the management of stock, including recycling. The proposal for improving the process gained agreement and additional funding from commissioning colleagues, and this will mean much extended use of devices such as I pads, I pods and light writers for people with communication difficulties.
- The **Tissue Viability Service** marked the international 'Stop The Pressure' awareness day on 17th November 2016 through a number of initiatives. This included training in pressure ulcer management and prevention for carers, raising public awareness in local shopping centres and drop-in clinics at health centres in the area. The service has worked closely with colleagues in Podiatry to develop a new wound formulary which will assist all clinicians involved in wound care in the community.

South Essex Learning Disability Services

- The **Occupational Therapy Posture Service** is a collaborative project between Occupational Therapy, Speech and Language Therapy and Physiotherapy. Clinics are held with follow-up appointments, with the aim of improving the functional ability of those with complex postural needs; prevention/slowing down if further postural issues; improved collaboration between services in the management of an individual's posture; increased awareness of families and carers of the impact of postural issues.
- The LD Psychology Service has been working for a number of years to increase accessibility for people with LD who may require a dementia assessment. In 2016, the remit was extended to consider the **support offered by the LD Service to those with a diagnosis of dementia**. A multi-disciplinary group have produced a checklist that can be used as a guide for assessment, hence ensuring that a holistic approach is adopted and all possible interventions and forms of support are considered.
- The LD Psychiatrists have increased their role in **offering home visits** for those people with an LD who present with acute deterioration in mental health and/or challenging behaviour outside of planned clinics.
- The LD Health Facilitation Service has been **praised for the support given to those people with LD and their relatives/carers who were at the end of life care pathway and died due to physical health problems.** This praise was given to them following an independent review into the death of people with LD known to SEPT following a national report into the mortality of people with LD, specifically premature deaths.
- The LD community nursing service (Health Facilitation Service and Intensive Support Team) now offer a **daily duty system**. A Duty Person is allocated each day to ensure that all new referrals are screened in a timely manner and that assessments for new referrals are planned and undertaken. They also respond to crisis calls and ensure that, where indicated, an urgent home visit is made or regular telephone contact is maintained. If, following the call to duty, it is felt that the individual requires more intensive and consistent support then they are allocated to a member of the Intensive Support Team.

South Essex Mental Health Services

- **REACH (Recovery, Empowerment, Achievement, Community and Hope), the South East Essex Recovery College**, was launched in January 2017. The previous work done by SEPT mental health services to pilot a Recovery College set the foundation to develop South Essex Recovery Colleges and SEPT mental health have continued to be a key driving force in the development of REACH and

continue to be an active consortium partner in REACH. REACH is an environment where people with lived experience support one another to a better way of life, creating opportunities to learn in a safe and supportive environment and to apply learning in daily life.

- South East Essex Community Perinatal Mental Health Services were successful in clinically leading a joint bid with North Essex Partnership Trust colleagues and Mental Health Commissioners for additional funding from 2016/17 to 2018/19 to **develop an Essex wide Specialist Community Mental Health Perinatal Service**. Significant progress has already been made to recruit the additional perinatal mental health staff required, draft out a service specification, begin to consult on a service model involving women with lived experience in all levels of the mobilisation plan, service design etc.. and ensure that effective links with all perinatal pathway partners are developed.
- Building on service user and focus group feedback, the **Therapy For You service has developed its on-line programme further**. This is now being re-filmed into shorter sections to meet the needs of the typical digital user of today to improve engagement. A social media campaign has been organised to operate alongside the new on-line programmes to also improve access to psychological therapies.
- The Trust has successfully run its first **cross specialties group with people from COPD, Cardiac and Stroke Services with support from IAPT.** The group was successful and the outcomes were positive both quantitatively and qualitatively. This **trans-diagnostic group** is run over five sessions and focusses on mood management, acceptance and change.
- Physiotherapists who are all trained as Postural Stability Instructors as an add-on skill and knowledge for **Falls Prevention and Management** have initiated balance and strength exercise programmes on wards at Rochford, Basildon MHU, Mountnessing Court and Meadowview. This has enabled the provision of strength and balance exercises classes for Older Adults in South Essex area as part of a multifactorial intervention programme as recommended by NICE Clinical Guidelines The Physiotherapy department is currently developing a similar 12 week balance and strength exercise programme for older adults in the community who would have otherwise been admitted for falls and fractures that may impact negatively on their functional abilities and mental health.
- **Mindfulness Based Interventions (MBIs)** have a strong evidence base across a number of mental health diagnoses. A multi-disciplinary steering group produced a Mindfulness Strategy and, in order to ensure an appropriately trained workforce is available to deliver effective MBIs, twelve multi-disciplinary staff completed a nationally recognised teacher training course in Mindfulness Based Cognitive Therapy (MBCT). MBIs are now being delivered across IAPT, Recovery and Well-being, First Response and In-patient Teams.
- An **Intermediate Care Transformation Joint Partnership between SEPT and North East London NHS Foundation Trust** is being progressed to create a community based solution that is able to flex capacity to manage patients in their own home environment, supporting patient to achieve optimal independence and reduce dependence on health and care packages for as long as possible. The success of the new model will be in part driven by a consistent and efficient referral pathway into the intermediate beds regardless of provider to ensure there are no avoidable delays in the discharge pathway. This will be achieved through a single referral pathway process for all intermediate care beds (both SEPT and NELFT) overseen through a bed screener.
- SEPT has been cited in the national Centre for Mental Health report on "Carers Support – Mental Health Carers Assessments in Policy and Practice" published in January 2017 as **'a carer-focussed organisation'**. The report includes examples of good practice in SEPT including the local authority funded carer link workers integrated into community mental health teams across Southend, Essex and Thurrock who have been integral to providing holistic and recovery focussed care for people with mental health needs and their carers.

Specialist Mental Health Services

Secure services in Essex, Beds and Luton:

- Brockfield House has actively **increased patient participation in recruitment and local induction** for secure services. Patients now assess participants in pre-interview workshops, sit on the interview panel, and deliver components of the local induction programme. The feedback from both patients and staff has been very positive.
- A **peripatetic team of support workers** has been introduced at Brockfield House. The purpose of the team is to have fully inducted and trained members of staff who can be used flexibly within the service. The team reduce the use of bank and agency staff by flexibly filling gaps in the ward rota's due to annual leave, sickness, requirements for patient escorts or increased levels of observations.

- The SEPT **Criminal Justice Liaison and Diversion service**, which commenced as part of the wave 1 national pilot was **extended** in October 2016 to provide a whole Essex service. This has been achieved by working with NEP to ensure that Liaison and Diversion services deliver the national specification. Lord Bradley visited the pan–Essex liaison and diversion service in January 2017.
- Robin Pinto Unit in Luton introduced a **multi-disciplinary team (MDT) handover**. The handover gives the opportunity for all the MDT to be appraised about each patient at the start of the working day, allowing for a dynamic assessment of risk. The project received a STARS award for improving patient safety.

Child and Adolescent Mental Health Services (Tier 4 in-patients – Poplar Ward):

- The service has made significant headway in **reducing restrictive practice** on the unit. Just a few examples include, reviewing access to bedrooms, the introduction of mobile phone handsets and reduction in the number of restraints.
- Clinical leads on the unit have worked closely with counterparts in NEP CAMHS PICU to ensure there are **clear pathways in place** to assist with the smooth transition of young people from Poplar to PICU, and back out again, where a clinical need arises.
- The education unit for the service has achieved a **Good rating from OFSTED** at its recent inspection.

West Essex Adult and Older People's Community Health Services

- As part of the development of **community respiratory services**, the clinical liaison staff at the Single Point of Access have been trained to deliver a guidance pathway for patients known to the Community Respiratory Specialist Team so they can access agreed advice / pathways until 21.00 seven days per week. This enables patients to access the right support and advice to be able to self-manage during periods of exacerbation. This supports the delivery of out of hospital care and it is envisaged that this initiative will contribute to the system target for the reduction in non-elective attendances and admissions to hospital.
- As part of winter resilience initiatives, we identified that there was a need to improve the timeliness of streaming and treatment available to children at the front door of the **Urgent Care Centre, Whipps Cross**. Following discussion with the Clinical Commissioning Group and a successful funding bid, we piloted a GP with Special Interest (GPwSI) scheme, working across the urgent care centre and the emergency department. This has resulted in 680 children being seen in the service, with only 43 children being referred onto the paediatric emergency department, demonstrating the value of early and robust paediatric streaming and timely treatment.
- The **Care Home Multi-Disciplinary Team (MDT) CQUIN** has focused on the development of multi-disciplinary teams in care homes and SEPT has been a significant driver in both developing and delivering the model. This has resulted in better partnership working between care home staff, community matrons, District nurses and the MDT co-ordinator. Working together with the MDT coordinator and other partnership organisations ensures any barriers/actions identified at MDT meetings can be managed in a multidisciplinary forum which enables staff to work together in supporting the care homes to make change happen. Effective use of available capacity has also been demonstrated as the MDT co-ordinator can discuss the outcome of the MDT in relation to particular care home with relevant staff thereby reducing unnecessary overlapping activity between professionals. Community matrons are now calling the MDT co-ordinator proactively to ask advice regarding issues within the care homes.
- From 1st January 2017 the **Musculoskeletal (MSK) Physiotherapy Service** began to roll out a 'self-referral' service for patients. This commenced in the Harlow locality on 1st January, Uttlesford on 1st February and completed with roll out in Epping in March 2017. Patients aged 18 and over can self-refer to the service either by completing a questionnaire on the SEPT website or by telephone. This service has been commissioned by the West Essex Clinical Commissioning Group and is aimed at enabling patients to access the service in a timely and convenient manner without having to see their GP. It will also reduce demand on primary care, ensuring the best use of healthcare resources across the system. The MSK team continue to work closely with the Clinical Commissioning Group in adapting and continuing to improve access to this service.
- SEPT has taken an active leadership role in the development and delivery of the **Neighbourhood Model of Care** across West Essex over the last year. The development of the neighbourhood model of care has provided the opportunity to work with colleagues across the health, social care and voluntary sector to be patient-centered, act as equals and empower staff on the front line to develop new ways of working and ensure ownership of out of hospital care targets. We have contributed to specific projects

in all 5 West Essex neighbourhoods which aim to improve care closer to home for patients. These have included care home and domiciliary provider support, risk stratification and contributing to newly set up Frailty Clinics, care homes, care providers and risk stratification with which SEPT are fully involved, supporting the system targets around out of hospital care and avoiding unnecessary emergency admissions. We have recently aligned our Clinical Team leadership with that of social care and primary care to ensure robust governance and local neighbourhood leadership.

Workforce Development

Having the right people, with the right skills, in the right roles at the right time is absolutely critical to the delivery of our quality aims and priorities. This section therefore details some examples of workforce initiatives that the Trust has undertaken over the past year - these initiatives have been designed to help to build the workforce of the future and upskill current staff, ensuring that the workforce is trained to the highest standards so that they can provide the safest and best possible care for patients and users now and into the future.

Progression Pathways and Apprenticeship

There have been some alterations to the progression paths that are offered in the Trust as the universities and Trust prepare for the implementation of the apprenticeship levy and the removal of grants for nurse training.

As Anglia Ruskin University (ARU) are no longer offering the Foundation Degree which has been used by the Trust for some years, a partnership arrangement has been formed with Essex University for the delivery of the Higher Apprentice in Health and Social Care. This is a Level 5 qualification and delivers a similar skill set to the previous training. Progression from the Higher Apprenticeship Associate Practitioner qualification (Level 5) on to qualified nurse status will continue to be offered via a 'top up' route but this will also have an apprenticeship standard attached to it so that it will be possible to pay for this from the apprenticeship levy from 2018. Currently, the Trust has 5 Mental Health Work based learning students who are nearing the end of their course and 2 Adult nursing students who will complete later in 2017.

These programmes, combined with the Level 2 and Level 3 Heath Care Support Worker apprenticeships enable the Trust to offer clinical progression routes for staff. The Trust has a large non-clinical workforce as well and is committed to ensuring that there are development pathways for these staff. Apprenticeships are currently being offered in Business Administration (and there are staff in the Trust on all levels up to Level 4/5), Customer Service and Education and Training. Further apprenticeship routes will be considered as the standards are developed.

Trailblazer Work

The changes to funding from Health Education England regarding nurse training, and the Government focus on apprenticeships, has meant that the Trust has started to prepare for apprenticeship nurses. SEPT has been involved in the development of the nursing standards and hopes to be one of the early implementers. The new standards will be ready for implementation from 2017 and the Trust will be working to find partner education providers.

The Trust is also the lead provider for development of the Psychological Well-being Practitioner apprenticeship standard. This has been an area of workforce that the Trust wanted to develop and it is felt that the apprenticeship route will promote recruitment from the local community which should aid retention. It is anticipated that this standard will be ready in early 2018.

Student Education Facilitators (SEF) and Assessors

The SEFs are continuing to develop their roles and support students across the Trust. They are developing a number of short teaching sessions on areas of particular interest to students in the Trust and they lead on the delivery of the Associate Practitioner course. They have promoted the monthly student forums which are now held in Rochford as this has easy access by train.

Two dedicated assessors have been recruited to support the apprenticeship programmes delivery across the Trust. They will be running the 'off-work' learning sessions and working with the learners in their work-base to assess their progress.

Leadership Development

The Trust has invested in leadership development to support the in-house programmes and extend the access to NHS Leadership Academy courses. Additional optional modules have been added to the in-house management/leadership development programme with workshops on developing resilience and confidence building.

In addition, Health Education England has franchised delivery of the NHS Leadership Academy's "Mary Seacole" Programme through local trusts and this is being offered to staff at Band 7. This is a six month leadership development programme designed by the NHS Leadership Academy in partnership with global experts, the Hay Group, to develop knowledge and skills in leadership and management.

Further progression is then offered via the Anglia Ruskin Health Partnership Integrated Leadership Programme. This programme focusses on developing strategic thinking and offers learners the opportunity to take up short placements in other organisations within the local health and social care economy.

Resources

The Trust has continued to upgrade training facilities and equipment. Further work will be undertaken on the training venues at Epping and Rochford to ensure maximum use is made of the rooms.

E-portfolio systems are now being investigated which will enable the Trust to eliminate the need for paper files of learners' work and will enable the assessors to access work without needing to meet directly with the students.

Student Placements

The Trust has introduced the new nursing curricula. This means that practice staff are working with students on different curricula but with the support of the student facilitators - this transition has gone very smoothly. Running two curricula does mean that there can be difficulties with allocation of placements as the placement timetables are not co-ordinated. However, the placement teams in the Trust and the universities have worked hard to ensure that all students have had a rewarding placement experience and the student feedback has been very positive.

Service User Co-Production – The Buddy Scheme and Course Evaluation

The Mental Health Buddy scheme, whereby all second year Mental Health students at Anglia Ruskin University have been partnered with a service user and given the opportunity to undertake structured discussions with them on aspects of care has continued to be very well-received and was commended by the Multi-professional Deanery. Part of the Deanery Action Plan asked the Trust to consider extending the scheme to other professions. This is not quite as straightforward as other student groups tend to be smaller and tend to be on placement at diferent times. However, the workforce development team are working with the Occupational Therapy leads and plan to introduce this over the next year as a pilot.

The Trust has a very dedicated group of service users who assist with the Buddy Scheme and other projects within Workforce Development. In particular over the past year they have been involved in evaluating many of the Trust's mandatory training courses and all revised courses will be signed off by the serivce user group before delivery.

Section 3.3: Overview of the quality of care offered in 2016/17 against selected local indicators

As well as progress with implementing the quality priorities identified in our Quality Report/Account last year, the Trust is required to provide an overview of the quality of care provided during 2016/17 based on performance against selected local quality indicators. The Trust has selected the following indicators because they have been regularly monitored by the organisation, there is some degree of consistency of implementation across our range of services, they cover a range of different services and there is a balance between good and under-performance.

Data for the services which transferred out of SEPT (Bedfordshire and Luton Mental Health on 1st April 2015, Suffolk Community Health Services from 1st October 2015 and Child and Adolescent Mental Health Services (CAMHS) from 1st November 2015) have been removed from this section to allow a representative comparison of 2016/17 performance with previous years.

Trust wide indicators

The Key Performance Indicator (KPI) targets were established with the Commissioners: for C. Difficile and MRSA bacteraemia cases they must be solely attributable to the Trust and avoidable after investigation via root cause analysis (RCA).

PATIENT SAFETY

Hospital Acquired Infections

Data source: Infection Control Dept
National Definition applied: Yes

Infection Control Measure		2014/15 Outturn	2015/16 Outturn	2016/17 Target	2016/17 Outturn
Mental Health Services	Cases of avoidable C.Difficile	0	0	0	0
	Cases of avoidable MRSA Bacteraemia	0	0	0	0
Community Health Services	Cases of avoidable C.Difficile	0	0	0	0
	Cases of avoidable MRSA Bacteraemia	0	0	0	1

There was one case of MRSA Bacteraemia reported in West Essex. This was reported as a Serious Incident and areas of learning for both Plane ward staff and the District Nursing team were identified.

PATIENT SAFETY

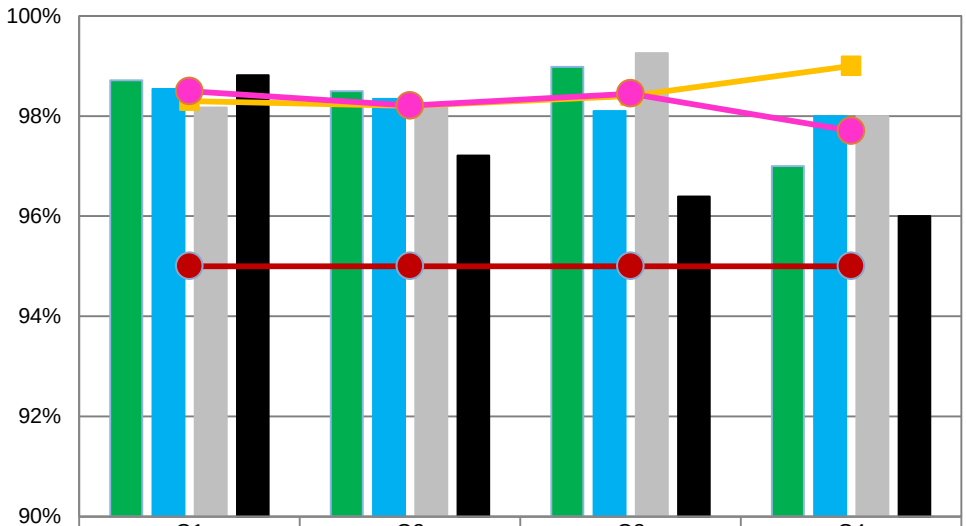
Data source: Safety Thermometer
National Definition applied: Yes

Safety Thermometer (Harm Free Care)

A monthly census is taken of patients in our care which meet the national criteria for Safety Thermometer to measure four areas of harm. Censuses are taken in over 100 teams covering adult and older people wards and community teams, but excluding specialist services, on a monthly basis.

The areas of harm are:- Category 2 / 3 / 4 Pressure Ulcers (acquired in care or outside our care), Falls within 72 hours, Catheter Urinary Tract Infection (UTI) or Venous Thrombo-Embolism (VTE).

The graph below show the percentage of patients that were visited or were an inpatient on the census date, who had not acquired any of the four harms whilst in SEPTs care. During 2016/17, SEPT successfully achieved above the 95% target. This information is reported to the Trust Board monthly as part of the Board of Directors Scorecards.



	Q1	Q2	Q3	Q4
Bedfordshire CHS	99%	98%	99%	97%
South East Essex CHS	99%	98%	98%	98%
West Essex CHS	98%	98%	99%	98%
South Essex MH	99%	97%	96%	96%
SEPT 2015-16	98%	98%	98%	99%
SEPT 2016-17	98%	98%	98%	98%
Target	95%	95%	95%	95%

PATIENT EXPERIENCE

Complaints

Data source: Datix
National Definition applied: Only to K041-A Submissions to the Department of Health

Complaints referred to the Parliamentary & Health Service Ombudsman

During 2016/17 a total of 5 complaints (2.4%) were referred to the Parliamentary & Health Service Ombudsman. This is six less than the 11 (5%) referred in the previous year.

One was partially upheld and the Trust was asked to acknowledge failings and apologise for the impact this had on the patient. The Trust was also asked to produce an action plan to describe the lessons learned and what the Trust will do to avoid a recurrence in the future.

The PHSO investigation has been discontinued for one referral and investigations are ongoing for the other three complaints.

Complaints closed within timescales

The "% of Complaints Resolved within agreed timescales" indicator is a measure of how well the complaints-handling process is operating. The agreement of a timescale for the resolution of a complaint is identified in the NHS Complaints Regulations, but these do not stipulate a % target to be achieved. The Trust believes that commitments to complainants should be adhered to and aims for 100% resolution of all complaints within the agreed timescale with the complainant. This year the Trust has achieved 99% for complaints closed within agreed timescale. This is an improvement on the 98% achieved in the previous financial year

Non-Executive Director Reviews

An important part of the complaints process is the independent reviews of closed complaints by the Non-Executive Directors (NEDs). The complaints are selected at random each month. The reviewer will take into consideration the content and presentation of the response, whether they feel the Trust has done all it can to resolve the complaint and if they think anything else could have been done to achieve an appropriate outcome.

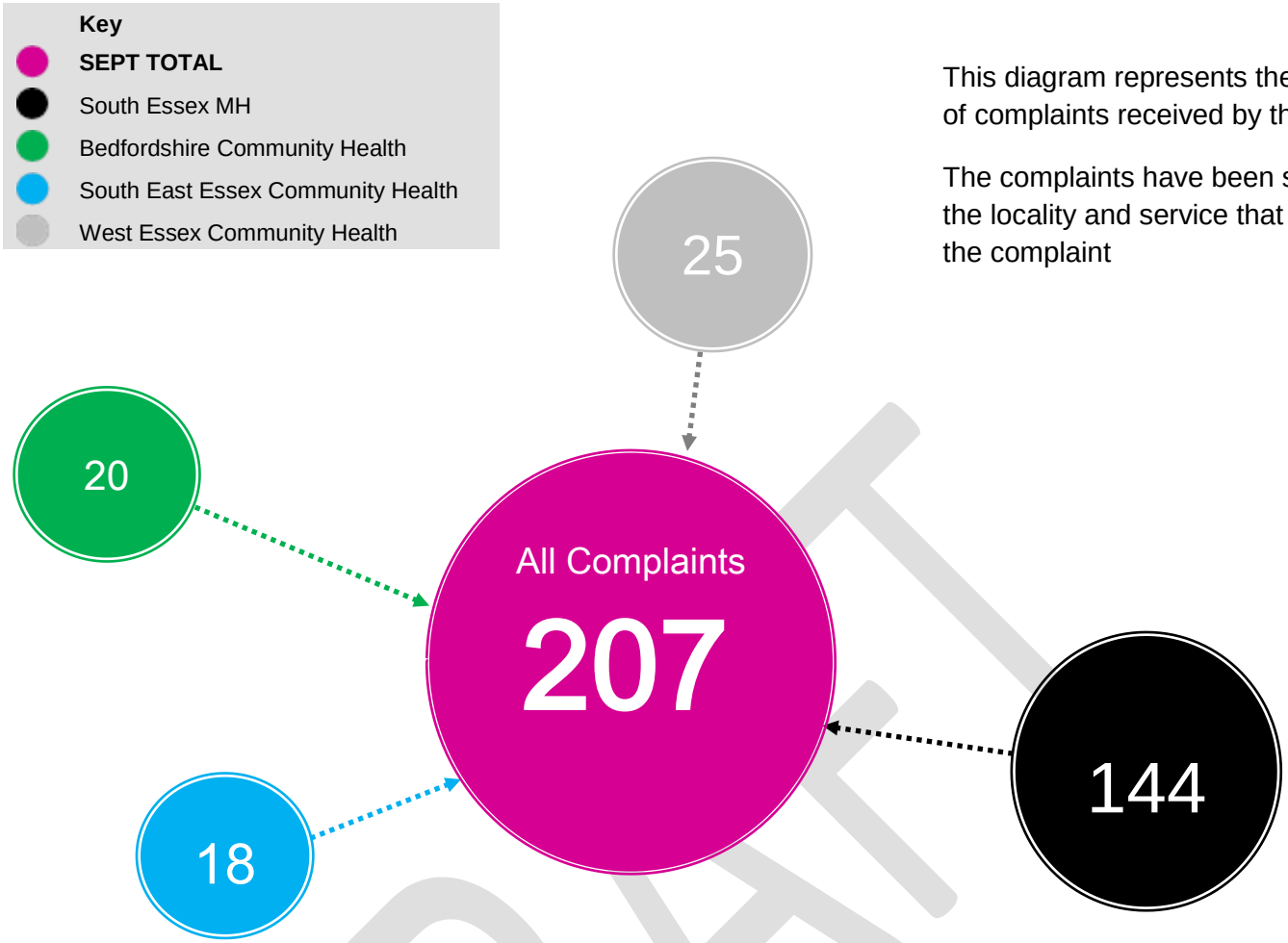
During 2016/17, the NEDs reviewed 56 complaint responses. The majority received a good or very good rating for how the investigation was handled and the quality of the response.

Number of formal complaints received:

Performance Indicator	2014/15	2015/16	2016/17
Number of formal complaints received	**377**	**237**	**207**
Comprising:			
Total received Mental Health Services	*277*	*153*	*144*
Total received Community Health Services	*100*	*84*	*63*
Number of complaints withdrawn	**12**	**5**	**3**

*Please note: The figures stated in this section of the report (and those reported in the Trust's Annual Complaints Report) do not correspond with the figures submitted by the Trust to the Health and Social Care Information Centre on our national return (K041A). This is because the Trust's internal reporting (and thus the Quality Report / Account and Annual Complaints Report) is based on the complaints **closed** within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints **received** within the period.*

Complaints Received by Locality and Service



This diagram represents the number of complaints received by the Trust.

The complaints have been split by the locality and service that received the complaint

Number of active complaints at year-end: At year end, the number of active complaints was 22 which is a decrease from the position as at the end of March 2016 which was 23. All active complaints are on target to be responded to within their agreed timescale, by the end of May 2017.

Number of complaints upheld / partially upheld: A total of 208 complaints were closed during the year of which 3 were withdrawn.

Performance Indicator	2014/15	2015/16	2016/17
Number of complaints upheld	34	18	29
Number of complaints partially upheld	133	137	121
Number of complaints not upheld	69	74	47
Totals	**236**	**229**	**197**

The remaining 11 complaints closed in 2016/17 comprise: 5 not investigated (consent not given), 3 withdrawn, 2 conduct and capability and 1 locally resolved.

Patient Advice and Liaison Service queries and locally resolved concerns:

In addition, the Trust received a total of 1154 Patient Advice and Liaison Service queries and 175 locally resolved concerns in 2016/17.

Nature of complaints received:

The top three themes for complaints for both mental health and community during 2016/2017 were dissatisfaction with treatment, staff attitude and communication. The top three themes for the Trust also apply nationally across the spectrum of health services. The table below shows the outcomes of the closed complaints for each of these three themes - 2015/16 figures are included for comparison.

Top Three Complaint Themes	Total Number of Complaints Received		Upheld		Partially Upheld		Total Upheld or Partially Upheld	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Unhappy with treatment	47	23	3	1	31	15	34	16
Staff Attitude	41	42	3	3	19	25	22	28
Communication	29	26	1	6	27	15	28	21

The remaining number were either not upheld, not investigated (no consent) or withdrawn.

The category ‘unhappy with treatment’ covers a wide spectrum. In some cases, complainants had certain expectations; however this was contrary to their clinical need. The Trust was, therefore, limited in providing solutions to these complaints.

PATIENT EXPERIENCE

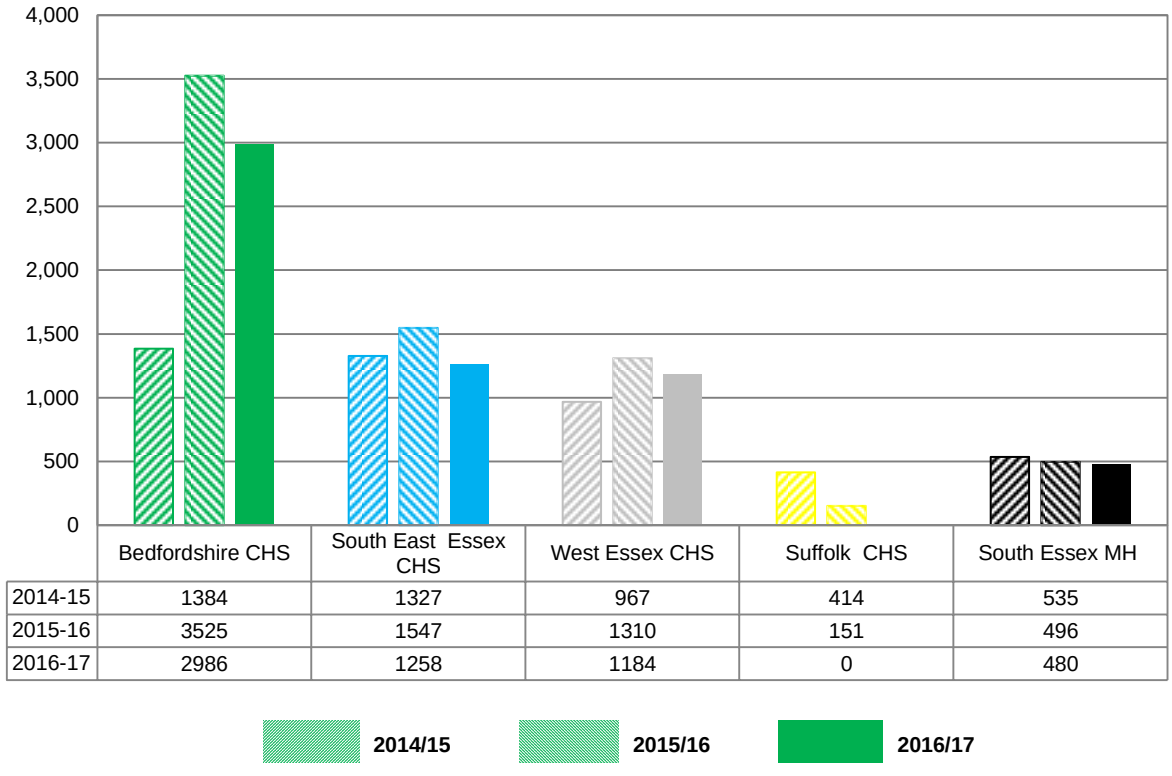
Compliments

Data source: Datix
National Definition applied: N/A

Positive feedback is important to the Trust and is shared with staff and services across the Trust. All staff are encouraged to send the compliments they or their service receive to be logged and reported on. Compliments are published in the Trust publications and reported to the relevant Clinical Commissioning Groups. This year the Trust has received 5908 compliments, which represents a decrease of 1121 for the same services in 2015/16. The Community Health Services have experienced the biggest decrease, however, it should be noted that many of their compliments are taken from the Friends and Family Tests and various audits and they can therefore fluctuate accordingly over the year.

> "I just wanted to say a very big thank you to all the staff on Poplar Ward for all your work and efforts. You have given me my little girl back and I am so grateful."

Compliments Received	2014/15	2015/16	2016/17
Bedfordshire CHS	1384	3525	2896
South Essex MH	535	496	480
South East Essex CHS	1327	1547	1258
West Essex CHS	967	1310	1184
Suffolk CHS	414	151	N/A
SEPT	**4627**	**7029**	**5908**
SEPT Ex Suffolk	**4213**	**6878**	**5908**

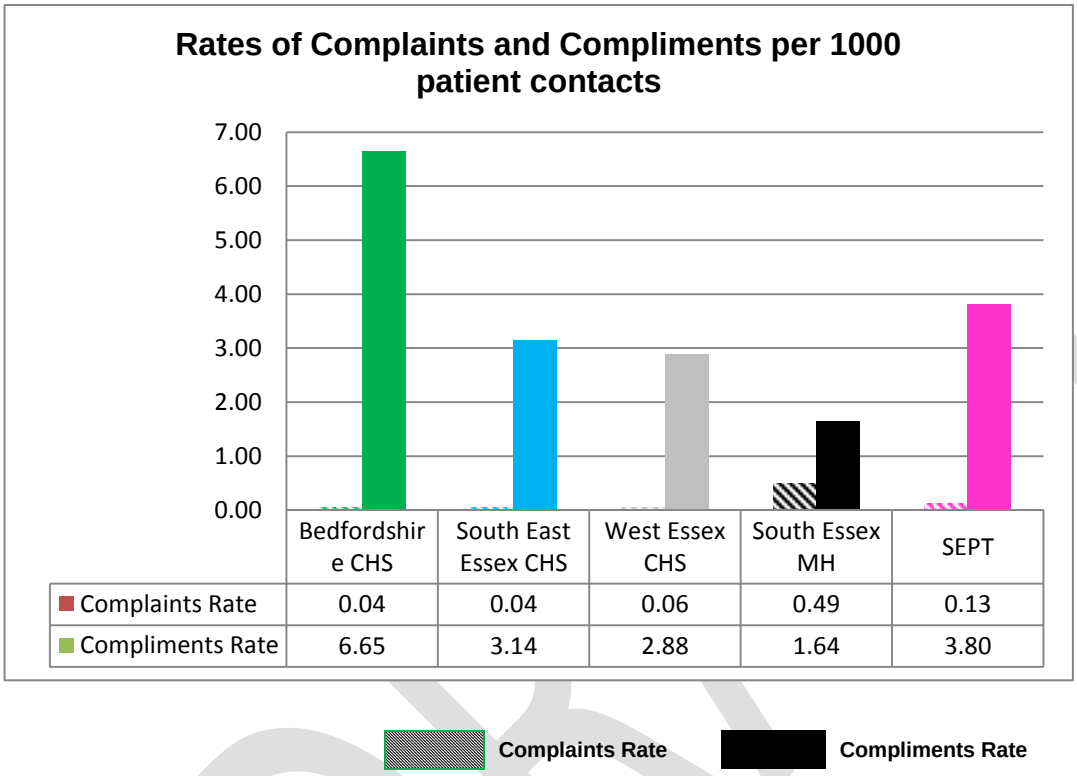


	Bedfordshire CHS	South East Essex CHS	West Essex CHS	Suffolk CHS	South Essex MH
2014-15	1384	1327	967	414	535
2015-16	3525	1547	1310	151	496
2016-17	2986	1258	1184	0	480

Rate of Complaints and Compliments

Data source: SEPT systems (Datix and FFT)
National Definition applied: N/A

A comparison of complaints and compliments as a rate per 1,000 patient contacts demonstrates that the rate of compliments in each locality was significantly greater than the rate of complaints received during 2016/17.



	Bedfordshire CHS	South East Essex CHS	West Essex CHS	South Essex MH	SEPT
Complaints Rate	0.04	0.04	0.06	0.49	0.13
Compliments Rate	6.65	3.14	2.88	1.64	3.80

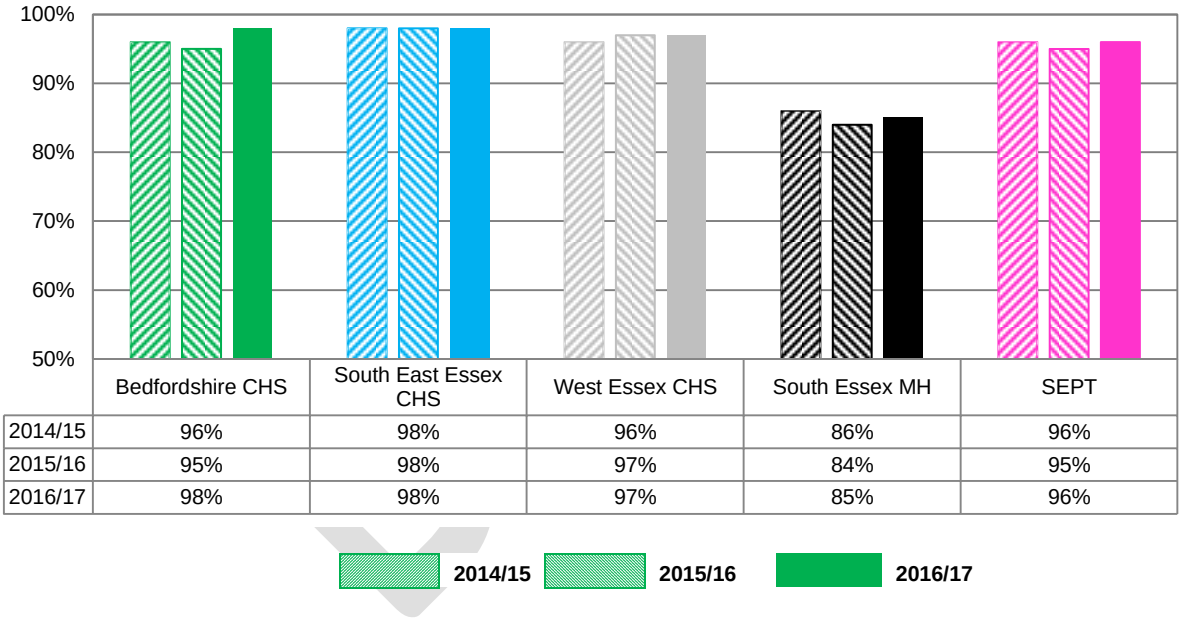
Unified Friends and Family Test

Data source: Unified Patient Survey
National Definition applied: N/A

This survey draws together the NHS Friends and Family Test and a further series of questions around key areas we identified together with people who use our services.

In 2013/14, the Trust implemented a new unified patient survey. This draws together the national NHS Friends and Family Test (FFT) – detailed below - and a further series of local questions around key areas we identified together with people who use our services (detailed in Section 3.5). The Surveys are sent to all patients who have recently been discharged, either from inpatient services or community caseloads as well as some patients who have chronic long term conditions to ensure they continue to receive a good service. Carers and guardians are also asked to complete the survey for those unable to fill it in themselves. Surveys are coded so that feedback can be provided at team-level; managers and teams receive scores and comments from the Friends and Family Test as well as from the locally agreed questions on areas that matter to our patients.

"How likely is it that you would recommend the service you provide to a friend or family member who needed similar care or treatment"



	Bedfordshire CHS	South East Essex CHS	West Essex CHS	South Essex MH	SEPT
2014/15	96%	98%	96%	86%	96%
2015/16	95%	98%	97%	84%	95%
2016/17	98%	98%	97%	85%	96%

96% of the 10,081 responses to the FFT received from service users in 2016/17 indicated that they would be either "likely" or "very likely" to recommend the Trusts' services. The Trust continues to maintain a high recommendation percentage while seeking to increase the actual number of responses received and taking action on the feedback received.

Further details in terms of seeking and acting on service user feedback are included in Section 3.5 of this Quality Account.

In this section of the report a selection of Key Quality Indicators are presented to show performance for the community health services of Bedfordshire, South East Essex and West Essex over the past 12 months and where possible up to the past 36 months.

Breastfeeding

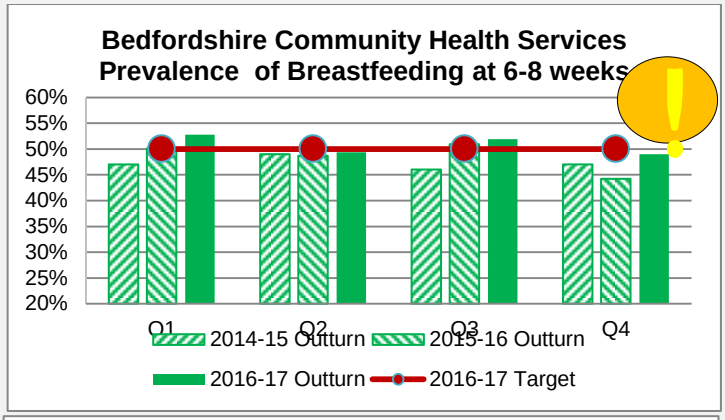
CLINICAL EFFECTIVENESS

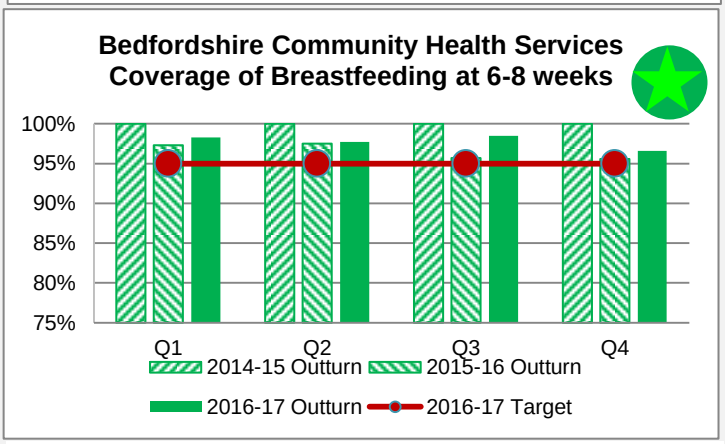
There are two types of breastfeeding measure used within community services. The first is breastfeeding coverage, which is the number of babies aged 6-8 weeks with breastfeeding status recorded. The second is breastfeeding prevalence, which is the number of babies being breastfed at the 6-8 week check.

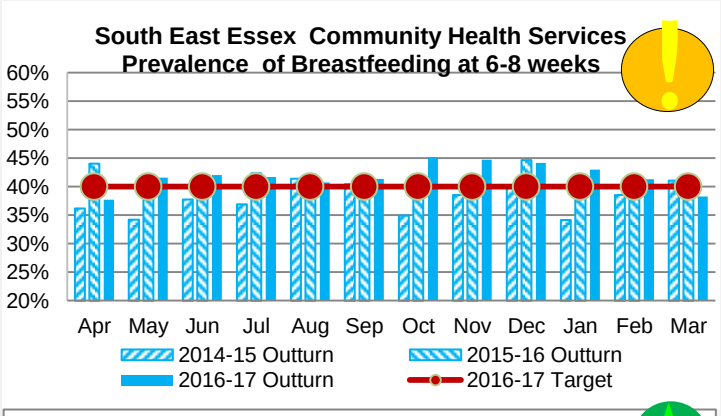
In Bedfordshire Community Health Services (BCHS) during 2016/17 the coverage of breastfeeding has exceeded 95% in every quarter and therefore provided good data quality. As in other previous years breastfeeding prevalence continues to increase in both Bedford Borough and Central Bedfordshire and this year reached its highest overall rate of 50%. The service is working on maintaining that high rate through a number of evidence based methods known to support mothers and babies. BCHS was re-accredited as UNICEF Baby Friendly in 2015 and is now working towards the Baby Friendly Gold Award. BCHS has been identified as a centre of excellence in the delivery of Antenatal information about breastfeeding. The Baby Friendly team has developed a specialist service supporting mothers and babies and received 100% positive feedback following analysis of patient experience submitted by families. Breastfeeding Buddies who volunteer to support across Bedfordshire have grown in number and provide a unique mother to mother support for breastfeeding mothers.

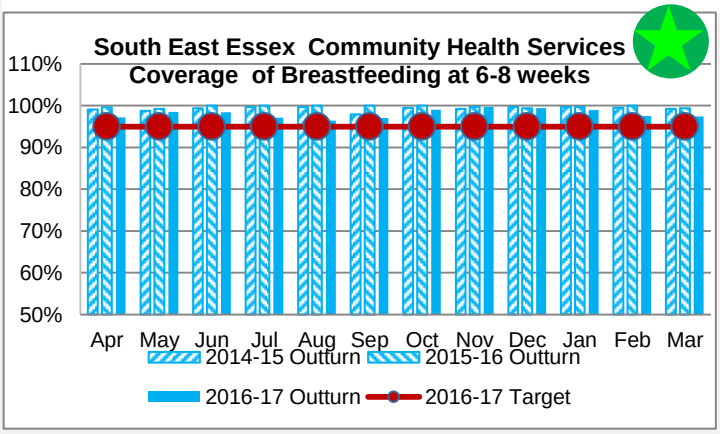
In South East Essex Community Health Services there has been a significant improvement in the 6-8 week breastfeeding rate in the second half of the year. The target of 40% prevalence was achieved for 10 months over the past year with 2 months just missing the target by less than 3%. There is a demographic difference between the two Local Authorities with the breastfeeding rate in Southend at 44.5% for the whole of 2016/17. To support and improve breast feeding rates we have invested in the Unicef Baby Friendly accreditation. In South east Essex we have achieved Level 3 the highest level of achievement. Breast feeding targets are not solely the responsibility of the health visiting service but shared with other providers such as maternity services and children's centres. In Southend we are working with children's centres to offer appropriate support and training for parents and we have worked with the local maternity services to support them with their Unicef Baby Friendly Accreditation.

Data source: SystmOne
National definition applied: Yes









18 Week Referral to Treatment

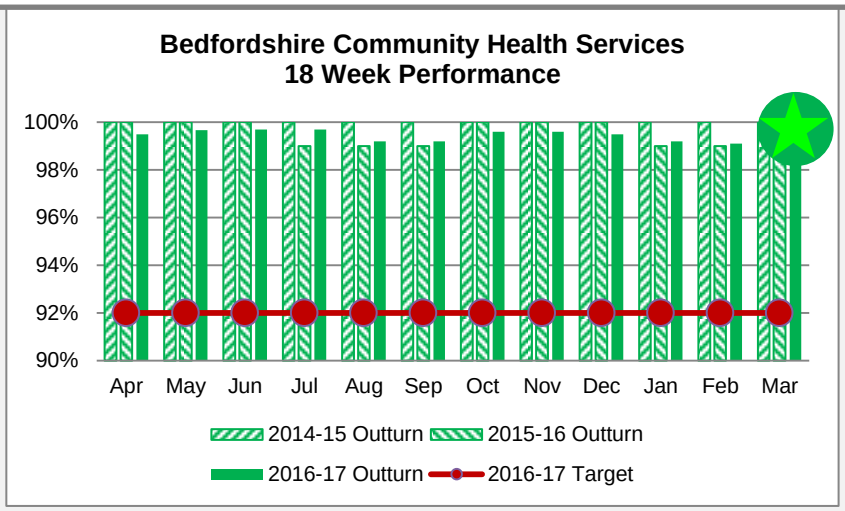
PATIENT EXPERIENCE

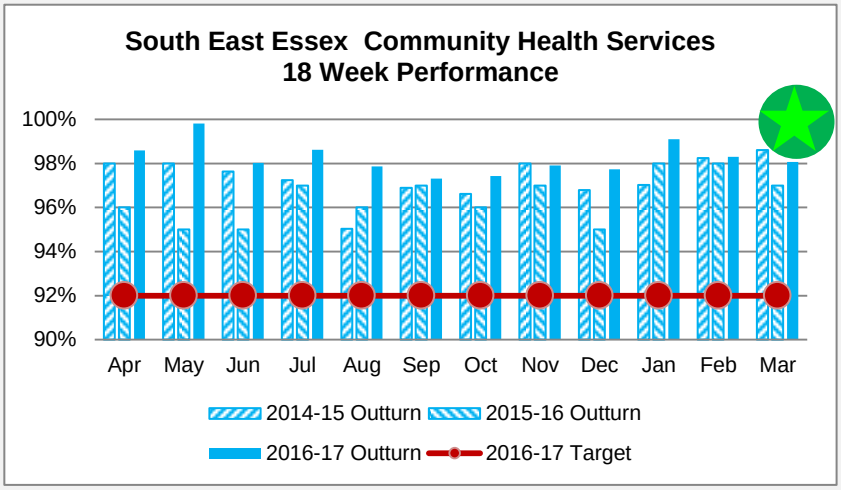
18 week referral to treatment performance measures the length of time in weeks between referral into the service and the end of each month. This is an important measure as it describes the length of time patients are waiting for treatment.

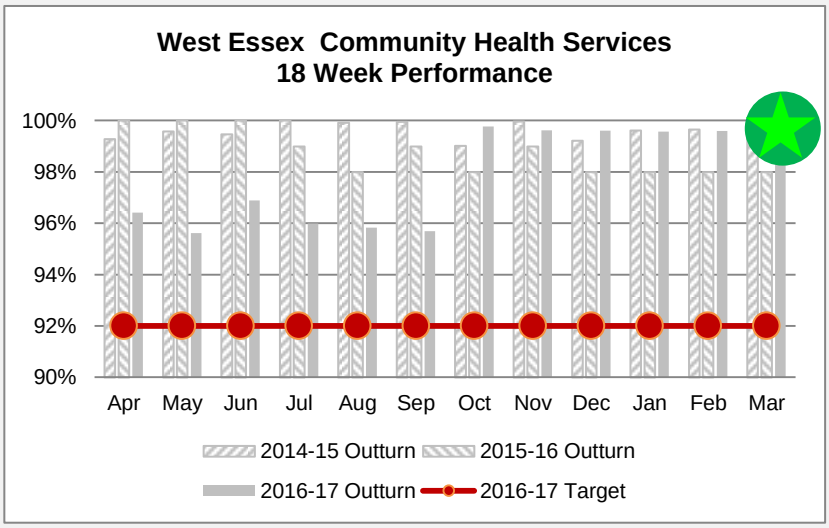
Community Health Services in all three localities consistently achieved the target of 92% every month in 2016/17.

Data source: SystmOne

National definition applied: Yes





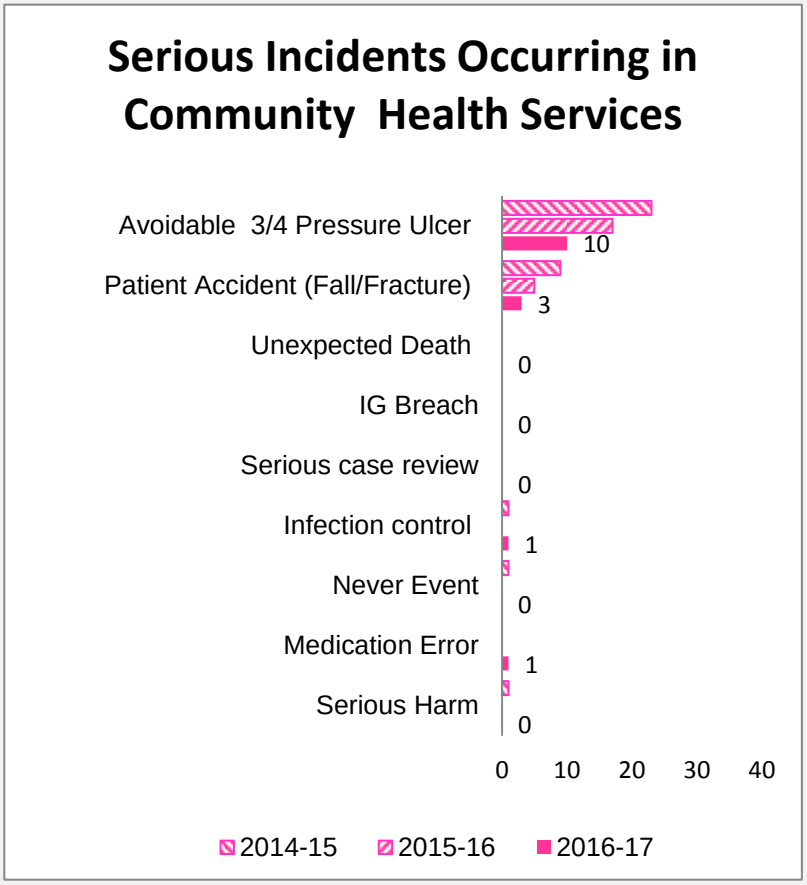


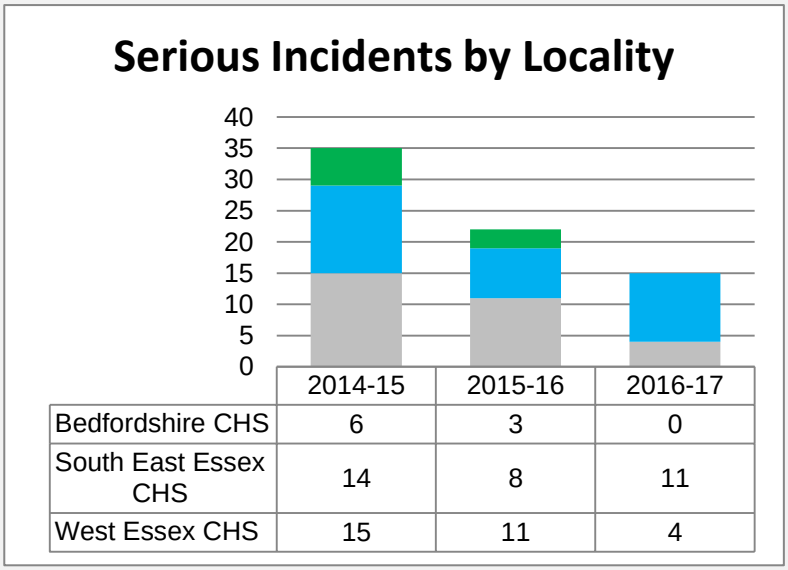
Serious Incidents
PATIENT SAFETY

Monitoring of the number and nature of Serious Incidents, identification of learning and embedding learning back into clinical practice, is a key part of the Trust's patient safety.

The Trust reported 15 serious incidents in Community Health Services in 2016/17 compared to 22 during 2015/16. Three of these incidents were falls leading to fractures, a decrease (improvement) of 2 on last year. The continued decrease in the number of Serious Incidents in the community is a major achievement for the Trust which has been made possible by the widespread implementation and adoption of the principles of our "Sign Up to Safety" campaign.

Please Note : One additional SI reported for SEECHS in 2015-16 following identification of an avoidable grade 3/ 4 pressure ulcer following RCA after preparation of last year's Quality Report / Account.





	2014-15	2015-16	2016-17
Bedfordshire CHS	6	3	0
South East Essex CHS	14	8	11
West Essex CHS	15	11	4

Serious Incidents
PATIENT SAFETY

Monitoring of the number and nature of Serious Incidents, identification of learning and embedding learning back into clinical practice, is a key part of the Trust's patient safety.

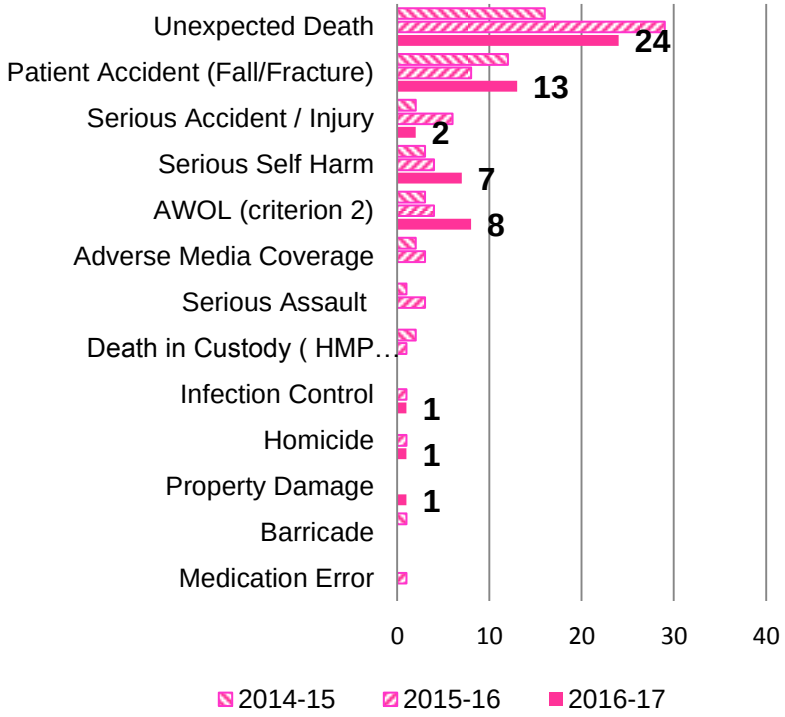
The Trust reported 57 serious incidents (SIs) in Mental Health Services in 2016/17 compared to 61 during the previous year.

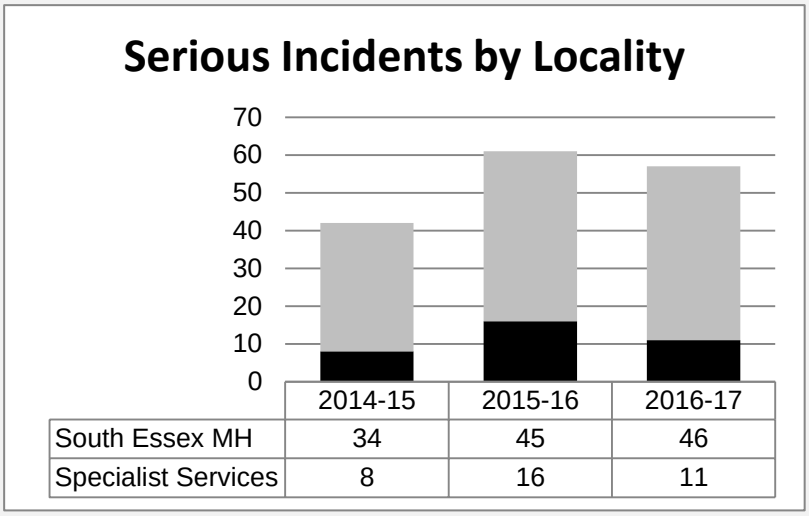
It is pleasing to note that the number of unexpected deaths has decreased from 29 last year to 23 in Mental Health Services and 1 in Specialist Mental Health Services in 2016/17.

The number of Serious Incidents in Specialist Services has decreased from 16 last year to 11 in 2016/17. In Specialist Services, although the number of AWOLS has increased from 4 to 8, there has been a decrease in the number of Serious Accidents from 6 last year to 2 in 2016/17 and reductions in other categories of serious incidents.

The Trust is committed to achieving an ambition of zero avoidable suicides by 2017 and has prioritised suicide reduction through its sign up to safety campaign. A comprehensive forward looking action plan has been developed to deliver transformational change to how staff assess and plan for safety within services, supported by the plan to commission specific suicide prevention training for all staff, underpinned by a cultural review of the organisations' understanding and attitudes towards suicide prevention.

Data source: Serious Incident Database
National definition applied: EoE and Midlands definition applied





	2014-15	2015-16	2016-17
South Essex MH	34	45	46
Specialist Services	8	16	11

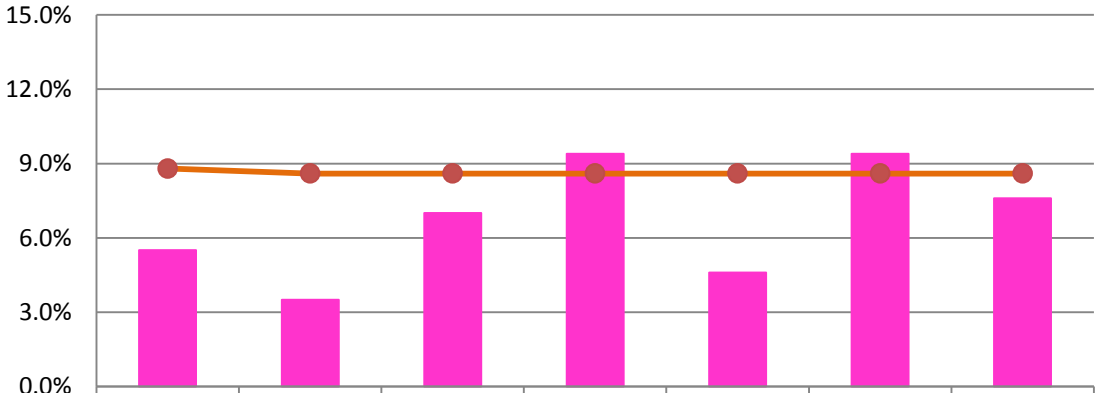
Readmissions
CLINICAL EFFECTIVENESS

Readmission rates have been used extensively to conduct national reviews into the effective delivery of health services as well as CQC cross-checking arrangements. The number of re-admissions, as well as the % re-admission rate are monitored regularly throughout the organisation. Performance is monitored at ward, speciality and locality level to ensure that any deviation from expected numbers can be quickly located and investigated. The targets for adult and older people re-admission rates are derived from the 2015/16 NHS Benchmarking Club (further information can be found at www.nhsbenchmarking.nhs.uk). In the graphs below, good performance is illustrated by levels of activity below the target line.

Data source: SEPT System (IPM) **National definition applied:** Yes

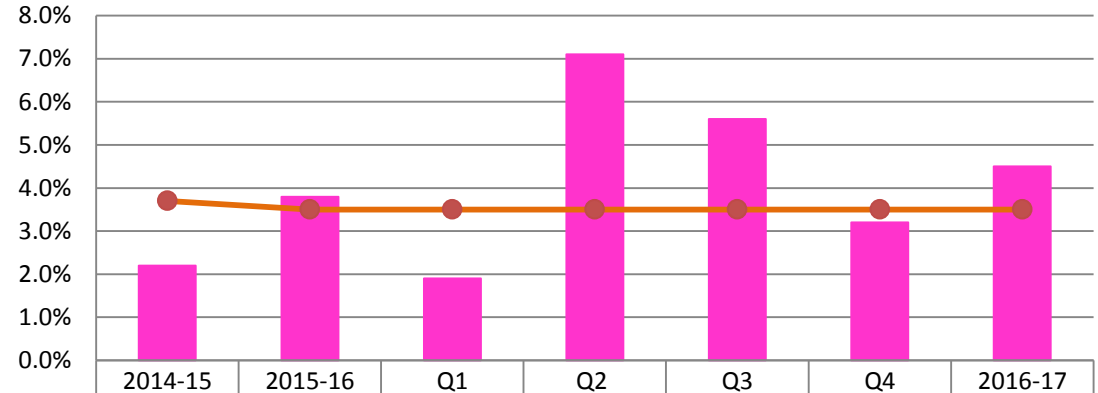
The target % for Adults Re-Admitted within 30 days has been achieved in the first and third quarters and for the year as a whole. However the target has been breached in the second and fourth quarter. Elderly Re-admissions achieved the target in the first and fourth quarters, but have breached the target in the second and third quarters and for 2016/17 as a whole. This % for Elderly readmissions represents 11 readmissions out of a total of 244 discharges. Due to reporting challenges associated with the implementation of a new information system for Mental Health services in 2016/17 (outlined in section 2.4.6), this data has only recently been available to the Trust and action is now being taken to follow up the reported performance.

Adult Patients Re-Admitted Within 30 Days (Mental Health)



	2014-15	2015-16	Q1	Q2	Q3	Q4	2016-17
SEPT	5.5%	3.5%	7.0%	9.4%	4.6%	9.4%	7.6%
Target	8.8%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%

Elderly Patients Re-Admitted Within 30 Days (Mental Health)



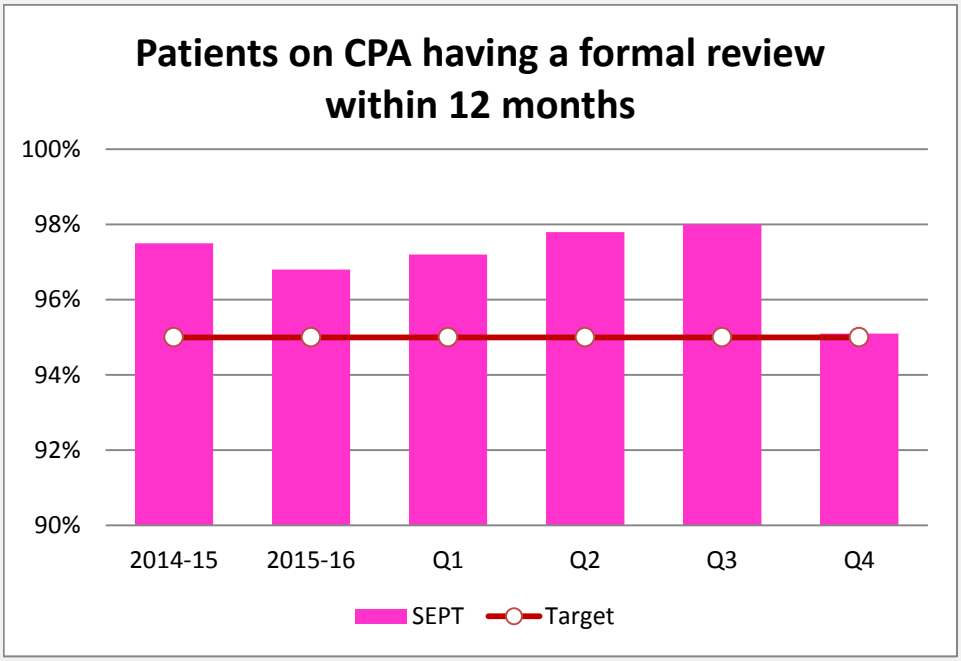
	2014-15	2015-16	Q1	Q2	Q3	Q4	2016-17
SEPT	2.2%	3.8%	1.9%	7.1%	5.6%	3.2%	4.5%
Target	3.7%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

Section 3.4: Performance against key national priorities

In this section we provide an overview of performance in 2016/17 against specified key national targets relevant to SEPT's services contained in NHS Improvement's (NHSI) Single Oversight Framework. The Single Oversight Framework was introduced on 1 October 2016 to replace the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework'. It is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. NHS Improvement specified in their national guidance for Quality Reports 2016/17 which of these indicators should be reported within Quality Reports for 2016/17. Data for two targets from the Single Oversight Framework required to be included in Quality Reports (ie "Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay" and "Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team") has been reported in the national mandated indicators section of this report (section 2.5). SEPT is pleased to report that, with the exception of one indicator ("Early Intervention in Psychosis referrals treated within 2 weeks of referral with NICE compliant care packages"), compliance has been achieved across all indicators reported below throughout 2016/17.

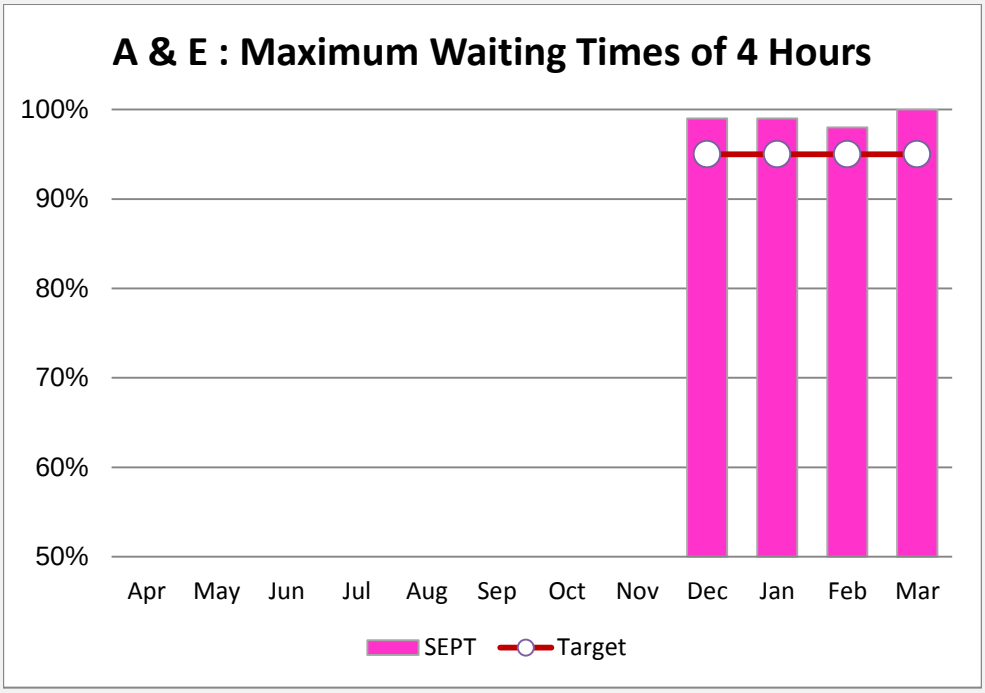
People having a formal review within 12 months

This indicator applies to adults who have been on the Care Programme Approach for at least 12 months. The target set by NHS Improvement (formerly MONITOR) of 95% provides tolerance for factors outside the control of the Trust which may prevent a review being completed for all patients every 12 months. Compliance has continually been achieved throughout 2016/17.



A & E: Maximum waiting times of 4 hours

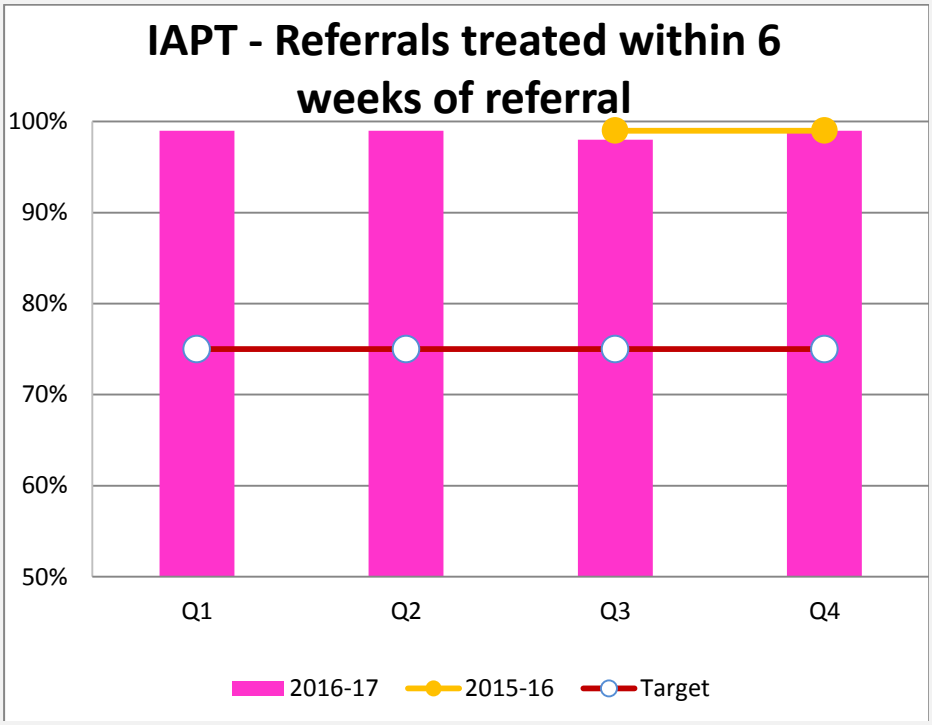
The NHSI compliance threshold is for 95% of patients to be admitted/ transferred or discharged from A & E within 4 hours of arrival. In November 2016 SEPT commenced management of the Urgent Care Centre in West Essex and has achieved this target during the remainder of 2016/17.

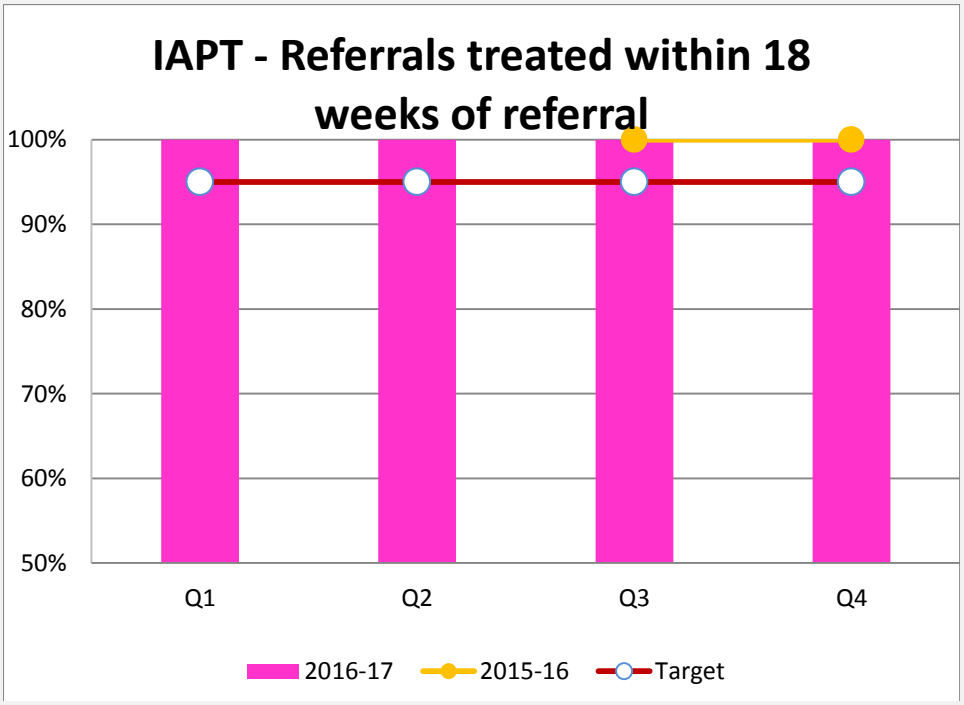


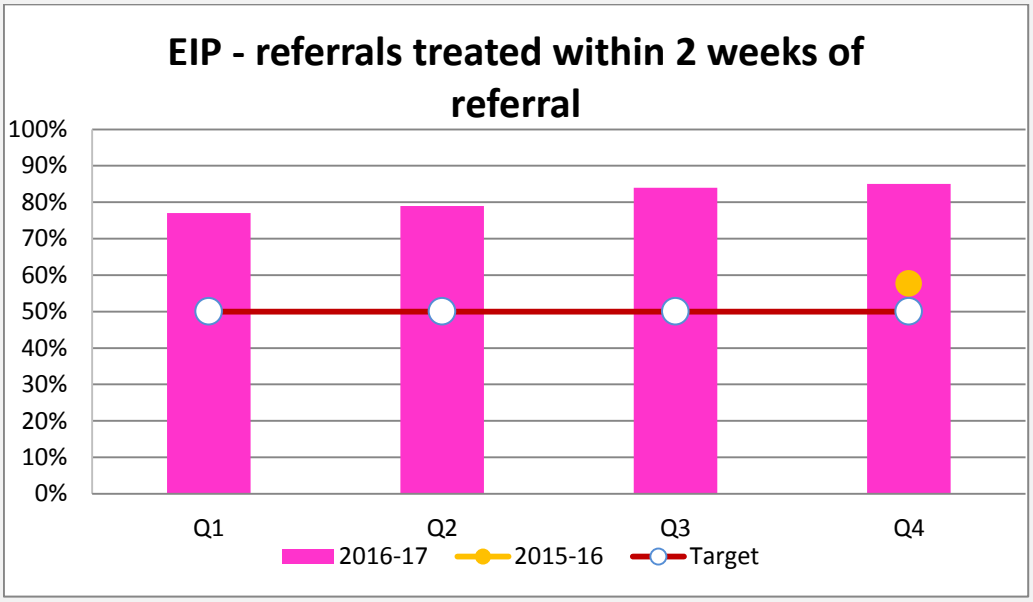
Improving Access to Psychological Services: Referrals treated within 6 weeks and 18 weeks of referral

These indicators were introduced from Q3 2015/16 to measure the time between referral and treatment by IAPT services.

Compliance with both of these targets has been achieved consistently throughout 2016/17







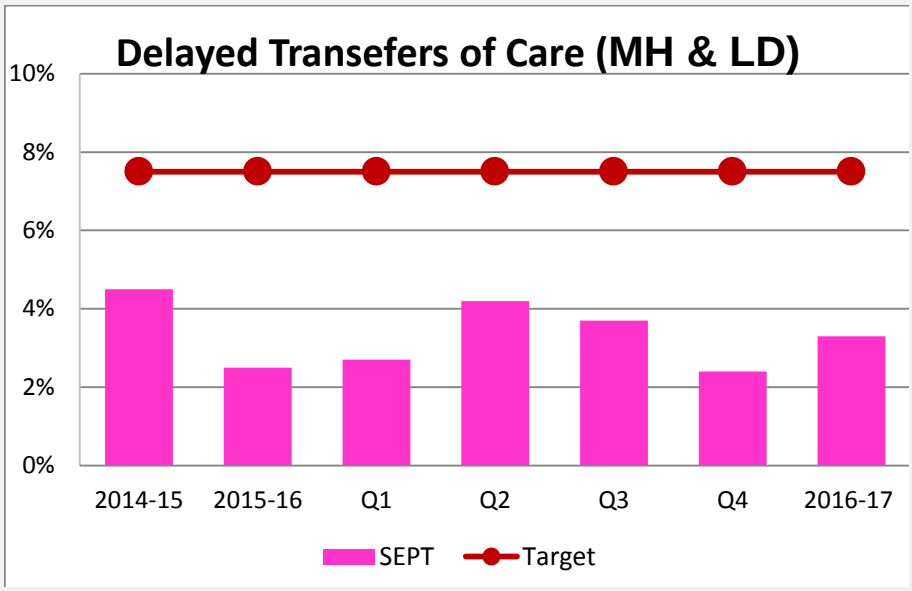
Early Intervention in Psychosis: Referrals treated within 2 weeks

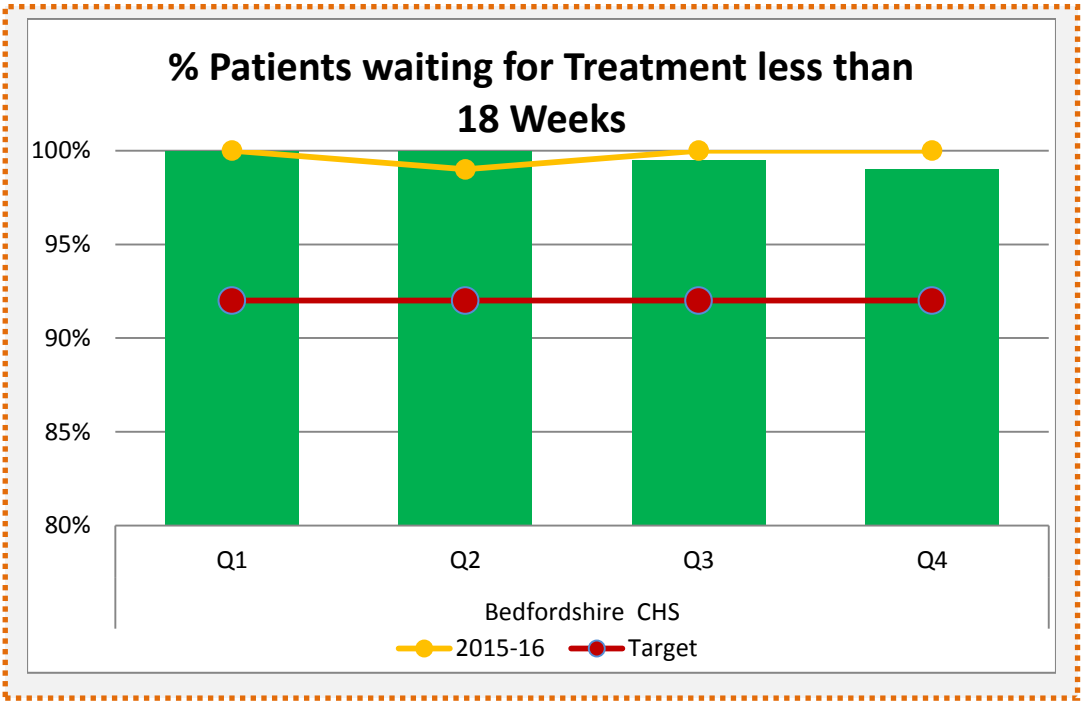
This indicator was introduced in Q4 2015/16 to measure the percentage of referrals for people with a first episode of psychosis who are treated within 2 weeks. From Q1 2016/17 it was enhanced to include compliance with NICE packages of care.

South Essex Mental Health Services are not currently commissioned to provide NICE compliant packages of care.

Delayed Transfers of Care (DTOCs) (MH & LD)

This indicator is calculated as the % of inpatient beddays lost to DTOCs due to either NHS or Social Care related issues for both mental health and learning disability services. The target which has been carried forward from the NHSI Risk Assessment Framework is less than 7.5%. This target has been achieved consistently throughout 2016/17.





% Patients waiting for treatment less than 18 weeks

This indicator measures the treatment waiting times for patients on non-admitted consultant-led pathways. The maximum waiting time is 18 weeks and the target is 92% of those still waiting. This target has been consistently achieved throughout 2016/17.

Only Bedfordshire CHS has a GP to consultant referral pathway for Paediatrics.

Section 3.5: Listening to our patients and service users

We believe that receiving and acting on feedback from our service users is crucial to maintain the high quality standards we have set ourselves and work continues to increase the feedback received. This section of our Quality Account outlines some of the ways in which we capture feedback from people who use our services together with some examples of changes we have made and outcomes resulting from that feedback. Information in terms of the results of the Friends and Family Test (FFT) is included in Section 3.3 of this report (local quality indicators).

Patient Survey Feedback

The Trust has in place a unified patient survey - this draws together the national NHS Friends and Family Test (FFT) and a further series of local questions around key areas we identified together with people who use our services. Surveys are sent to all patients who have recently been discharged, either from inpatient services or community caseloads as well as some patients who have chronic long term conditions to ensure they continue to receive a good service. Carers are also asked to complete the survey for those unable to fill it in themselves.

The Patient Experience Team provides team managers with regular reports which detail the results from the Surveys for their team. Managers review the content of these reports and discuss the feedback with their team or individual where appropriate, using it as an opportunity to reflect on practice and look for improvements. Managers are encouraged to use positive feedback to share and reinforce good practice, as well as encourage further participation in the survey.

Question	SEPT Overall Scores 2015/16	SEPT Overall Scores 2016/17	Increase / decrease between 2015/16 and 2016/17 scores
To what extent did you feel you were listened to?	9.3	9.3	➡
To what extent did you feel you understood what was said?	9.4	9.4	➡
To what extent were staff kind and caring?	9.6	9.6	➡
To what extent did you have confidence in staff?	9.5	9.5	➡
To what extent were you treated with dignity and respect?	9.6	9.6	➡
To what extent did you feel you were given enough information?	9.4	9.4	➡
How happy were you with the timing of your appointments?	9.3	9.3	➡
How would you rate the food?	6.7	6.9	⬆
To what extent would you say the ward/clinic was comfortable?	8.8	8.8	➡
To what extent would you say the ward/clinic was clean?	9.3	9.3	➡

A total of 10,081 responses were received to the Survey in 2016/17. The results of the answers to the local questions are detailed in the table above (figures denote average score out of 10).

Food continues to show the lowest satisfaction rating although this has increased over the year. It should be noted though that responses in this particular category are very low. The Food Task & Finish Group originally set up last year developed a Food Strategy for the Trust - as part of that, another complete audit of the food service (including tasting) was undertaken by the Patient Experience Team. Further audits continue to be undertaken and will continue into the future.

Other Key Patient Experience Engagement Activities

Mystery Shopper Programme: Mystery Shoppers are patients and carers who give anonymous feedback about their actual experiences of using services, naming the staff they have had contact with. The feedback is monitored by Directors and Team Managers. Individual staff receive feedback in supervision sessions with their manager on how their practice has been perceived by patients and carers. The feedback received has a direct impact on patient and carer experience and outcomes, systems and quality. Mystery Shoppers can opt to give feedback via completing questionnaires, email and telephone. Feedback specifically about issues they may have encountered in accessing or using SEPT services which relate to the Equality and Diversity protected characteristics is also captured.

SEPT On the Spot: These events were set up last year to incorporate the previous "Take it to the Top" and "Let's Talk About "events that took place across the Trust. The aim of these events was to give service users, carers, members of the Trust and governors as well as the Public a chance to speak directly to the Chief Executive about the services provided by SEPT. These were held across all localities, and included different presentations from teams relevant to the locality as well as updating everyone on the trusts planning process and the merger with NEP. Feedback was generally positive although attendances did vary considerably from locality to locality.

Stakeholder Forums: Service users, carers and staff are invited to discuss services in their area and share feedback with the Trust. Forums are chaired by an associate locality director who is supported by operational staff. These are well received and some smaller forums were also held more as discussion groups. These all include patients, carers and local voluntary organisations.

Service User/Carer Involvement: One of the Trust's priorities has been to involve service users and carers more to play a meaningful role not only in current services but also the future of Trust services. A service user and carer reference group was set up to discuss the merger and begin co-production work on the clinical model for the new Trust.

Examples of actions we have taken / outcomes from service user feedback we have received

The following are just a few examples of actions we have taken / outcomes that have been achieved as a result of listening to feedback from our patients, service users and carers over the past year:

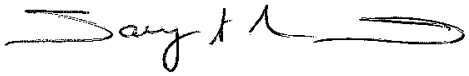
- Specific changes on how we communicate with patients and service users (eg appointment letter content, answerphone messages).
- Clearer information leaflets regularly updated.
- Staff introducing themselves appropriately continuing the "Hello my name is" campaign.
- Greater involvement of carers in the care of those they look after.
- Service user involvement in staff training giving the lived experience viewpoint.
- Adaptations to clinical areas.
- Varying the number and location of local forums in response to those who were either experiencing difficulties to attend or who had not been engaged with before.
- Strengthening and expanding the "Buddy" scheme, where service users and carers are "buddied" up with a student nurse ensuring the lived experience contributes to the trainees learning.

CLOSING STATEMENT FROM SALLY MORRIS, CHIEF EXECUTIVE

I am proud to present our quality achievements for 2016/17 in our final year as SEPT. I am grateful to you for taking the time to read this report and I hope it has been presented in a clear and useful way for you.

As I mentioned earlier, SEPT merged with NEP on 1 April 2017 to become Essex Partnership University NHS Foundation NHS Trust (EPUT). Throughout the year, our Interim Board of Directors will receive monthly reports on progress against the new organisation's quality goals. These meetings, as well as various other Trust meetings, are open to the public. I would like to encourage you to attend our monthly Board Meetings and other public events. At every meeting there is an opportunity for you to ask any questions of the local staff and managers responsible for care in your area. Details of all these meetings are available on our website https://eput.nhs.uk/

2017/18 will be an exciting time for the new Trust and I hope that you will be able to come to future meetings to be involved. We look forward to seeing you.



Sally Morris
SEPT Chief Executive 2016/17 /
Chief Executive of the Interim Board of Directors, EPUT from 1 April 2017

If you have any questions or comments about this Quality Report or about any service previously provided by SEPT (now provided by Essex Partnership University NHS Foundation Trust), please contact:

Faye Swanson
Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Email: faye.swanson@eput.nhs.uk

ANNEXE 1 – Comments on the Quality Report / Account

We sent the SEPT Quality Report / Account to various external partners to seek their views on the content of the report. The responses received are outlined below for information – we thank them for taking the time to consider the information and for providing their comments.

TO BE INSERTED INTO FINAL DOCUMENT FOR PUBLICATION

ANNEXE 2 - Statement of Directors' Responsibilities for the Quality Report / Account

Please note, due to the timing of the Quality Report production and the merger of SEPT and NEP to form EPUT, this statement has been signed by the Board of Directors of EPUT in May 2017.

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 2016/17 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to May 2017
    - papers relating to quality reported to the board over the period April 2016 to May 2017
    - feedback from commissioners dated *{XX May 2017}*
    - feedback from governors dated *{XX March 2017}*
    - feedback from local Healthwatch organisations dated *{XX May 2017}*
    - feedback from Overview and Scrutiny Committees dated *{XX May 2017}*
    - the Trust's complaints report *(appertaining to 2016/17)* published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated *{XX May 2017}* and presented to the Board of Directors in May 2017
    - the 2016 national patient survey published on 15th November 2016
    - the 2016 national staff survey published on 7th March 2017
    - the Head of Internal Audit's annual opinion over the trust's control environment dated *{XX May 2017}*
    - CQC inspection report dated 19th November 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date: {DATE} Signature to be inserted on approval (Acting Chairman of the Interim Board of Directors, EPUT)

Date: {DATE} Signature to be inserted on approval (Chief Executive of the Interim Board of Directors, EPUT)

ANNEXE 3 - Independent Auditor's Report to the Council of Governors on the Annual Quality Report

TO BE INSERTED ON PUBLICATION OF FINAL REPORT

GLOSSARY	
CAMHS	Child and Adolescent Mental Health Service
CIPs	Cost Improvement and Income Generation Plan
CCG	Clinical Commissioning Group
CHS	Community Health Services
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CRHT	Crisis Resolution Home Treatment
CQUIN	Commissioning for Quality and Innovation
DoH	Department of Health
DTOC	Delayed Transfer of Care
DVT	Deep Vein Thrombosis
EIS	Early Intervention Service
EPUT	Essex Partnership University NHS Foundation Trust
FT	Foundation Trust
GP	General Practitioner
HOSC	Health Overview and Scrutiny Committee
HRA	Health Research Authority
IAPT	Improved Access to Psychological Therapies
IT	Information Technology
KPI	Key Performance Indicator
LD	Learning Disabilities
LTC	Long Term Condition
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning System
MHS	Mental Health Services
MHRA	Medicines and Healthcare Products Regulatory Agency
MHU	Mental Health Unit
MRSA	Type of bacterial infection that is resistant to a number of widely used antibiotics
MSK	Musculoskeletal
NCAPOP	National Clinical Audit Patient Outcome Programme
NCB	National NHS Commissioning Board
NEP	North Essex Partnership NHS Foundation Trust
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NIHR	National Institute for Health Research
NHSI	NHS Improvement (previously Monitor), the health sector regulator
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NRES	National Research Ethics Service
PICU	Psychiatric Intensive Care Unit
POMH UK	Prescribing Observatory for Mental Health UK
QIPP	Quality Innovation Productivity and Prevention
RCA	Root Cause Analysis
REC	Research Ethics Committee
SEPT	South Essex Partnership University NHS Foundation Trust
SI	Serious Incident
SUTS	Sign Up To Safety national campaign
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism – blood clots

This page is intentionally left blank

Appendix D

East and North Hertfordshire NHS
NHS Trust

Quality Account
2016-17

DRAFT FOR STAKEHOLDER COMMENT

To be amongst the best

Contents

Part 1:		
1a	Statement on quality from the Chief Executive	3
1b	About us	4
1c	Planning for the future	10
Part 2:		
2a	Priorities for improvement for 2017/18	15
2b	Review of quality performance in 2016/17	18
2c	Statements of assurance from the Board	41
2d	Performance against national core indicators	49
Part 3:		
3a	Review against selected metrics:	58
	• Safety	59
	• Clinical effectiveness	61
	• Patient experiences	62
3b	Duty of Candour	69
3c	Sign up to Safety	70
3d	Staff survey	70
3e	Care Quality Commission inspections	72
3f	Our staff	75
3g	Performance against national requirements	82
	Appendix 1 – Staff survey results	83
Annex		
1	Statements from stakeholders	84
2	Statement from auditors	84
3	Statement by the Directors	84

www.facebook.com/pages/East-and-North-Hertfordshire-NHS-Trust/15001842484

http://twitter.com/enherts

https://plus.google.com/117135604279206909718

https://www.youtube.com/user/Enherts

We always appreciate feedback from members of the public. If you'd like to tell us your thoughts on the Quality Account or suggest ideas for items to focus on in the future please let us know. We can be contacted by email ftmembership.enh-tr@nhs.net

Part 1

1a Statement on quality from the Chief Executive
1b About us
1c Planning for the future

1a Statement on quality from the Chief Executive

2016/17 marks the year of a strong focus on partnerships. Creating a NHS that is sustainable in the future requires flexibility and the drive to optimise care and treatment through working alongside partners in the community, with academic establishments and industry. Our staff are working hard to streamline services and are being assisted by industry experts to become more efficient by cutting out unnecessary steps or actions. Alongside this 2016/17 has seen significant investment in information technology, cutting out paperwork and ensuring we're working towards having systems that 'talk to each other' wherever healthcare needs are provided. This is difficult work but ultimately our patients should see the benefit as information becomes more readily available and people will have better access to help manage their own care.

The Trust continues to make progress with improving patient outcomes. Over 97% of patients staying overnight have consistently reported in the Friends and Family Test that they would recommend the Trust for care or treatment. Mortality rates are lower than ever and the care of patients suffering from stroke continues to improve. The falls rate continues to be low amongst our peers and the Trust has been chosen to support Dementia UK by becoming a host organisation for an Admiral Nurse initiative.

Staff are key to being a successful organisation delivering high quality care. With this in mind I am really pleased about the staff development opportunities that have been introduced during the year. A new cultural programme supported by a variety of leadership and development opportunities available to all staff will assist in their personal and professional development, which in turn will translate into better patient care. I am also pleased that staff say they feel engaged in the work they do and feel they are involved in developments as the organisation goes through considerable change.

As we enter 2017/18 there are challenging yet exciting times ahead. I am confident of our staff's ability to be resilient and to embrace the changes ahead. We know that we have more work to do on improving communication and some of the administrative functions. The service developments highlighted within the report will help to address these matters.

Finally I would like to thank our staff for their continued and tremendous dedication towards delivering and improving services. To the best of my knowledge the information in this document is accurate.

Nick Carver, Chief Executive

1b About us

East and North Hertfordshire NHS Trust provides secondary care services for a population of around 600,000 in East and North Hertfordshire as well as parts of South Bedfordshire and West Essex; and tertiary cancer services for a population of approximately 2 million people in Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

The Trust has a turnover of approximately £423m and employs 5,560 whole time equivalent members of staff.

During 2016/17:

		
150,000 people attended the Emergency Department	101,000 people were admitted	604,000 people attended out-patient appointments

Our hospitals

The Trust manages in-patient services at the Lister Hospital; out-patient services at Hertford County Hospital and the new Queen Elizabeth II (QEII) Hospital; and cancer services at the Mount Vernon Cancer Centre. Renal dialysis is provided from four satellite units and the Trust manages a community children's and young people's service.

Therapy services are provided under a service level agreement with Hertfordshire Community Trust and Pathology Services are provided by a consortium arrangement in which the Trust is a partner.

The **Lister Hospital** is a 730-bed district general hospital in Stevenage offering general and specialist hospital services. It provides a full range of medical and surgical specialties together with maternity and children's service . General wards are supported by critical care (intensive care and high dependency) and coronary care units, as well as pathology, radiology and other diagnostic services. There are specialist sub-regional services in urology and renal dialysis; and chemotherapy services are delivered via the Lister Macmillan Cancer Centre.

	Feedback from NHS Choices gives the Lister Hospital 4 stars out of 5 based on 424 ratings.
Requires improvement	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'requires improvement'

…the Triage nurse made sure I was seen very quickly and then another nurse took great care with me and was so lovely. I had obs, an X ray and a doctor consult and was in and out in 3 hours. The department was clean and I even got a cup of tea. Thank you!

Emergency Dept, March 2017

Had a 24 hour blood pressure monitor fitted and two months later still waiting results? Try and speak to staff but getting nowhere. Very frustrating!

January 2017

I recently saw a doctor in your ENT outpatients clinic after a nasal injury. The doctor was kind, caring and extremely professional. They explained everything thoroughly. At the end of my visit I [felt] confident that everything was healing as it should.

ENT, February 2017

The **Hertford County Hospital** provides outpatient and diagnostic services including:

- Radiology and Pathology
- A range of outpatients clinics
- GP out-of-hours service
- Specialist children's centre
- Physiotherapy and other therapies

	Feedback from NHS Choices gives Hertford County Hospital 3.5 stars out of 5 based on 22 ratings.
Good	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'good'

… was expecting to have a long wait, I was seen within 10 minutes of arrival, the staff was so helpful and caring, excellent service, thank you.
X-ray, October 2016

… receptionist hardly looked up the entire time and was very rude. The nurse was friendly which was good. I had to change the address on my mother's notes and was told to do that elsewhere downstairs and then the receptionist downstairs told me it wasn't their job and I went back to be told again it was obviously my fault and it was too much trouble. The actual clinical staff were friendly but the clerical staff terrible.
Outpatients, May 2016

The **Mount Vernon Cancer Centre,** based in Northwood in Middlesex, provides tertiary radiotherapy and local chemotherapy services from facilities leased from Hillingdon Hospitals NHS Foundation Trust.

The Cancer Centre offers a comprehensive radiotherapy service via nine linear accelerators and has Cyberknife™ and TrueBeam™ technology. Many patients are involved in clinical trials for both chemotherapy and radiotherapy treatments. There are two inpatient wards and a range of day-case services are offered.

Other services include:

- The Paul Strickland Scanner Centre providing comprehensive scanning services for the diagnosis, treatment, monitoring and research of cancer and other serious diseases, using leading edge PET/CT, MRI and CT scanners
- The Lynda Jackson Macmillan Centre providing support, information and therapies (eg massage) to people affected by cancer
- The Michael Sobell House (MSH) palliative care unit offers hospice services for those at the end of their lives, and their families. MSH has an inpatient unit and a day centre.

The Cancer Centre is supported by a wide range of volunteers easily identifiable by their yellow sashes or badges.

Feedback from NHS Choices specifically for the Cancer Centre is not collected.	
Requires improvement	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'requires improvement'

The new **Queen Elizabeth II (QEII) Hospital** is located in Welwyn Garden City. It is owned by the East and North Hertfordshire Clinical Commissioning Group, although clinical services are managed by the East and North Hertfordshire NHS Trust.

Opened in June 2015, on the site of the original QEII, the hospital offers a full range of outpatient, diagnostic (radiology, pathology and endoscopy), therapy and ante/post-natal services. It has a 24/7 urgent care centre for adults and children with minor injuries and illnesses and carries out some day case procedures. Pre-operative assessments are undertaken as well as care and treatment offered within The Vicki Adkins Breast Unit.

	Feedback from NHS Choices gives the QEII Hospital 4 stars out of 5 based on 109 ratings.
Requires improvement	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'requires improvement'

All staff members were very professional and in very good humour considering they were dealing with a human conveyor belt! I was called after a remarkably short time of about 15 minutes by another of the cheerful and pleasant staff, who sat me down, told me we very nearly shared the same birthdate, and took my blood painlessly and unnoticed whilst we laughed! I had such a good time in this spotless department that I want to go back again tomorrow!

Phlebotomy, February 2017

... The person who had originally told us to sit down said they couldn't remember having seen us coming to the desk 45 mins earlier.
…They then told us they will check us in now, so we had been sitting there all that time for nothing, this made us furious
…We got told there was a mix up as we were early
… They then said when we come next time just come to the desk to check in, that's what we did all along.

These two on this desk have no communication going on, and they are letting the patients down…we had to pay more on the parking as a result of them messing us about.

Fracture Clinic, January 2017

Satellite and Community Services

The Trust provides services in renal medicine and has satellite dialysis units at St Albans, the Luton & Dunstable Hospital, Bedford Hospital and the Princess Alexandra Hospital in Harlow.

The Trust offers community services for children and young people.

A strategy for quality

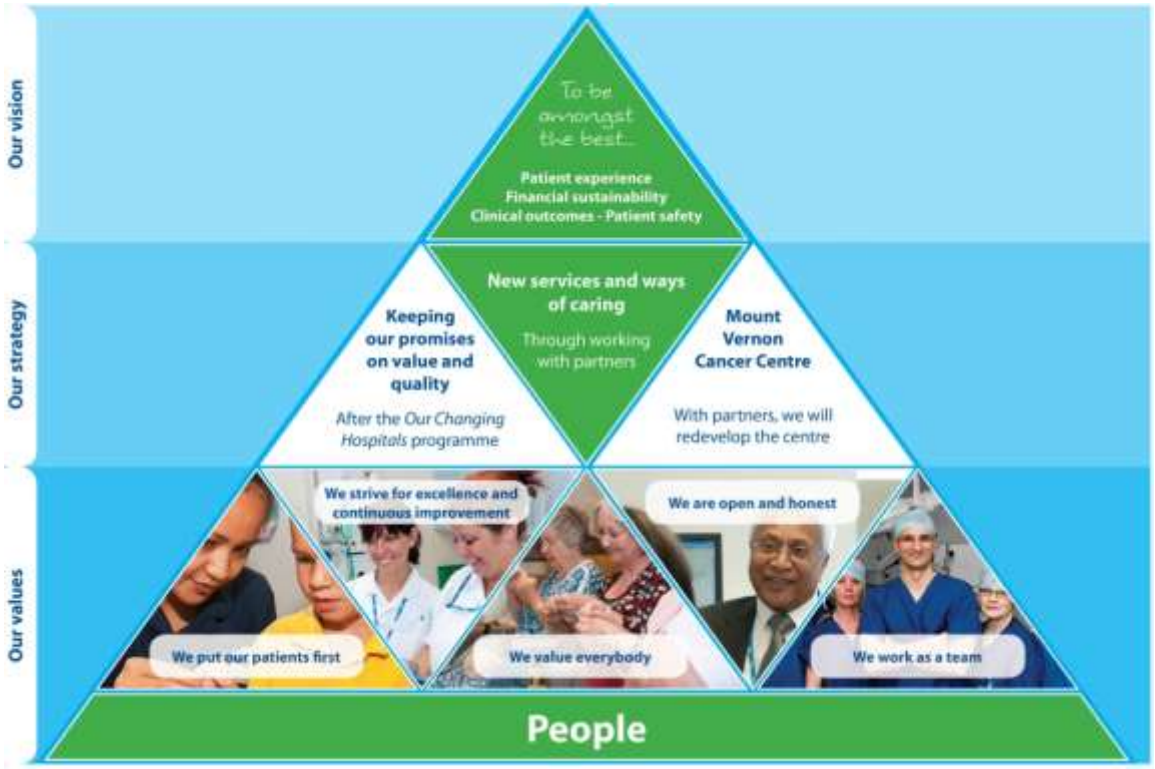
… they made me feel safe and made the whole experience tranquil and special.

… all the staff at the Lister were so reassuring, kind and warm that all my fears melted away.

Every midwife in the maternity unit and every doctor had time to talk to my husband and I, there was no clock watching and nothing was too much. The midwives on Gloucester ward are a credit to the Lister hospital and I will never forget the kindness that the management of Gloucester ward showed me. The management went above and beyond to make sure I was happy and comfortable, this sort of kindness is rarely seen anymore and for this I will be eternally grateful.

Maternity, January 2017

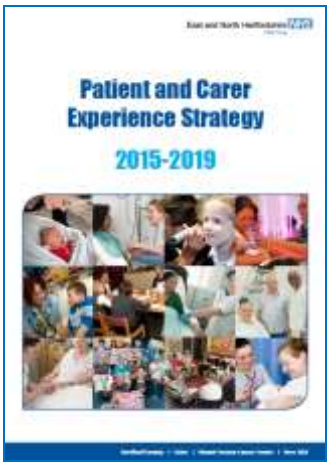
A diagrammatic representation of our quality strategy, with our vision ***"to be amongst the best"*** is shown in the picture below. Supporting the strategy are three strategic aims and the five Trust values. Underpinning the strategy are our staff.



Key to the delivery of the overall vision are a set of core values known as 'PIVOT'.

These values are incorporated into everyday working of staff and the business of the organisation.

The overarching quality strategy is underpinned by a range of supporting strategies, such as those shown below. Further information on the aims of these strategies is given in throughout this report.



Measuring and monitoring improvements

Within the Trust we collect information in a number of ways which can then be used to assess how effective our services are. We can use this information to plan future developments and improvements. Examples of our information collection methods include:

- Routine collection via the Patient Administration System – by inputting information about each individual's episode of care eg. diagnosis or length of stay we can generate a vast range of trends that can help in the future planning of services
- Surveys – results of national or local surveys help us to find out what our service users and staff think of our services
- Feedback from complaints and concerns allows us to rectify things that have not gone as well as planned
- Clinical audits help to assess if we are delivering services according to best practices
- National data collections for specific conditions allow for comparisons with other Trusts where we can learn from those performing better
- Special reviews or service evaluations undertaken by external agencies or partners provide critical appraisal. Results of such reviews are used as the basis for action planning. Service re-evaluation will often happen at a later date to confirm that quality is improved and sustained

Using the data available the Trust's clinical and management teams can measure how well we're performing. They will agree what to aim for in future – the *target or aim* - and a timeframe. Some of the performance measures and aims are mandated by NHS England and others are locally generated. Examples of these are given in section 2d.

Progress towards meeting the aims is routinely presented in reports, dashboards, graphs etc. Some of these are seen throughout this report. They are monitored by various groups, for example:

- Committees, including the Trust Board, who monitor progress
- Departments who review the outcomes and plan changes where necessary
- The executive team who scrutinise information, offering praise or challenge as necessary
- Commissioners (East and North Hertfordshire Clinical Commissioning Group) who purchase the Trusts services on behalf of the local community and scrutinise the outcomes to check that a high quality service is being delivered

By measuring outcomes regularly we can see if we are meeting our aims or not. If we are, then we'll set more demanding aims to raise standards further; if not we'll look at why and change how we do things to meet these aims.

Supporting teams to improve quality

The Trust has five clinical divisions: Medical, Surgical, Cancer, Women's and Children's and Clinical Support Services. Each is led by a Divisional Director and Divisional Chair. The divisions are separated into a number of clinical specialties each headed by a Clinical Director. The specialties are supported by senior nurses and managers. Together they are responsible for quality within their own areas.

The clinical divisions are at the forefront of our hospitals, delivering the care. Helping them to deliver high quality care are teams from the corporate divisions such as:

- Clinical advisors eg infection prevention and control team or the safeguarding team providing specialist advice and support
- Information team supplying data for service evaluation

- Education and Organisational Development teams ensuring staff are up to date with training and have opportunities for personal and career development
- Catering, portering, telephony, estates, supplies and cleaning staff who keep the day-to-day services running so that clinical teams can undertake their duties effectively
- Information technology teams keeping the IT systems running and supporting new ways of working with the increasing installation of electronic systems
- Human resources who support the recruitment and other staff management processes
- Those who support service evaluation and compliance such as the governance teams

The governance teams in particular support the clinical teams in delivering care that is safe, effective and provides a good experience. These teams eg. patient safety, patient experience, clinical audit & effectiveness, complaints and PALS together with those within the Company Secretary's office have a dual role – to support the delivery of optimum quality whilst also supporting staff and managing the effects of something going wrong or where care is sub-standard.

Committee structure

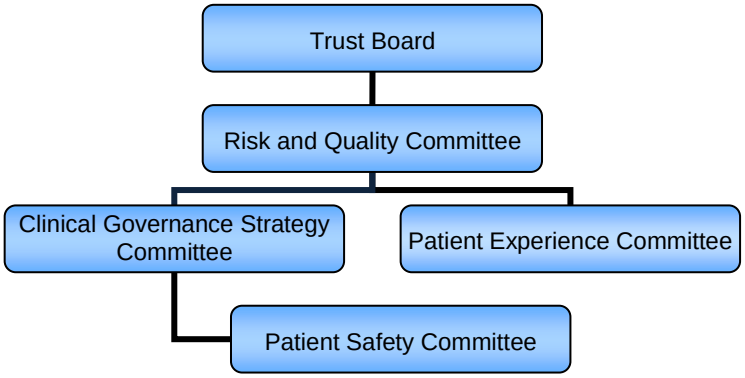
The Trust Board has overall responsibility for the delivery of quality. It scrutinises a range of quality indicators during its meetings which are held in public.

The Risk and Quality Committee (RAQC) has delegated responsibility for oversight of all aspects of quality. The committee holds executive directors to account on relevant aspects of their portfolio.

The main sub-committees for monitoring quality are the:

- Clinical Governance Strategy Committee (Chaired by the Medical Director)
- Patient Experience Committee (Chaired by a Non-Executive Director)
- Patient Safety Committee (Chaired by the Associate Medical Director for Patient Safety)

These each receive scheduled reports from departments, committees or individuals tasked with quality improvement, for monitoring and assurance purposes. Sub-committee membership comprises clinical and managerial staff; and a process of escalation enables significant achievements and any concerns or to be shared with the parent committee.



Performance reviews

Performance reviews are held every month. The executive directors meet formally with Divisional leads and their supporting staff to review all aspects of quality – to praise developments and the achievement of required standards; and to challenge any areas where improvement is required.

Rolling half days (RHD)

Each month (except January and August) all non-emergency activity is suspended for half a day to allow a significant proportion of team members to meet and review their practices. This dedicated time offers an opportunity to review outcomes such as audit findings, care reviews and incident investigations, and where necessary to make plans for improvement.

RHD 'learning points' and divisional reports providing tailored feedback are prepared by the governance teams and are circulated prior to the meetings for discussion. These highlight recent matters of concern or interest for sharing.

Local inspections

A number of inspections are undertaken whereby teams visit wards and departments to observe practices, discuss care with patients and their families and to discuss various aspects of care delivery with Trust staff. Such inspections may be undertaken by Trust staff, the Clinical Commissioning Group staff or members of the public/ patient representatives.

During 2016/17 inspections of the following services were undertaken:

- Emergency Department – safety and compliance teams
- Mount Vernon Cancer Centre – safety and compliance teams
- Ward 9A (Elderly Care) in February 2017 - Clinical Commissioning Group
- Medicines Management across 18 wards in January 2017 - Clinical Commissioning Group
- Emergency Department in November 2016 - Clinical Commissioning Group
- Mount Vernon Cancer Centre in November 2016 - Clinical Commissioning Group
- Ward 8b in October 2016 - Clinical Commissioning Group
- Visits by members of the public as part of a 15 steps challenge (a brief assessment based on initial opinions and observations formed within a few minutes of being on the ward)

These inspections are used to identify areas of good practice and identify where improvements are required. The involvement of clinical staff on an inspection team provides an opportunity for peer review and to share learning. Feedback from the inspections is reported back to staff in the relevant areas.

1c Planning for the future

Partnerships

The Quality Strategy diagram in section 1b shows "New services and ways of caring" as one of our strategic aims. To achieve this aim the Trust is a partner in the Hertfordshire and West Essex Sustainability and Transformation Plan (STP). Working with health and social care partners the Trust is developing new ways of working that will be sustainable in the long term. The plan is outlined in a document called '*A Healthier Future*'.

This sets out four main ways in which health and social care organisations plan to improve health and care in the future:

- Prevention – helping people to live healthier lives and live well with long term conditions
- Primary and community care – supporting more independent living through better coordinated care delivered at home or in the local community
- Acute care – using hospital care for specialist and emergency treatments only
- Improving efficiency – through better use of technology and resources

The acute care workstream aims to ensure that people only attend hospital when they need to ie. for emergency care and specialist care and treatment. The Trust is one of three acute trusts contributing to the STP – the others being West Hertfordshire Hospital NHS Trust (WHHT) and Princess Alexandra Hospital Trust (PAH). Each is working together to support each other where services become fragile. Called 'clinical service consolidation', the development of services across organisations will keep them local and sustainable. Examples of this support include:

- **Vascular surgery and interventional radiology:** The Trust is working with PAH to set up a vascular network covering the eastern area of the STP footprint
- **Paediatric urology:** The Trust will provide one day/week paediatric urology service at PAH to enable the continuity of this service
- **Nephrology:** Agreement in principle for the Trust to be the provider of outpatient and in-reach service at PAH
- **Specialist cancer surgery:** Agreement in principle for the Trust to become the specialist cancer surgery centre for complex urological cancer surgery referrals from PAH, avoiding the need for patients to travel into London for surgery from 2017/18 (subject to agreement with Specialist Commissioners).

In addition partnership working is aiming to:

- Standardise care and treatment to reduce unwanted variation
- Reduce the costs of non-clinical and back-office functions by sharing services where possible
- Develop electronic systems that will support decision making and information sharing, as per *Local Digital Roadmap*

Streamlining services

A team of Lean 6 Sigma specialists is currently employed by the Trust to re-design some processes that are not working as well as desired. The specialists work with clinical teams, managerial teams and external partners where relevant to analyse the current processes, looking at all the component steps and how these can be simplified to become more efficient. Examples of such projects and achievements are given below.

- The handover of patients, within 15 minutes, from ambulance crews to emergency department staff is now achieved in 81% of cases, compared with 10% before the project began. It is also possible to identify the reasons why the remaining cases were not achieved
- The preparation of 'to take out' medications currently takes 2 hours. Working with pharmacy staff the Lean team has redesigned a new process of working which should reduce the preparation time to 30 minutes, thereby potentially reducing discharge time by 90 minutes. Implementation will start once a new IT system change has been completed

- Patient experience and staff efficiency has improved in the Lister Macmillan Cancer Centre due to layout redesign, reduction of overbooking and the elimination of delays or replication of paperwork

The team has trained over 100 staff to date on the use of various Lean 6 Sigma tools and during 2017/18 will be working with the Organisation Development team to deliver a training programme for the whole Trust. Projects that have just started relate to waiting times for patients with cancer and the improvement of catering processes.

A company called Four Eyes Insight have been contracted to support the review of theatre services focusing on theatre productivity eg. improving scheduling and reducing cancellations. The company is currently working with a number of specialties with the improvements in outcomes becoming visible in 2017/18.

Technology

Some fantastic technology is employed for a range of clinical treatments such as robotic surgery and remote monitoring of health conditions. There are also sophisticated systems in use providing services such as access to test results. However the Trust is still largely paper-based and dependent upon systems that do not always 'talk to each other' or do not take advantage of the everyday technology now available.

The Trust's Information Management and Technology (IM&T) Strategy aims to address this imbalance.

"A successful NHS organisation needs up-to-date, trustworthy information and the technology and infrastructure in place to support staff to access the right tools and information as and when they need it."

"This strategy sets out to identify the essential information that the Trust needs to achieve its corporate ambitions at a strategic level and to deliver safe, efficient and effective clinical care."

The IM&T Strategy has six elements:

- Improving patient care by providing the right information at the right time to the right place
- Becoming the hospital of choice through improving patient experience by introducing services such as self check-in
- Delivering digital care through electronic records and prescribing
- Improving the IM&T function through standardization
- Producing an infrastructure fit for future development that is resilient and secure
- Using data to support decision making by improving access to real time information

An Innovation Programme was set up to deliver the objectives outlined within the Strategy, with resource and time assigned to the programme. There are 20 active projects. Most significantly, during 2016/17 staff prepared for the introduction of a system to support electronic observations and escalations (detailed later in the report). The system pilot commenced in March and the full roll-out is expected by July 2017. In addition, the foundations to support electronic prescribing are being put in place and the testing phase for a new patient administration system, called Lorenzo, is underway. Lorenzo is due for deployment in July 2017.

Engagement

The Engagement Strategy 2016-19 sets out the ambition and priorities for engagement over the next three years. It ensures we will further build our growing reputation for partnership working and community engagement.

The Strategy outlines our vision for:

- Community leadership
- Member development
- Service delivery, development and transformation
- Clinical engagement

The Engagement Strategy links with the Trust's work with media, MPs, communications, patient experience, workforce and organisational development. Our aim is to work with partners (service users, public, staff and other organisations) to identify our needs and aspirations then to develop and implement the plans to achieve service improvement.

University Trust Status

The Trust is delighted to have achieved University Trust status in early 2017. The Trust already has a successful working relationship with the University of Hertfordshire through its nurse training programme. It also has a shared commitment to research, education, service and teaching.

In future the partnership will provide a number of benefits:

- Quality of Care will be improved through enhanced opportunities in education, training, research and innovation
- Service improvement eg. through use of process engineering
- Public and Patient Engagement will be enhanced by close working with academics from the schools of Health and Social Work and Life and Medical Sciences
- The workforce will be enhanced by improved recruitment and retention and higher levels of knowledge, skills and expertise.

Learning and Development Strategy

The Learning and Development Strategy 2017-20 sets out how the Trust will ensure its workforce has the right knowledge and skills to deliver high quality care and is equipped to meet the challenges of the future.

The Strategy has four strategic goals:

- Create and sustain an educational experience for all learners that inspires them
- Develop a culture that recognises learners as individuals
- Links education to role and career development
- Develop the highest level of technical expertise utilising best practices and latest technology

The strategy outlines the tasks required to achieve the strategic goals such as introducing new roles; working more closely with university partners to support training and embracing technology such as simulation and use of mobile Apps. The strategy also focuses upon improved learning from things that haven't gone as well as intended; and also increases engagement with patients and the public to support self-care.

Part 2

2a	Priorities for improvement for 2017/18
2b	Review of quality performance in 2016/17
2c	Statements of assurance from the Board
2d	Performance against national core indicators

2a Priorities for improvement for 2017/18

In order to seek views about priorities for 2017/18 the following actions were undertaken:

- Existing priorities and indicators were reviewed to ensure they were relevant. This formed the basis of the debate during the consultation stages
- Review of areas of performance where local intelligence monitoring indicates there is further room for improvement eg. PALS concerns, complaints, NHS Choices, national surveys
- Review of the operating plan and workstreams outlined within the Sustainability and Transformation Plans
- Consideration of CQUIN requirements

In addition the opinions of staff and service users were sought from the following committees:

- Involvement Committee
- Patient Experience Committee
- Patient Safety Committee
- Clinical Governance Strategy Committee

The final decision on priorities was determined by the Executive Committee after deliberation of the findings and consideration of existing priorities and their outcomes. The results were presented to the Risk and Quality Committee for final approval.

Patient safety

1. Improve medication management

The pharmacy transformation programme 2017/18 will be introducing a range of medication related improvements.

Leads:
Medical Director
Director of Nursing & Patient Experience

- In-patient survey results of medication purpose >8.4
- In-patient survey results of medication side effects >4.8
- Introduce set of leaflets (subject to funding) for medication group eg painkillers, antibiotics
- Critical medication doses omitted <7% in medication thermometer
- Complete Medicines Optimisation Strategy milestones
- Demonstrate benefits on 3 wards of the hospital pharmacy transformation programme

2. Progress 'deteriorating patient' work

The introduction of electronic observations is intended to help identify and reduce deterioration.

Leads:
Medical Director
Director of Nursing & Patient Experience

- Rollout of Nerve Centre as per plan
- Undertake human factors review in maternity
- Improvement against results of 2015/16 Audit of Unexpected Critical Care admissions
- No. of cardiac arrest calls < 174
- Observation Compliance >=98%
- Identify all cases of poor escalation within SI reports (recorded on Datix)

Clinical effectiveness

3. Further reduce mortality

An on-going priority aiming to reduce mortality through service development and mortality reviews. Recognise the national importance placed on publication.

Lead: Medical Director

- HSMR <95.3
- SHMI 'within normal range' and 'below 110'
- SHMI (inc adjustment for palliative care) <98.5
- Mortality review – areas of concern discussed at each meeting of the Clinical Governance Strategy Committee
- Demonstrate learning from mortality review process

4. Further improve stroke standards

An ongoing priority to monitor the sustainability of changes following service expansion.

Lead: Chief Operations Officer

- 3 hour thrombolysis >=12%
- 4 hours to stroke unit >=90%
- 90% time on stroke unit >=80%
- 60 minute to scan >=90%

Patient experience

5. Improve communication

Communication failure remains one of the most common concerns identified via feedback mechanisms. Continuing service and staff development should reflect in this priority.

Leads:
Director of Nursing & Patient Experience
Chief Operations Officer

- Electronic survey results of involvement in decisions >83%
- National In-patient survey results of consistent information >7.8
- Electronic survey results of providing understandable answers >88% (doctors) and >90% (nurses)
- National In-patient survey results of having point of contact >7.8
- Reduce rate of communication related complaints per bed days <0.144%
- Reduce rate of communication PALS concerns per bed days

6. Improve nutrition and hydration	
To continue oversight of the delivery of the Food and Drink Strategy and evaluate the effectiveness of service redesign. Lead: Director of Nursing & Patient Experience	• In-patient survey results of quality of food >5.2 • In-patient survey results of choice of food >8 • In-patient survey results of help with eating >7.5 • Delivery of strategy milestones • Compliance with nutritional aspect of ward observational tool >=95%

7. Improve patient flow	
A new priority to evaluate the effectiveness of a variety of service transformation processes. Lead: Chief Operations Officer	• Reduce cancellations <504 • Reduce re-admissions <7.75% • Reduce delayed discharges from critical care • Discharge summary to GP within 48 hours • Reduce complaints relating to delays per 100 bed days <0.08%

Progress in delivering these priorities will be monitored by the following means:

- Scheduled reports to the Risk and Quality Committee / Trust Board:
    - Medical Director's Mortality Report
    - Director of Nursing's Patient Safety Report
    - Director of Nursing's Patient Experience Report
    - Chief Operating Officers update reports
- Monthly 'Floodlight' report to the Board
- Medication Forum
- Patient Safety Committee
- Monthly reviews of mortality concerns and quarterly thematic reviews at the Clinical Governance Strategy Committee
- Patient Experience Committee
- Nutrition Group

Trust Board papers are published on the Trust's website.

2b Review of quality performance in 2016/17

In the 2015/16 quality account a list of priorities for delivery during 2016/17 was stated. Progress against each of these priorities is given in the sections below.

Improving safety

Priorities	What success will look like
1. Improve medication management Medication audits show that initiatives to improve medication management are working. We wish to make further improvements in this area.	• In-patient survey results of medication purpose >8.4 • In-patient survey results of medication side effects >4.8 • Reduction of medication incidents resulting in harm <10% • Critical medication doses omitted <7% in medication thermometer • Complete Medicines Optimisation Strategy milestones • Medicines reconciliation within 24 hours of admission >80% • >90% administration of antibiotics within 1 hour of prescription for septic patients in the emergency department
2. Introduce Human Factors[1] There is increasing emphasis placed on this developing area nationally. It is also a priority identified within the Improving Patient Outcomes Strategy	• Deliver a new style serious incident investigation training >=4 times during 2016/17 • Undertake a human factors review of 2 clinical areas • Identify all cases of poor escalation within SI reports (recorded on Datix)

[1] 'Human factors' examines the interaction between a person and their working environment (team, organisational culture,

Priority 1: Medication management

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
1.1	Inpatient survey: - medication purpose	8.2	8.4	8.2		>8.4	
1.2	Inpatient survey: - side effects	4.4	4.8	4.8		<4.8	
1.3	% medication incidents leading to harm	11.96	11.76	10	**11.62**	<8.8	✘
1.4	% critical medication does omitted		21.92%	5.31%		<7	
1.5	Medicines Optimisation Strategy milestones		115	125		>125/144	
1.6	% medicines reconciliation within 24 hours of admission			76.1%	**84%** **(2016)**	>80%	✓
1.7	Admin of antibiotics within 1 hour of prescription for septic patients in the emergency department			Q3 60% Q4 56%	**47%**	>90%	✘

Priorities 1.1 & 1.2 - Inpatient survey

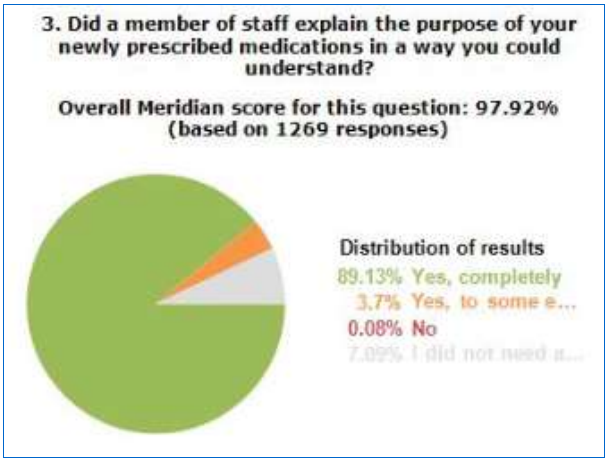
The national in-patient survey measures two important aspects of medicines management:

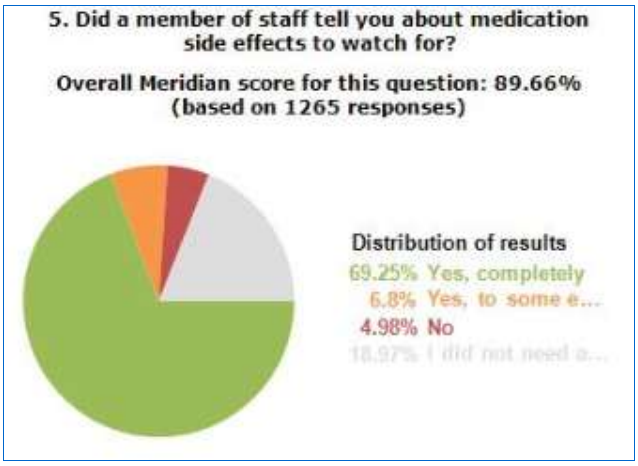
- staff explained the purpose of medications in a way a patient could understand
- staff explained about medication side effects to watch out for at home

The results from the 2016 survey are shown below.

Awaiting result – due May

Almost 1270 people contributed to the Trust's electronic pharmacy survey during 2016/17 whereby two of the questions asked replicated those of the national survey. The results are shown in the pie charts below.





Priority 1.3 - Medication incidents leading to harm

1033 medication incidents were reported by staff during the year, the vast majority causing no harm.

The data below looks at harm rates. However, caution must be applied as the numbers are very small and this information is only reliable if all medication incidents are reported; and also. The aim was to reduce the rate of harm by 10% compared to the previous year ie 8.8% of all medication incidents.

Although not meeting the overall aim the number of harm-related incidents is small. During the year 2.9% of medication incidents led to significant harm.

	16/17	Aim	Met
No. harm incidents	**120**	-	-
% harm incidents (all harm incidents)	**11.62**	<8.88	✘
No. moderate & severe harm & death incidents)	**30**	-	-
% incidents (moderate, severe & death incidents)	**2.9**	<2.56	✘

Of greater importance is the learning that has occurred as a result of these incidents. Some examples include:

- Change in process in the delivery of chemotherapy
- Recording of first antibiotic doses on the 'give now' section of the medication chart
- Enhanced education
- Changes in identification markings on insulin pens

Priority 1.4 - Medication omission audit

Medication is considered to be delayed if it is administered more than 60 minutes, but less than 2 hours late. An omitted dose is defined as one either not given or given more than 2 hours late.

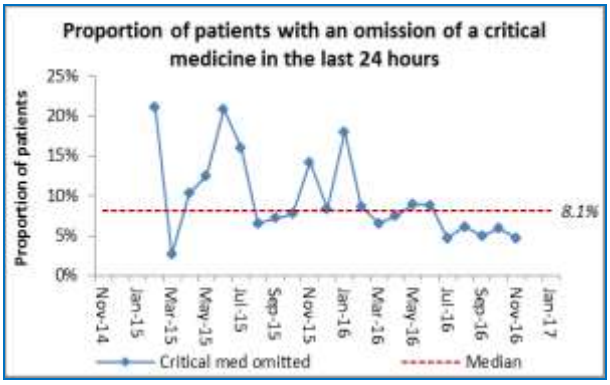
Some medications are known as 'critical' where delay or omission may have a significant impact upon a person's health or wellbeing. Examples of such medications are insulin for diabetes, anti-Parkinson's drugs and anticoagulants.

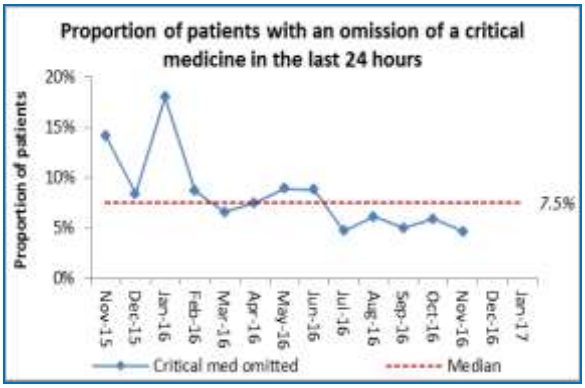
The annual audit of delayed or omitted critical medication shows the following (add once analysed):

	May 2014	January 2015	December 2015	January 2017
Total no. of critical drug doses	1432	2547	6236	
% of doses given correctly	76.75%	89.16%	92.67%	
% of doses omitted	**21.92%**	**10.33%**	**5.31%**	
% of doses delayed	1.33%	0.51%	2.02%	

The Medication Safety Thermometer is a national standardised audit tool that measures medication-related errors. Data is collected by nurses and pharmacists on one day each month on 100% of patients present on six medical wards, five surgical wards and two wards at the Cancer Centre. The data collected is entered onto the national thermometer web-tool. This generates charts summarising ENHT results and compares the results with data from other Trusts.

Results of omitted critical medications for the last two years, and for the last year are shown in the charts below. These show an improving picture from a 2 year median of 8.1% to a 1 year median of 7.5%. There is also a reduction in variation indicating that quality improvement methods are becoming embedded.





Although data continues to be collected each month a change to the national web-tool means that more recent graphs are not yet available.

To help reduce medication omissions the Trust has:

- increased to three the number of wards offering self-medication, with self-medication offered to patients with Parkinson's Disease on a further two wards
- fitted patient-own-drug lockers with each nurse having their own key to retrieve medication thereby saving time taken by nurses searching for keys

- taken a focused approach on critical medications such as anticoagulants and insulin working with staff on targeted projects

The Trust is increasing the number of non-medical prescribers, such as specialist nurses. Such staff can prescribe and administer specific medications in the absence of a doctor thereby streamlining care delivery.

Weekly drug chart reviews have been piloted on four wards. Pharmacy staff join medical and nursing staff to look at prescribing quality with the emphasis on learning and accurate prescribing. This practice will be extended to other wards during 2017/18.

Priority 1.5 - Implement Medicines Optimisation Strategy

The Trust's Medicines Optimisation Strategy was published in July 2014. It was based upon a national framework which helps Trusts to evaluate practices and identify areas of good practice and where development is required. Year on year actions have been implemented to continuously improve upon the original baseline score of 115/144. Actions undertaken in 2015/16 increased the score to 125/144 and actions undertaken in 2016/17 have resulted in a score of xxx/144.

Some achievements in the last 12 months include:

- More than 85% of outpatient prescriptions at the Lister site are dispensed within 15 minutes; and more than 95% within 30 minutes. Overall patient satisfaction for the pharmacy outpatient prescription service is above 96% month on month
- The Lister dispensing service is available 7 days per week (reduced hours at weekend)
- A clinical pharmacy service is provided at the weekend to five wards where there is a high turnover of patients or a most pressing need for support. This service provides enhanced services such as patient counselling and efficient dispensing of discharge medications at a ward level

A new pharmacy stock control system will be introduced in June 2017. It will ultimately form the platform to develop electronic prescribing in the future. The Hospital Pharmacy Transformation Programme Plan was approved at Trust Board and will inform the medicines optimisation strategy in the future.

Priority 1.6 - Medicines Reconciliation

Medicines Reconciliation ensures that medicines prescribed on admission correspond to those taken before admission. Matching such records helps to reduce medication error. Pharmacy staff discuss medications with patients/ carers and use records from primary care (eg. Summary Care Records) to help ensure this match.

The Trust aimed to complete medicines reconciliation on more than 80% of patients within 24 hours of admission. For January 2016 - December 2016 Medicines Reconciliation was completed as follows:

	Target	Achieved	Met
Within 24 hours	80%	84%	✓
Within 48 hours	90%	95%	✓
Within 72 hours	95%	96%	✓

The targets for 2017 have increased and data for January to March against these targets is shown below.

Clearly the targets are more challenging with March data showing compliance in all areas.

	Target	Jan	Feb	Mar
Within 24 hours	85%	82%	82%	92%
Within 48 hours	95%	97%	94%	99%
Within 72 hours	100%	99%	99%	100%

In Quarter 3 (2016/17) 461 medicines reconciliations were completed within 24 hours of admission on the five wards mentioned in priority 1.5 above. This equates to 34 per weekend who would otherwise have had to wait until Monday morning for a pharmacy review. Such weekend working supports the delivery of accurate medications and therefore safer and efficient care.

Priority 1.7 - Sepsis – antibiotics within an hour

"If your immune system is weak or an infection is particularly severe, it can quickly spread through the blood into other parts of the body. This causes the immune system to go into overdrive, and the inflammation affects the entire body. This can cause more problems than the initial infection, as widespread inflammation damages tissue and interferes with blood flow. The interruption in blood flow leads to a dangerous drop in blood pressure, which stops oxygen reaching your organs and tissues."

NHS Choices, April 2017

Recognition of sepsis and prompt action is vitally important to prevent further harm or death as deterioration may be rapid. Data available in April 2017 shows sepsis mortality at 87 (HSMR) and 107 (SHMI) for the period Jan-Dec 2016. [Please see priorities 3.1 & 3.2 for an explanation of mortality].

New NICE guidance was released in 2016 which resulted in the revision of policy and the development of sepsis proformas (in line with the Sepsis Trust). Teaching and awareness raising continues both around early recognition and appropriate management.

The 2016/17 CQUIN set targets relating to sepsis. These challenging targets aim to promote early screening to identify people with potential sepsis and to start treatment within the hour. The achievement against these targets is shown in the table below.

	2016/17	Aim	Met
Screening of all ED patients	**92.5%**	≥90%	✓
Administering antibiotics within 1 hour to ED appropriate patients	**45%**	≥90%	✗
72 hour review of ED patients	**91%**	≥90%	✓
Administering antibiotics within 1 hour to appropriate ward patients	**47%**	≥90%	✗

To support delivery of improved sepsis management a wide range of initiatives are being implemented:

- Permission granted for certain groups of nurses to give antibiotics without prior prescription by doctors to support the delivery of antibiotics within one hour (via the recently approved Patient Group Direction)
- Collaboration with the NerveCentre project group to develop an automated sepsis tool on the electronic observations system, prompting early response when sepsis is suspected
- Prompt action in the Emergency Department is being supported with the provision of a Sepsis trolley containing all relevant information and supplies
- 3 month trial of a neutropaenic sepsis alert card for cancer patients

- The appointment of an additional Sepsis Nurse (bringing the complement to three) to support educational initiatives
- Provision of e-learning

The Lean 6 Sigma team are working with emergency department staff to triage patients with suspected sepsis and initiating treatment within one hour. The team has examined the current process and are now at the point of trialling a new way of working.

Priority 2: Introduce Human Factors

Human Factors is being used increasingly to understand the complexity of healthcare and to identify both causes of error and ways to eliminate the potential for error. It is described by leading international expert as:

> "enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings"
>
> Dr Ken Catchpole

This is a new priority for the Trust and one which has little previous history with which to compare.

	Human factors	15/16	16/17	Aim for 16/17	Met
2.1	Deliver a new style serious incident investigation training >=4 times during 2016/17		**4**	>=4	✓
2.2	Undertake a human factors review of 2 clinical areas		**1**	2	=
2.3	Identify all cases of poor escalation within SI reports (recorded on Datix)	14 (calendar year 2015)	**22** (calendar year 2016)	Identify	✓

Priority 2.1 - Training

Root cause analysis training has been undertaken for many years but during 2016/17 the incident investigation training has been modified to include human factors.

The training:

- uses everyday examples of humans interacting with their environment
- focuses on a true story where greater attention to human factors may have saved a life
- helps staff to see the importance of their role within their environment and how they can make it safer
- focuses on the system and not individual blame

During 2016/17 four training sessions were held attended by 11 consultants and 40 senior nurses/ managers. Many of these staff are now able to participate in serious incident investigations.

Priority 2.2 - Human Factors Review

It was intended that two comprehensive reviews would be completed during 2016/17. One has been completed comprehensively and the Trust is progressing a series of other workstreams with human factors elements.

A full human factors review was undertaken within the Theatres department by national human factors expert Dr Jane Carthey. Observations of twenty-five different operating lists were carried which found some reassuring aspects:

> "The majority of theatre teams observed are exemplary"
> Dr Jane Carthey

- Surgeons, anaesthetists and senior theatre nurses who are really good at flattening the hierarchy
- Well-structured team briefs

Other areas were identified where improvements were required.

Action	Improvement
Ensure team briefs are carried out on the Emergency List in main theatres	All emergency operations are now detailed on a white board which is updated throughout the day as necessary. This supports the delivery of the team brief, particularly where there is a change of operating team
Team briefs should start with all team members being present	Theatre staff have been instructed to ensure all staff are present before undertaking the team brief
Verbal confirmation that the swab and instrument count is correct at the end of the procedure should be given	The verbal swab and instrument count is confirmed prior to the scrub nurse completing the last part of the theatre checklist.

The maternity team bid for funding to "Introduce Human Factors to improve our safety culture particularly in relation to working in teams, critical language and working in a culture of psychological safety and situational awareness to reduce harm".

The team was successful in securing over £80,000 to train 114 staff members in human factors. The actions to implement this work will be undertaken during 2017/18.

Procedures undertaken in the cardiac catheter laboratory were reviewed to ascertain compliance with a national safety standard on interventional procedures. The review confirmed that the procedures were undertaken in line with guidance but required some updates to policy and documentation.

Priority 2.3 - Serious Incidents (poor escalation)

The Trust's electronic incident management system has been tailored to capture themes common within serious incidents. Such themes include patient factors, staff/ team factors, education, equipment or organisational factors. One theme relates to poor escalation – where a patient shows signs of deterioration but has not been escalated to a more appropriate or senior member of staff for action to be taken in a timely way.

The Trust uses the National Early Warning Score (NEWS) where each observation eg. pulse rate is assigned a score between zero (no concern) and three (serious concern). Adding up all the scores gives an overall score which is used to make a decision about escalation – whether it is needed; and if so to whom.

During 2016 (calendar year) poor escalation featured in 22 of 62 serious incidents. This compares with 14 in the previous calendar year. Once the electronic observations system is

introduced in all areas by July 2017 the automatic escalation function will be enabled. This means that any concerns will be communicated automatically to relevant doctors and critical care outreach staff. Meanwhile work is ongoing around raising awareness about escalation.

Improving clinical outcomes

Priorities	What success will look like
3. Further reduce mortality This is a significant priority for the Trust. Whilst the HSMR remains better than national average the SHMI still remains a concern	• HSMR <95.3 • SHMI 'within normal range' and 'below 110' • SHMI (inc adjustment for palliative care) <98.5 • Improvement against results of 2015/16 Audit of Unexpected Critical Care admissions • No. of cardiac arrest calls < 174 • Observation Compliance >=98% • Mortality review – areas of concern discussed at each meeting of the Clinical Governance Strategy Committee
4. Further improve stroke standards There remain delays in transferring people to the stroke unit. Additionally the Trust wishes to evaluate the impact on standards of the increased activity associated with acceptance of patients from the Harlow area	• 3 hr thrombolysis >=12% • 4 hrs to stroke unit >=90% • 90% time on stroke unit >=80% • 60 minute to scan >=90%

Priority 3: Further reduce mortality

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
3.1	HSMR (3 month arrears)	88.96	92.31	93.31	**95.18**	<=95	=
3.2	SHMI	111.76	112.9	109.7	**105.61**	<=108	✓
3.3	SHMI (adjusted for palliative care)	100.43	100.51	98.69	**95.5**	<=98.5	✓
3.4	Unexpected admissions to critical care	Audit completed	Audit completed	Audit completed	**N/A**	Complete audit	-
3.5	Cardiac Arrests	174	203	208	**127 YTD**	<174	
3.6	Observation compliance	95.88	95.49	93.61%	**96%**	>=98%	✗
3.7	Mortality review	N/A	N/A	Undertaken	✓	Undertake	✓

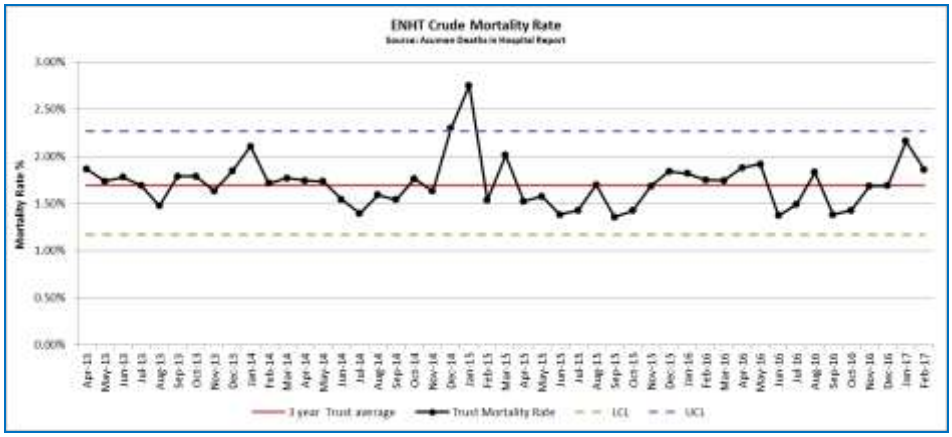
There are three main types of mortality indicator:

- Crude Mortality
- Hospital Standardised Mortality Ratio
- Summary Hospital Mortality Index

Crude mortality is a simple analysis of the percentage of patients who die in hospital against the total number of discharges from hospital. It makes no adjustment for patient acuity (how unwell they are).
Recently introduced benchmarking data shows the average national crude inpatient mortality is 1.4%; and is 1.5% within the East of England region. The Trust has a slightly higher rate at

1.7% as shown in the table below although this is against an expected 1.8% and reported as "significantly better than expected".

Time period	Crude mortality rate
3 year average rate	1.67%
2016/17 year to date (March 2016-February 2017)	1.7%



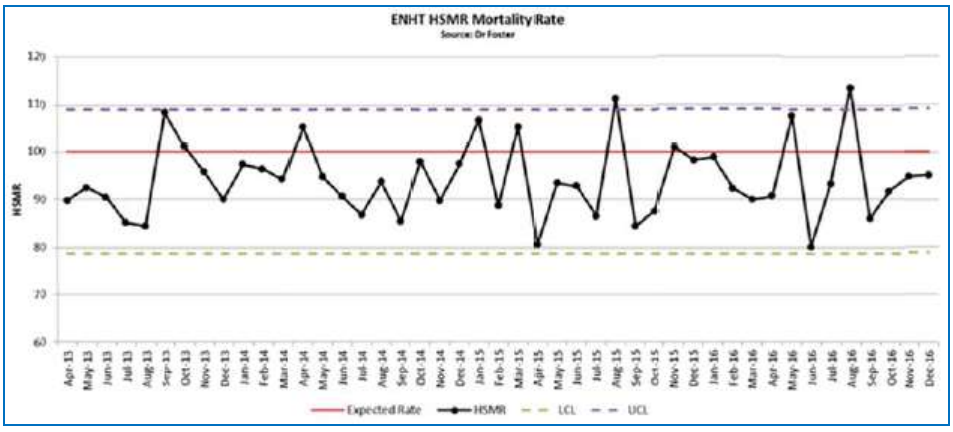
Changes in clinical pathways, where patients are seen via ambulatory routes (walk in day care) and where 'hospital avoidance' initiatives become more prevalent, may lead to a rise in crude mortality in the future as only the sickest people are admitted.

Priority 3.1 - Hospital standardised mortality ratio

The Hospital Standardised Mortality Ratio (HSMR) measures in-hospital mortality for 80% of the most common diagnosis categories resulting in patient deaths.

It is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of local adjustments (eg patient age and patient acuity). This adjustment allows comparisons to be made with other trusts. HSMR can also be adjusted to account for the impact of palliative (end of life) care. The England average is always 100 (red line in the graph below). A lowering number indicates an improving position and a number below 100 is better than average.

The Trust's HSMR position for the twelve months to December 2016 was **95.18** and is rated statistically as "as expected". The Trust's position relative to its East of England peers is 6th of 17.



HSMR can be used to calculate mortality in a number of ways such as for particular diagnostic groups eg. heart attack or asthma. It is therefore possible to see which conditions result in higher than expected mortality enabling staff to explore why this might be the case.

Priority 3.2 - Summary Hospital-level Mortality Index

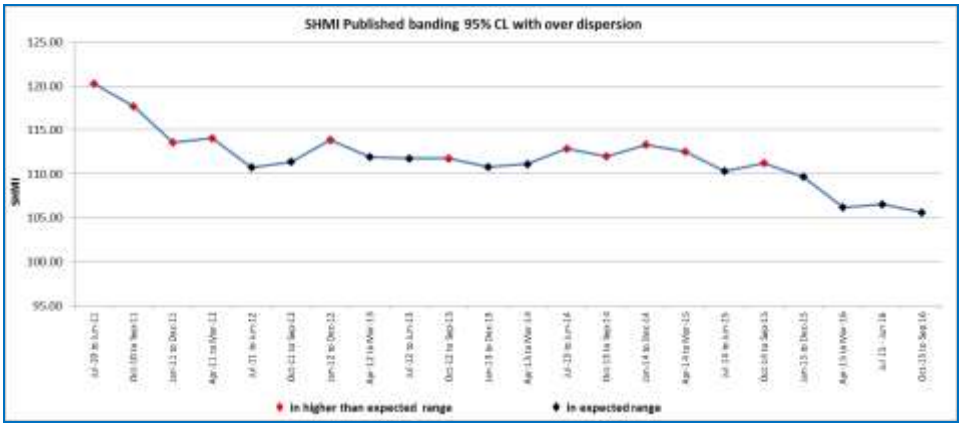
The Summary Hospital Mortality Index (SHMI) measures hospital mortality outcomes for all diagnosis groups along with deaths in the community up to 30 days after discharge. SHMI data is 7-9 months in arrears and is not adjusted for palliative care.

Whilst the Trust performs better than average using the HSMR it performs worse than average when measured using the SHMI methodology. The discrepancy is partly accounted for by 7-day provision of palliative care services in the Trust and the provision, as with a small minority of other trusts, of hospice services. For these reasons the Trust also reports SHMI that has been adjusted for the palliative care influence.

It is notable that the Lister Hospital has a significantly higher proportion of patients with end-stage respiratory and cardiac diseases who are admitted to die in the Trust compared to the norm in England.

The SHMI for the period October 2015 to September 2016 is **105.6** and is within the 'as expected' range. This sees the Trust ranking 10th out of 17 across the East of England.

The graph below shows the improvements in SHMI over the last five years.



Within the Trust we use two approaches to identify areas for investigation into potential mortality problems:

- diagnosis groups with the highest number of deaths as small improvements in care could benefit a large number of patients
- diagnosis groups with high 'excess' deaths - the actual number of deaths over the expected number for our population

The two tables below show:

- five diagnoses resulting in the highest number of deaths
- five diagnoses with the highest number of "excess" deaths

CCS Group	Number of spells	Observed deaths	Expected deaths	SHMI Oct15-Sep16	SHMI performance change
Pneumonia	1,766	377	328.49	114.77	▼
Acute Cerebrovascular Disease	783	130	136.64	95.14	▲
Urinary Tract Infection	1,746	101	109.52	92.22	▲
Acute Unspecified Renal Failure	439	87	72.93	119.29	▼
Congestive Heart Failure, nonhypertensive	512	77	76.14	101.13	▼

Diagnosis group	Number of spells	Excess deaths	SHMI Oct15-Sep16	SHMI Jul15-Jun16	SHMI performance change
Pneumonia	1,766	49	114.77	113.7	▼
Acute Bronchitis	1,148	17	136.83	143.4	▲
COPD	925	16	126.99	108.4	▼
Acute Myocardial Infarction	633	14	130.40	122.3	▼
Acute Unspecified Renal Failure	439	14	119.29	112.2	▼

Clinical and managerial staff work together and with community partners to improve the management of patients with these conditions.

Pneumonia, Acute Bronchitis & Chronic Obstructive Pulmonary Disease (COPD)

- Progress continues on the joint actions agreed with the CCG following receipt of a report from the Royal College of Physicians Review
- Telephone community consultations continue providing a point of access for GPs to engage respiratory consultants regarding management of complex conditions in the community
- The Community team continues to establish itself, working with GPs to highlight frequent attenders and support early discharge from hospital
- Continuation of the Acute Chest Team
- 7 day respiratory service
- Implementation of best practice care bundles for the management of COPD and pneumonia

Patients from other medical specialties who deteriorate and require respiratory support are transferred to the respiratory service. Any deaths are therefore assigned to the respiratory service. So despite improvements within the respiratory services the mortality rate has not fallen at a pace to reflect this work. Consideration of how this may be better managed in the future is underway. It is also noteworthy that over 200 patients per annum are treated on an ambulatory basis when previously they were admitted so the 'least ill' patients, who are likely to survive, are no longer included within the data collection.

Acute Kidney Injury (AKI)

Recent developments of note include:

- ICE (pathology reporting system) now has electronic AKI alerting functionality and will be used later in the year with Lorenzo (new patient administration system) implementation to support early identification
- Policy change regarding gentamycin (antibiotic) following evidence of increased incidence of AKI with a single dose

Acute Myocardial Infarction (Heart attack)

HSMR for Acute Myocardial Infarction has reduced to 130.1 falling within the “as expected” range for the rolling 12 months to December 16.The Cardiology team is in the process of investigating the details of the deaths underpinning this data.

The service is also looking at accuracy of primary codes and depth of coding to ensure the deaths are correctly assigned with the correct codes.

Priority 3.3 - Adjusted SHMI

Priority 3.2 referenced the fact that the SHMI value includes those patients who have died following a stay in the Trusts hospice or after receiving palliative care. This partly accounts for a higher than average SHMI rate.

To understand the SHMI without the effect of the hospice or palliative care an adjusted SHMI can be calculated which allows for a more fair comparison with other organisations.

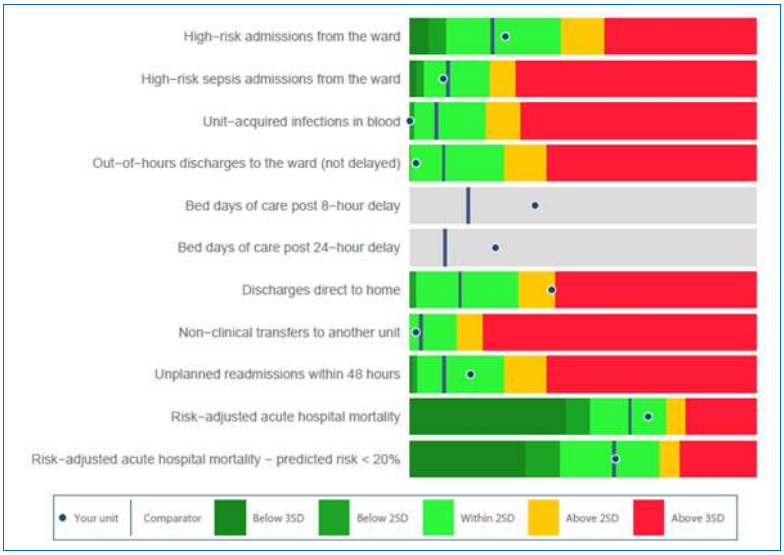
The latest data for an adjusted SHMI shows its value to be at 95.5 surpassing the aim of below 98.5.

Priority 3.4 - Unexpected admissions to critical care

If a patient deteriorates to the point where treatment or care ordinarily available on the ward is insufficient to cope with the patient’s needs the patient will be admitted to the Critical Care Unit. This may be as a result of either rapid deterioration or a failure to act upon the earlier signs of the patient deteriorating, ie worsening clinical observations as described in Section 2.3.

In 2016/17 229 patients were admitted from the wards to critical care. This compares to 233 in the previous year. It is difficult to tell from the data whether these admissions result from unexpected and rapid deterioration or whether the deterioration could have been prevented through earlier intervention.

Despite having a number of unexpected admissions the critical care unit delivers good outcomes. The Intensive Care National Audit and Research Centre (ICNARC) report, which covered admissions to the critical care unit between April and September 2016, provides benchmark data on the performance of the unit. The outcomes of patients admitted to critical care were favourable with four of eight indicators showing performance better than comparative units; and a further four within the ‘as expected’ range. The mortality rate is the same as the national average.



The area of concern is the number of people being discharged home directly from critical care rather than attending a ward for step-down care and rehabilitation. A lack of beds readily available on the wards means that it is sometimes challenging to transfer a patient from critical care as soon as they are well enough. Recent policy has placed transfers from critical care as a bed management priority.

An audit of unexpected admissions to critical care was not undertaken during 2016/17 but will be repeated during 2017/18.

The Trust's Deteriorating Patient Action Plan is a multifaceted set of actions to help identify and reduce the number of patients who deteriorate. The plan is complex and addresses:

- Observation competencies
- Management of patients who are dying
- Use of checklists and common communication to share concerns promptly
- Compliance with surgical checklists
- Clarity over the management of patients receiving care from multiple teams
- Identification and management of sepsis
- Acting early on test results

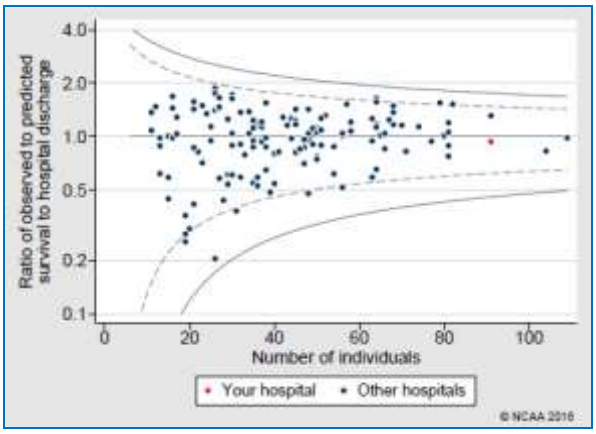
Progress with implementing the plan is monitored by the Patient Safety Committee with the results ultimately measurable using the mortality indicators but supported by a range of other indicators such as ICNARC.

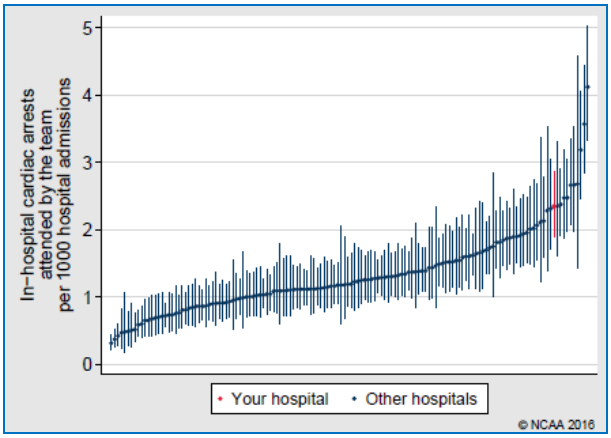
Priority 3.5 - Cardiac Arrests

If deterioration is not acted upon quickly the patient's survival may be compromised potentially leading to a cardiac arrest.

During 2016/17 127 (YTD) cardiac arrest calls were made (excluding those from the Emergency Department).
The National Cardiac Arrest Audit (NCAA) data for April – September 2016 show that the cardiac arrest team attended cardiac arrests of 92 patients.

44 survived the cardiac arrest and ultimately 21 (22.8%) survived to discharge. This is very slightly less than predicted although NCAA data does not take account of the risk factors associated with the local population group.





The attendance by the resuscitation team at cardiac arrests, per 1000 hospital admissions, is high compared to other organisations. This demonstrates a commitment to supporting clinical teams.

Actions undertaken by the resuscitation team include:

- Commencement of a 10 minute team brief commenced in November 2016 to discuss all arrests and assign any outstanding audit documentation
- Implementation of the new RESPECT form in January 2017, working closely with the End of Life team. Trust statistics show we have more arrests in the 85+ age range suggesting that further work is required on the use of do not resuscitate orders where applicable

Priority 3.6 - Observation compliance

Effective identification and management of deteriorating patients requires strict adherence to undertaking timely and complete observations eg. blood pressure measurement; and prompt escalation to senior staff to instigate actions where deterioration is recognised. This was described in more detail in sections 2.3 and 3.4.

Compliance with completing observations fully is measured routinely through a records audit. During 2016/17 the average compliance rate based on 8068 observation charts reviewed was 96%.

The Trust introduced NerveCentre in March 2017.

Observations are recorded on this electronic system which enables remote view so doctors and senior clinical staff can review observations and advise staff/ prioritise their work accordingly. Starting with paediatrics the system will be rolled out to all areas by July 2017. Once rolled out the automatic escalation alerts will commence.

This is a really exciting development and the outcomes relating to deterioration, cardiac arrests and unexpected admissions to critical care will be closely monitored.

Priority 3.7 - Mortality Review Process

The Trust has an established mortality review process:

- Details of deaths are captured via the bereavement service
- Health records are transferred to the mortality review office
- A reviewer, not involved in the patients care, reviews the notes and completes an electronic mortality review questionnaire identifying whether there were any concerns (eg gaps or omissions in care) or not
- Where a potential area of concern is identified the reviewer asks the deceased patient's consultant to review the care and treatment given. This is undertaken as a discussion amongst senior and junior staff during their specialty's Rolling Half Day session. An opinion is provided and if appropriate actions to rectify any shortcomings
- Discussion of any areas of concern and the findings following specialty review by the Clinical Governance Strategy Committee on a scheduled monthly basis. Likelihood of death is considered and an opinion made as to whether further action is required
- Learning is shared via the Rolling Half Day learning points or as deemed appropriate by the committee

A central database holds the details of the reviews and the process is coordinated via the Clinical Audit and Effectiveness Office.

Oversight and challenge is undertaken via Mortality Review meetings with the Clinical Commissioning Group and NHS Improvement. These meetings monitor not only the findings of the review process but also progress in reducing mortality overall.

The mortality review process is closely linked with the incident management process with some deaths being investigated as serious incidents where more in-depth investigation is required. This also ensures that the Duty of Candour is met.

The Trust has 32 trained mortality reviewers in place. All are consultants from the clinical divisions. Reviews of 1295 case notes of people who died in our hospitals have been undertaken during the year representing 84% of total recorded deaths from 1 April 2016 to 31 March were reviewed. This is a vast improvement compared with 45% in the previous year. Whilst striving to meet the >=95% target this remains challenging for the consultants given the multitude of calls on their time coupled with additional winter pressures.

At the time of writing the report the Trust is awaiting information regarding the implementation of the national standardised mortality review methodology.

Priority 4: Further improve stroke standards

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
4.1	60 minute to scan	87.77%	82.89%	89.2%	**92.7%**	>=90%	✓
4.2	3 hour thrombolysis for stroke	10.08%	7.36%	7.47%	**6.1%**	>=12%	✗
4.3	Admission to stroke unit within 4 hours of arrival	66.25%	51.89%	62.33%	**78.6%**	>=90%	✗
4.4	90% time in dedicated stroke unit	72.71%	73.87%	82.12%	**87.3%**	>=80%	✓

Priorities 4.1-4.4 - Stroke

A stroke is caused by a lack of oxygen to the brain. This may be due to a bleed (haemorrhagic stroke) or a clot (ischaemic stroke). Only those who have had an ischaemic stroke can be treated by thrombolysis (an anti-coagulant delivered via a drip). Giving an anticoagulant to someone who has had a haemorrhagic stroke is inappropriate so it is important that patients are scanned soon after arrival to the emergency department to see which type of stroke they have had. Thrombolysis must be given within three hours of the onset of symptoms.

In an ideal situation the process for managing strokes is as follows:

- an ambulance is called as soon as symptoms suggest a stroke
- the ambulance arrives quickly and alerts the hospital that a person with a suspected stroke is due to arrive
- The stroke team will be waiting for the patient's arrival and will quickly assess them and arrange for a scan
- Scan is completed quickly, within 60 minutes of arrival
- Once an ischaemic stroke is diagnosed the thrombolysis will start (within 3 hours of onset of symptoms)
- The patient will be admitted to the stroke ward for intensive treatment and rehabilitation.

✓ 92.7% of patients were scanned within one hour of arrival. There is a well-established process to ensure this is undertaken.

✗ 6.1% of patients received thrombolysis within 3 hours. Achievement of the 12% target was met during only one month in the year.

An audit was undertaken of a sample of patients to understand why there were delays in thrombolysis. The results found:

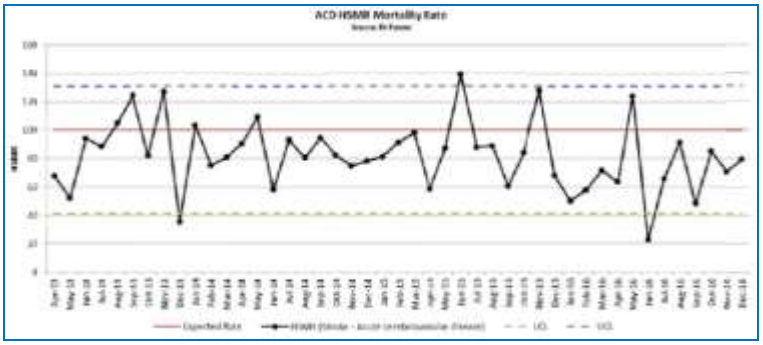
- Only one quarter of patients arrived within the 'thrombolysis time window' due to significant delays in patients calling for an ambulance and delays in the ambulance transfer
- It was not possible to thrombolyse 30/65 patients because the time of onset was unknown
- During the day 73% of those who received thrombolysis did so within 1 hour (average 38 minutes); out of hours this fell to 25% with delays due to other operational pressures
- No patients were missed that should have been treated

A number of actions have been identified such as a patient campaign to raise awareness of symptoms; pre-alert via GPs; better access to blood analysers for immediate test results and improved liaison with the stroke telemedicine service.

✘ 78.6% of patients were admitted to stroke unit within 4 hours of arrival. Since September 2016 the standard of reaching 90% has not been achieved. The number of patients attending the ED suffering a stroke has increased, largely due to accepting patients from West Essex. Together with challenges within the ED to manage an increasing workload it has not been possible to deliver this four hour initiative. The Trust produces a report each month of the patients who do not meet this target and work is underway to understand where the problems are in order to rectify them.

✓ 87.3% of patients spent more than 90% of time admitted on the stroke unit. Stroke services are centralised on 2 wards where staff and facilities are optimised to care for patients with strokes. All efforts are undertaken to ensure patients who have suffered a stroke are admitted to these wards.

Mortality (HSMR) remains very good at 67.8 (lower than expected) for the 12 month period to December 2016.



The latest SHMI release for the 12 month period to September 2016 has seen a significant improvement with SHMI falling to 95.14.

A variety of changes have taken place in Stroke care to improve outcomes for patients. The success of these has been evidenced by obtaining a high rating of the service in the quarterly Sentinel Stroke National Audit Programme report produced by the Royal College of Physicians (Aug- Nov 2016).

Current on-going initiatives include:

- Recruitment of two clinical fellows (doctors) and a Stroke Matron
- Development of a Thrombolysis action plan to fine tune internal processes and improve the thrombolysis pathway, including the pre- hospital Pathway

- Collaboration with external providers, eg Charing Cross to formalise a Thrombectomy (clot removal) pathway. This pathway supports transfer of suitable patients for further treatment
- Increase by 6 of the number of stroke beds available over the winter
- Introduction of a Stroke care bundle

I was seen by the consultant who I saw originally on the date of my stroke - it is always preferable to see the same consultant throughout as they are familiar with your history.

Stroke Clinic, Lister Dec-16

Improving patient experiences

Priorities	What success will look like
5. Improve communication Communication failure remains one of the most common subjects identified via feedback mechanisms. As the culture programme strengthens we wish to evaluate the impact upon user feedback.	• In-patient survey results of involvement in decisions >6.8 • In-patient survey results of consistent information >7.8 • In-patient survey results of providing understandable answers >8.1 (doctors) and >8.0 (nurses) • In-patient survey results of having point of contact >7.8 • Reduction in rate of communication related complaints per bed days <0.144% • Reduction in rate of communication PALS concerns per bed days (from Q1 to Q4) • Implementation of the Accessible Information Standard milestones
6. Improve nutrition and hydration The Food and Drink Strategy was launched in 2015. Improving nutritional care is the first ambition	• Obtain feedback from patients about new menus • In-patient survey results of quality of food >5.2 • In-patient survey results of choice of food >8 • In-patient survey results of help with eating >7.5 • Delivery of strategy milestones • Compliance with nutritional aspect of ward observational tool >=95% • Delivery of the Healthy Food CQUIN

Priority 5: Improve communication

		13/14	14/15	15/16	16/17	Aim for 16/17	Met	Meridian
5.1	Survey - involved in decisions	6.8	7.3	6.8		>6.8		83.75%
5.2	Survey - consistent information	7.7	7.7	7.8		>7.8		
5.3	Survey - understandable answers (doctors)	7.8	7.8	8.1		>8.1		88.36%
5.4	Survey - understandable answers (nurses)	7.8	8.3	8.0		>8.0		90.91%
5.5	Survey- point of	7.6	7.8	7.8		>7.8		

		13/14	14/15	15/16	16/17	Aim for 16/17	Met	Meridian
	contact							
5.6	Complaints about communication (per 100 bed days)*	*0.16%* *FCE**	*0.19%* *FCE**	0.32%	0.21% (Q1-3)	Improve[Ψ] (<0.144%)	✓	
5.7	PALS concerns - communication (per 100 bed days)	*0.28%* *FCE**	*0.48%* *FCE**	0.57%	0.21% (Q1-3)	Improve	✓	
5.8	Accessible Information Standards					Implement		

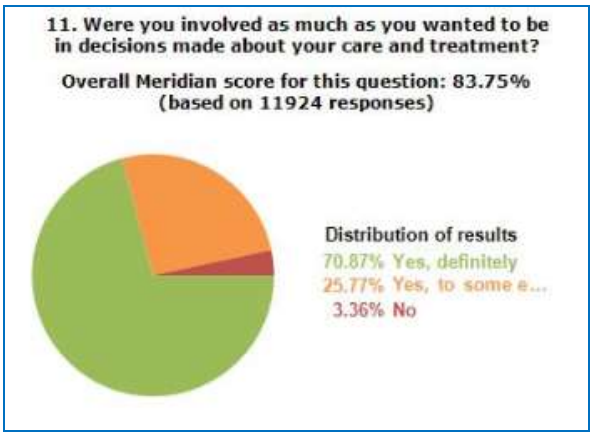
*Bed days - number of beds occupied at a particular point in the day.
FCE – Finished consultant episode
[Ψ]The aim for 2016/17 was inaccurately stated in the 2015/16 report. Indicators measured since 2013/14 show complaints with communication as an element whereas the aim to reduce complaints to <0.144% was based on communication being a primary subject

Priorities 5.1- 5.5 – Inpatient survey scores

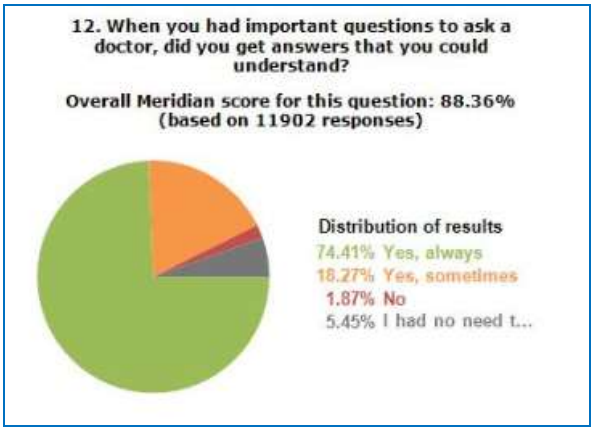
Five questions in the national in-patient survey relating to communication have been monitored over a number of years. These are weighted scores with a maximum score of 10.

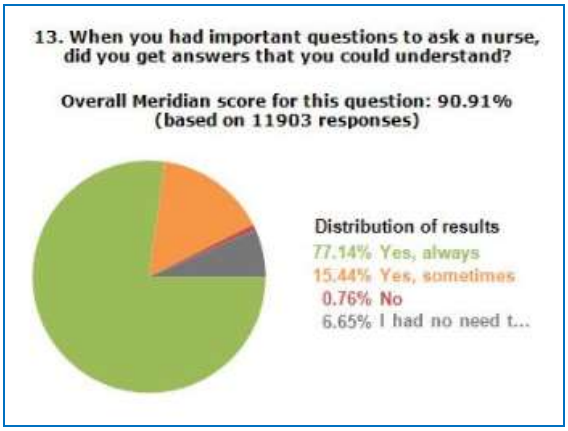
The results are shown in the table above where it can be seen that…due May

Three of these questions are also asked routinely using the electronic survey system Meridian. During 2016/17 almost 12,000 patients participated in the survey and the results are shown in the three pie charts below.



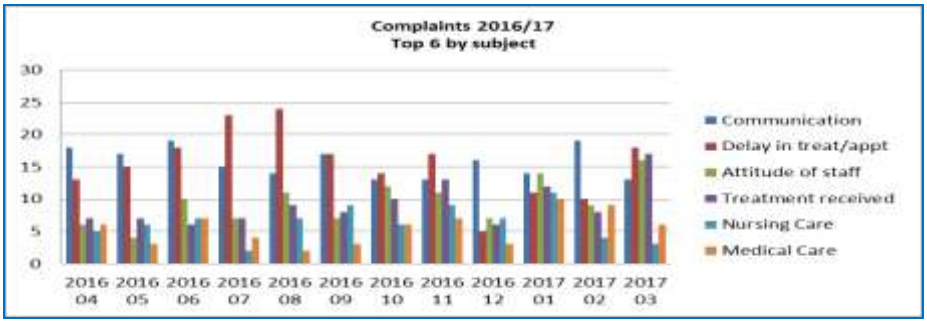
Add commentary comparing with national scores once released





Priority 5.6 & 5.7 – Complaints and PALS concerns about communication

The graph below shows the categories accounting for the greatest number of complaints for 2016/17, by primary subject.



…we understood the reasons for the delays, which were due to emergency cases parachuting in, and the staff were very communicative about what was happening - they kept us updated and did their very best to squeeze her [daughter] in that day, managing to fit her in at about 3pm in the end. The nurse on the ward was unfailingly kind and helpful, plying us with drinks, keeping us updated and bringing toys/dvds to occupy our daughter during her long wait. The surgical team were also very good with her and communicated well with us both before and after the operation.

Day Surgery, March 2017

i have already emailed but had no reply, not even an acknowledgement, approximately 2-3 weeks ago. Living a distance from the hospital we only get feedback from family nearby. We have heard reports of our relative being seen and then left with sheets off and curtains open-on view to all who walked past! A request to speak to Doctors about the diagnosis/ condition and plan of care has not happened. The on time a doctor did speak to us whilst we were visiting, they were abrupt and impatient. As the patient now has a terminal diagnosis, it would be nice if the family could talk to the teams involved in his care?! it would be nice, as we are visiting this weekend, for someone to be around to talk to us,,,,but i am guessing this is unlikely to happen,,,,not impressed.This has been happening at 2 locations: ICU, and the ward he is on at the moment which i am unsure of which it is.

January 2017

Although the number of complaints and concerns needs to be acknowledged it is more useful to measure the rate of complaints and concerns per activity level to get a better understanding of whether the proportion of complaints or concerns is changing.

The rate of formal complaints and concerns reported to the complaints service and to the Patient Advice and Liaison Service (PALS) regarding 'communication' is given below (please note this is where communication features within the complaint, not just as the primary subject).

	No. of complaints & PALS (communication) per 100 bed days				
	2015/16	**2016/17**			
		Q1	**Q2**	**Q3**	**Q4**
Complaints	0.32%	0.21%	0.23%	0.19%	
PALS	0.57%	0.18%	0.16%	0.29%	

- ✓ An improvement of complaints and PALS relating to communication per bed days can be demonstrated compared with 2015/16 figures (0.32% & 0.57% respectively)
- ✓ When analysing complaints where communication was a primary subject this has reduced per 100 bed days from 0.144% to 0.08%

Trying to reduce complaints is a challenge because of the wide ranging concerns. Whilst each complaint or concern is dealt with individually the larger picture is about preventing them in the first place. Work described throughout this report such as streamlining processes, developing staff and the culture in which they work and enhancing technology will all support more efficient working in the future. This should therefore promote getting things right in the first instance.

Priority 5.8 Accessible Information Standards

A group oversees the review of practices and implementation of initiatives to comply with the NHS Accessible Information Standard. The standard aims to ensure information is available in a variety of formats to meet the needs of our patients and the public. The following have been put in place this year:

- A list of 'mandatory demographics' has been set up on Lorenzo to include hearing, sight and speech in preparation for the go-live
- The mapping of services is underway within the divisions to understand the full implications of the standards and actions required
- Awareness of the Standard has been raised and the National e-learning module is available on the intranet
- Agreement that a dot is to be put on the front of the patient's health records to show that there is an information requirement
- A sentence has been added to appointment letters to ensure patients/ carers are prompted to inform the Trust if they have any information or communication needs. This is being piloted at MVCC
- Disabledgo have assessed all areas with hearing loops
- The Lorenzo team is working with outpatients staff on letter templates.
- Communication books are available on all wards
- Outpatient clinic appointments can be extended if requested by a clinician
- A Patient Information Leaflet production and review process in place

Priority 6: Improve nutrition and hydration

The Catering Team have been recognised nationally by "Food for Life" and have been awarded the bronze standard. The Trust is one of only fifty-five "in house" hospital catering departments to have received this award. The Catering Mark awarded reflects removal of harmful additives and trans-fats from menus, and that the majority of food available is prepared freshly. Assurance is in place that meat is traceable and from farms that adhere at least to minimum standards of animal welfare.

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
6.1	Feedback from patients about new menus				Received	Obtain feedback	✓
6.2	Survey - Quality of food	4.8	4.4	5.2		>5.2	

6.3	Survey - choice of food	8.3	8.4	8		>8	
6.4	Survey - help with eating	7.4	6	7.5		>7.5	
6.5	Delivery of strategy milestones				Delivered	Deliver	✓
6.6	Compliance with nutritional aspect of ward observational tool			95.25%	96.52%	>=95%	✓
6.7	Delivery of the Healthy Food CQUIN				Delivered	Deliver	✓

Priorities 6.1– Patient feedback & 6.5 Food & Drink Strategy milestones

The catering team is constantly working to receive feedback from which to improve their services. At the same time staff continue to develop choices and services to improve meals and mealtimes in line with the Food and Drink Strategy.

The Food and Drink Strategy was developed in 2015 by the Nutrition & Hydration Steering Committee. Progress is monitored at bi-monthly meetings attended by a multi-disciplinary team consisting of medical, nursing, catering and allied health professionals.

The strategy's ambitions cover 3 areas:

1. Providing good nutritional care for our in-patients
2. Promoting healthier eating for patients staff and visitors
3. Supporting sustainability and reducing food wastage

Protected mealtimes are embedded across the organisation, ensuring that patients receive the help they need to eat and drink. Two Housekeeping Training Co-ordinators have been appointed to support ward housekeepers by ensuring a patient has the correct meal. These staff members have knowledge of all special menus and have direct access to the chef should any changes be required. They are also able to support the food service if required.

Examples of service developments include:

- Expansion of the range of patient menus to meet the therapeutic, religious and cultural needs of our patients to improve patient choice. This includes an a la carte menu for patients requiring a texture modified diet and an option for vegans
- The catering team are working with paediatric staff to review portion sizes and the type of food available that appeals to young people. A young person's menu is being considered which will also be available for young people being cared for on adult wards
- Review of the provision of meals for our patients with dementia, providing finger foods, and supporting Trust wide initiatives for carers at ward level
- John's Campaign has been introduced which encourages carers to remain with their loved ones in hospital to provide help with care such as feeding. In return support such as reduced car parking and discounts on food etc. are being made available
- Carers of patients with a learning disability are encouraged to stay and this has been shown to lead to a shorter length of stay for the patient
- Sandwiches are available at lunch-time and in the evening and snacks are available between meals
- Snack bags are available for carers which has received great praise
- Milk is delivered to the discharge lounge area for patients to take home with them so they can have a hot drink when they go home

- Provision of information for patients and staff at ward level that includes patient bedside menu booklets and a ward level catering services directory
- Piloting of a new nutrition care plan for use at ward level

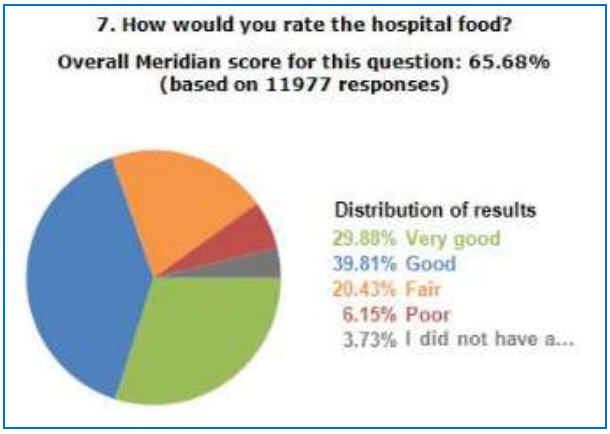
Developments have also been made which support staff, for example:

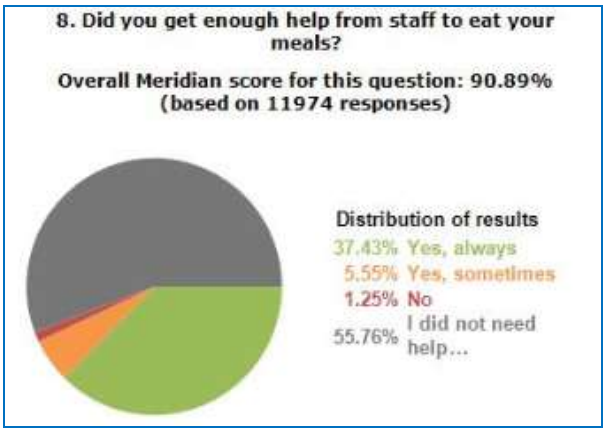
- Provision of a range of education and training opportunities for staff working across the Trust. This includes Hospitality Operating Standards Training (HOST) for housekeeping staff, food and nutrition awareness training for catering staff, and e learning opportunities managed through the Electronic Staff Record (ESR);
- Developed a new Nutrition and Hydration page on the Trust intranet for staff to access information

Priorities 6.2-6.4 – Survey results

Awaiting national survey results – due May.

A number of national survey questions are included within the Trusts standard electronic surveys. Almost 12,000 responses regarding food rating and assistance to eat meals is given in the pie charts below.





Priority 6.6 – Assessment

The Trust measures a number of matters relating to nutrition on a monthly basis. One of these measures is completion of the Malnutrition Universal Screening Tool (MUST). This assessment tool looks at the patient's height, weight, recent weight loss and illness to identify an overall risk of malnutrition. This score then determines the action to be taken eg. referral to a dietician.

✓ The assessment tool was completed for 96.52% of patients on admission (against a plan of >95%).

Other assessments recorded show that there has been an improvement in all the areas measured compared to the previous year.

Question	**2015/16 (5910 responses)**	**2016/17 (8450 responses)**
Was the patient weighed (or upper arm circumference measured) on admission	91.09%	93.95%
Was the patient weighed at least every 7 days	88.51%	92.09%
Was the screening tool updated every 7 days	92.06%	94.16%
Were food charts accurately completed	87.67%	89.7%
Was assistance to eat given where indicated	89.88%	90.96%

Was a nutritional care plan documented for those at risk of malnutrition	85.74%	88.99%

Priority 6.7 – Healthy Food CQUIN

The healthy food CQUIN aims to promote and provide healthy food options for staff, visitors and patients. It involves a number of initiatives:

- The banning of:
    - price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS)
    - advertisement on NHS premises of HFSS
    - sugary drinks and HFSS from checkouts
- Ensuring that healthy options are available at any point including for those staff working night shifts

A project plan is in place with coordination overseen by the Food and Nutrition Group. Some of the actions completed are as follows:

- Two thirds of catering staff have received the healthy eating awareness training
- All meals are evaluated to determine the fat, sugar and salt content – with information displayed in staff restaurants
- All meals advertised are under 500 calories
- There are no advertisements of HFSS foods
- HFSS foods and sugary drinks are no longer sold at checkout points, and have been replaced by fruit
- Baked crisps have been introduced as a healthier options – these are selling well
- New menus are approved by dieticians
- Nutritional information cards are available at cold food self-service cabinets
- Lower calorie sandwich options are available
- An agreement has been reached between WHSmith's and NHS England to ensure the hospital outlets are CQUIN compliant (changes implemented by 23rd February)
- All fronts to drinks vending machines, except one have been changed, with healthier drinks at the top and full sugar at the bottom on the selection area
- The Health@Work service can refer eligible members of staff for a free 12 week referral to Weight Watchers or Slimming World

2c Statements of assurance from the Board

This section contains the statutory statements concerning the quality of services provided by the Trust.

Review of services

During 2016/17, the East and North Hertfordshire NHS Trust (ENHT) provided and/or sub-contracted 32 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant services by the ENHT for 2016/17.

Participation in clinical audits

During 2016/17 45 national clinical audits and 9 national confidential enquiries covered relevant health services that ENHT provides.

During that period ENHT participated in 43 (96%) national clinical audits and 9 (100%) national confidential enquiries of the clinical audits and national confidential enquiries which it was eligible to participate in.

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2016/17
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2016/17, and for which data collection was completed during 2016/17, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National Audits	Eligible	Participated	% Cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	93.71%
Adult asthma (BTS)	Yes	Yes	100%
Adult Cardiac Surgery	No	Services not undertaken	
Asthma in Emergency Departments	Yes	Yes	100%
Bowel Cancer Audit Programme (NBOCAP)	Yes	Yes	80% (last report)
Cardiac Rhythm Management (CRM)	Yes	Yes	92%
Chronic Kidney Disease in primary care	No	Not applicable	
Congenital Heart Disease (CHD)	No	Not applicable	
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	The database is still open (it closes on the 30th of April). We are currently approx. 99% but will be 100% compliant
Diabetes (Paediatric) (NPDA)	Yes	In progress	tbc
Endocrine and Thyroid National Audit	Yes	Yes	tbc
Falls and Fragility Fractures Audit programme (FFFAP) – Fracture Liaison Database	No	No Fracture Liaisons Service	
Falls and Fragility Fractures Audit programme (FFFAP) - Falls	No	Audit starts May 2017	
Falls and Fragility Fractures Audit programme (FFFAP) – National Hip Fracture Database	Yes	Yes	100%

National Audits	Eligible	Participated	% Cases Submitted
Head and Neck Cancer Audit (DAHNO)	Yes	Yes	tbc
ICNARC Case Mix Programme	Yes	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Yes	Yes	0% due to lack of resource
Learning Disability Mortality Review	No	Audit starts in 2017/2018	
Major Trauma (Trauma Audit & Research Network) (TARN)	Yes	Yes	61%
National Audit of Dementia	Yes	Yes	100%[1]
National Audit of Pulmonary Hypertension	No	Not a specialist pulmonary hypertension centre	
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	No	Audit starts in 2017/2018	
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery - Use of blood in Haematology	Yes	Yes	100%
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery - Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	78%
National Diabetes Foot care Audit – Adults (HSCIC)	Yes	No[2]	
National Diabetes Inpatient Audit – Adults (HSCIC)	Yes	Yes	100%
National Pregnancy in Diabetes Audit – Adults (HSCIC)	Yes	Yes	100%
National Diabetes Core Audit – Adults (HSCIC)	Yes	Yes	In progress
National Emergency Laparotomy Audit (NELA)	Yes	Yes	83%
National Heart Failure	Yes	Yes	98.8%
National Joint Registry	Yes	Yes	99.8%
National Lung Cancer Audit (NLCA)	Yes	Yes	tbc
National Neurosurgery Audit Programme	No – not undertaken within the Trust		
National Ophthalmology Audit	Yes*	No[3]	
National Prostate Cancer	Yes	Yes	tbc
AAA Repair (National Vascular Registry) -	Yes	Yes	tbc
Carotid Endarterectomy (National Vascular Registry)	Yes	Yes	tbc
Lower Limb Amputation (National Vascular Registry)	Yes	Yes	tbc
Lower Limb Angioplasty/Stenting (National Vascular Registry)	Yes	Yes	tbc
Lower Limb Bypass (National Vascular Registry)	Yes	Yes	tbc
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
Nephrectomy audit	Yes	Yes	100%
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	tbc
Paediatric Intensive Care (PICANet)	No	Do not have Paediatric Intensive Care	
Paediatric Pneumonia	Yes	Yes	In progress (data entry closes 30th April)
Percutaneous Nephrolithotomy	Yes	Yes	100%

National Audits	Eligible	Participated	% Cases Submitted
Prescribing Observatory for Mental Health	No	Not relevant	
PROMS (Patient Reported Outcomes Measures) Elective Surgery	Yes	Yes	tbc
Radical Prostatectomy Audit	Yes	Yes	100%
Renal Replacement Therapy	Yes	Yes	100%
Rheumatoid and Early Inflammatory Arthritis - Clinician/Patient Follow-up	Yes	Yes	100%
Rheumatoid and Early Inflammatory Arthritis - Clinician/Patient Baseline	Yes	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	97%
Severe Sepsis and Septic Shock – care in emergency departments	Yes	Yes	100%
Specialist rehabilitation for patients with complex needs	No	Service not relevant	
Stress Urinary Incontinence Audit	Yes	Yes	100%
UK Cystic Fibrosis Registry	No	Do not treat patients	

[1] The Trust submitted 40 cases to the National Dementia audit which is the recommended minimum for national audits. The original target was 50 but was reduced following consultation with the national body due to lack of resources.
[2] National Diabetes Foot Care audit did not take place as the specialty did not have the required input from the community podiatrists
[3] National Cataract audit - we did not take part due to the lack of funds available to purchase & install the audit software.

National Confidential Enquiries	Eligible	Participated	% Cases submitted
NCEPOD Child Health Clinical Outcome Review Programme – Chronic Neurodisability	Yes	Yes	100%
NCEPOD Child Health Clinical Outcome Review Programme – Young Peoples Mental Health	Yes	Yes	In progress
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	Yes	Yes	100%
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	100%
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	Yes	Yes	100%
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance	Yes	Yes	100% (no maternal deaths)
NCEPOD - Medical & Surgical Clinical Outcome Review Programme - Acute Pancreatitis	Yes	Yes	100%
NCEPOD - Medical & Surgical Clinical Outcome Review Programme – Cancer in Children and Young People	Yes	Yes	100%
NCEPOD - Medical & Surgical Clinical Outcome Review Programme - Non-invasive ventilation	Yes	Yes	In progress
NCEPOD - Mental Health Clinical Outcome Review	No	Not applicable	

National Audits

The reports of 18 national clinical audits were reviewed by the provider in 2016/17 and the following are some of the actions ENHT intends to take to improve the quality of healthcare provided.

National audit	Actions to be taken
National Pregnancy in Diabetes	• Improve pre-conception care. Educate GPs, Practice nurses, Diabetes Nurse/ Midwives • Enhance resources (esp Specialist Midwife hours) in joint antenatal clinic (Med and Obstetrics)
National Neonatal Audit Programme	• Improve compliance with observations and documentation • Monthly audit by band 6 nurses and data manager • Check delivery room (including theatres) temperatures and transfer preterm babies using transport incubator
National Hip Fracture Database	• Improve liaison with anaesthetic department • Full physiotherapy staffing and a Sunday service to be available
RCEM Mental Health: care in emergency departments	• Develop a Mental Health Risk Assessment Triage proforma • Review findings and proposed re-audit with the Mental Health Team

Local audits

The reports of 122 local clinical audits were reviewed by the provider in 2016/17
and the following are some of the actions ENHT intends to take to improve the quality of healthcare provided.

Local audit	Actions to be taken
Audit of palliative care triage tool	• Establish possible reasons why the referral proforma is not being completed in all cases and ways in which this usage can be increased • Establish possible reasons why the RAG rating tool is not being completed. This should include discussion as to the possible re-design of the form (e.g. Colour printing to highlight the RAG rating section). • Identify on Infoflex the reasons why there may be delays to patients being seen.
Adherence to Hertfordshire Medicines Management Committee (HMMC) Recommendation in 2015	• Review ordering process for NFDs with procurement team • Send copy of Rifaximina and Dapagliflocin HMMC recommendations to Gastroenterologists and Endocrinologists
DNACPR – Elderly Care	• Reiterate the need to file DNAR forms in the front of the notes • Clinicians should review DNAR forms daily on ward rounds
Measure Vitamin D levels at diagnosis in all people with melanoma per NICE recommendation	• Ensure that the Plastic surgery team and the Multi-Disciplinary Team requests a measurement of Vitamin D for any newly diagnosed patient with Melanoma
Perineal Trauma	• Remind staff to give advice on perineal care for all women who have perineal trauma including those who do not require suturing

Research and development

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 2715.

During 2016/7 the Trust introduced a new Research Strategy which aims to enhance patient experience and outcome by offering research opportunity for all patients and staff. During its first year research participation has increased by 30% compared with 2015/16.

The Trust has a long history of being research-active as we seek to "enhance patient experience and outcome through research and innovation". We are part of the National Institute for Health Research (NIHR) therefore support health and care research which translate into new products, treatments and procedures. We work with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments and we train and develop researchers to keep the nation at the forefront of international research.

Trust staff are supported to apply for external research funding. Recent success includes:

- The Gynaecology Cancer Team has been granted an award to study to demonstrate that circulating tumour cells and lymphocytes in various solid tumours can be identified, quantified and used to monitor ongoing metastatic disease
- The Cardiology team has been awarded a grant for a project "*Assessing the effect of apixaban on endogenous fibrinolysis in patients with nonvalvularatrial fibrillation*"
- One of our Urology / Haematology Research Nurses won a place on the Clinical Academic Internship Programme), funded by Health Education England, which will provide a practical skills to undertake a research project

The Trust publishes research and for the period Jan 2016 – Dec 2016 produced at least 199 publications in peer-reviewed journals. Examples of how research and innovation at the Trust has had a positive benefit for patients are:

- The Renal Team has established a shared care space in haemodialysis. Some patients were trained to set up their own dialysis machines in the renal unit, self-needle, put themselves on the machine and take themselves off.
- The Respiratory Team contributed to the *Cancer Diagnosis in the Acute Setting (CaDiAS) Lung and Colorectal Research Study*. This study is important because a high proportion of lung and colorectal cancer patients are diagnosed after presenting as an emergency rather than after primary care referral
- The Radiotherapy Team, with support from the Bioengineering team, have developed an innovative 'fixation template device' for the delivery of high dose radiation (brachytherapy) in prostate cancer treatment. The Trust has worked with Health Enterprise East to review options to make this available on a commercial basis to other organisations

Central to the research activity are our patients. We have worked with patients to create videos that share their research experience to use as part of our training for research.

In November and December 2016 a hundred research participants were asked to rate their experience of taking part in research. 69% of participants rated their experience as excellent (10/10), and 29% rated the experience at 9/10. One participant commented:

"My research nurse has always been supportive, kind and caring and has always listened to my thoughts, doubts and concerns and has always put my mind at ease. She makes my two week treatments bearable."

Goals agreed with commissioners

A proportion of the ENHT's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the ENHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

CQUIN is a way of improving quality by providing a financial incentive. The Trust receives either a full or part payment depending upon the results it achieves. In 2016/17 £x.xx million of income was dependent upon achieving CQUIN targets. During the year we secured xx% of the CQUIN target generating £x.xx million of income.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at www.enht-tr.nhs.uk

The Trust main CQUINs for 2016/17 are set out in the table below, together with their full monetary value and details of whether or not these quality improvements were met.

	CQUIN	**Weighting (%)**	**Value awarded (£000s approx)**	**Achievement (%)**
1a	Staff health & wellbeing initiatives	10		
1b	Healthy food for NHS staff, visitors and patients	10		
1c	Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff	10		
2a	Timely identification and treatment of Sepsis – emergency department	5		
2b	Timely identification and treatment of Sepsis – in patient setting	5		
3a	Reduction in antibiotic consumption per 1,000 admissions	8		
3b	Empiric review of antibiotic prescriptions	2		
4	7 day pharmacy service	10		
5	Improving Patient Experience in out-patients	10		
6a	Increase in ambulatory care capacity (at Lister only)	10		
6b	Improved patient flow and reduction in patient delays	2.5		
7	Digital technologies - Pilot Phase of tele-monitoring for kidney disease patients on renal replacement therapy	5		
8a	Improved turnaround times for access to and reporting of outcomes from urgent radiology diagnostics for Patients attending ED requiring CT.	6.25		
8b	Improved turnaround times for access to and reporting of outcomes from urgent CT scans for Patients referred on the lung cancer pathway.	6.25		
		100%		

Statements from the Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is registered with some conditions. The Trust has the following conditions on registration.

Regulatory Activity	Lister Hospital*	New QEII	MVCC	Hertford	Bedford Renal Unit	Harlow Renal Unit
Treatment of disease, disorder or injury	Registered with conditions	Registered	Registered with conditions	Registered	Registered	Registered
Surgical Procedures	Registered	Registered	Registered with conditions			
Maternity and midwifery services	Registered with conditions	Registered		Registered		
Diagnostic and Screening procedures	Registered	Registered	Registered with conditions	Registered	Registered	Registered
Termination of Pregnancies	Registered	Registered				
Family Planning Services	Registered	Registered		Registered		
Assessment or medical treatment of people detained under the Mental Health Act 1983	Registered	Registered	Registered			

* Lister Hospital's registration includes the registrations for renal satellite units in St Albans Hospital and Luton and Dunstable Hospital.

The Care Quality Commission has not taken enforcement action against ENHT during 2016/17.

The ENHT has not participated in any special reviews or investigations by the CQC during 2016/17. However the Trust underwent a follow-up inspection as part of the overall inspection programme of all Trusts with the details reported in section 3e.

Data quality

The ENHT submitted records during 2016/17 to the Secondary Uses Service 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 and the patient's valid General Medical Practice Code is given in the table below.

	Included valid NHS Number	Included valid General Medical Practice Code
Admitted patient care	99.7%	99.7%
Out-patient care	99.9%	99.9%
Accident & Emergency care	98.7%	98.4%

Information Governance

The ENHT's Information Governance Assessment Report overall score for 2016/17 was 75% and was graded 'satisfactory' (green).

Clinical coding error rate

The ENHT was subject to the Payment and Tariff Assurance Framework (previously *Payment by Results* clinical coding audit) during the reporting period by NHS Improvement (previously by the Audit Commission then Monitor) and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

	Monitor
Primary diagnoses incorrect	5%
Secondary diagnoses incorrect	1.57%
Primary procedures incorrect	5.04%
Secondary procedures incorrect	0.54%

Following the new Head of Coding's review of the Trust's coding position a number of areas have been identified for initial focus. The Information Governance Audit has improved from Level 1 (fail) to Level 2 (managed) for clinical coding. ENHT will be taking the following actions to improve data quality and to support coding improvements:

- Coders have been linked with divisions to work with assigned teams for accurate coding and to promote learning. All Coding staff have a Divisional Lead Mentor, All Divisional Leads are Mentored by the Head of Coding
- Audit, including baseline audit for all specialties, is planned together with participation of coders on ward rounds
- Progress in clearing the coding backlog has been made. It is intended that 85% of records are coded by the first day of the month following discharge [There will always be a coding backlog as coding takes place after patients have been discharged]
- Clinical coding reports are being developed to support service improvement
- Data Quality review is undertaken and amendments made to capture accurate data
- Ward Clerk awareness raising to reduce variation of data entry across wards
- Standardisation of the ward clerk role to reduce variation of data entry across wards

2d Performance against national core indicators

In this section the outcomes of nine mandatory indicators are shown. This benchmarked data is the latest published on the NHS Digital website.

For each indicator the Trusts performance is reported together with the national average and the performance of the best and worst performing Trusts, where applicable.

Indicator 1 - Summary Hospital Mortality Index

		ENHT Previous Periods		ENHT Current Period	National Current Period
		Apr 15- Mar 16	Jul 15 – Jun 16	Oct 15-Sept 16	
a	Summary hospital-level mortality indicator ("SHMI") value	1.062	1.065	**1.056**	1
	SHMI banding	2 As expected	2 As expected	**2** **As expected**	-
b	Percentage of patient deaths with palliative care coded at diagnosis or specialty level	45.3%	45.8%	**44.19%**	29.75%

(Source: NHS Digital SHMI data)

The Trust considers that this data is as described for the reasons given in Part 2b, priority 3 of this report.

The ENHT has taken a number of actions to improve the SHMI rate, and so the quality of its services. These are detailed in Part 2b, priority 3 of this report.

Indicator 2 - Patient Reported Outcome Measure

Patient Reported Outcome Measures (PROMs) compare the outcomes relating to four procedures. These are measured by questionnaires both before and 6 months after surgery, to measure the extent of improvement. The measure given is an overall weighted assessment relating to function and feeling. The measure ranges from -0.594 to 1 where 1 is the best possible state of health.

		ENHT Previous Periods		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2014-15 (final)	2015-16 (provisional)	Apr 16-Sept 16 (provisional)			
a	Groin hernia surgery	0.073	0.093	0.077	0.089	0.161 Countess of Chester NHSFT	0.016 Dudley Group NHSFT
b	Varicose vein surgery	N/A	0.061	Insufficient data	0.099	0.152 Heart of England NHSFT	0.016 Kings College Hospital NHSFT
c	Hip replacement surgery	0.438	0.419		0.449	0.522 Northern Devon Healthcare NHST	0.329 Western Sussex NHSFT
d	Knee replacement surgery	0.302	0.315		0.337	0.430 Royal Devon & Exeter NHSFT	0.260 Royal United Hospitals Bath NHSFT

(Source: NHS Digital PROMS data)

The ENHT considers that this provisional data is as described for the following reasons. The Trust ensures the first questionnaire is provided to patients at the pre-operative screening stage. After this the patient's surgery may be outsourced to a different provider, hence insufficient data for assessment.

The ENHT has taken the following actions to improve these scores, and so the quality of its services, by reviewing data that is available and ensuring the process is followed as appropriate.

Indicator 3 - Readmissions

a	% patients aged 0-15 readmitted within 28 days of discharge	The national data set has not been updated since 2011/12 and was reported in previous Quality Accounts. Future releases have been suspended pending a methodology review
b	% patients aged 16 or over readmitted within 28 days of discharge	

(Source: NHS Digital Indicators/NHS Outcomes Framework 3)

More recent Trust data since 2012 is given below in the table.

Emergency readmissions to hospital within 30 days of discharge				
12/13	**13/14**	**14/15**	**15/16**	**16/17**
11%	10.52%	10%	8.54%	8.3%

The ENHT considers that this data is as described for the following reasons. The Trust is working with community partners to enhance care within the community settings and ensure information provided at the point of discharge supports ongoing care, therefore helping to prevent readmission.

The aim for 2016/17 was to reduce readmissions to 7.75%. The ENHT has taken the following actions to improve the score, and so the quality of its services by continuing the admission avoidance initiatives and auditing readmissions to identify the causes to see if anything should have been done differently.

Indicator 4 - Responsiveness to Personal Needs

This indicator is the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs as measured in the national in-patient surveys. The measurement is based upon patients reporting they are involved adequately in decisions about their care; they have privacy and understand their medications; they know who to contact after discharge if there is a problem or if they have any worries.

	Responsiveness to Personal Needs	**ENHT Previous Period**		**ENHT Current Period**	**National Current Period**	**Best Performer**	**Worst Performer**
		2013/14	2014/15	2015/16			
a	Responsiveness to the personal needs of patients	64.9	67	**66**	69.6	86.2 Royal Marsden NHSFT	58.9 Croydon Health

(Source: NHS Digital Indicators/NHS Outcomes framework/Domain 4.2)

The ENHT considers that this data is as described for the following reasons. The Trust is implementing the initiatives outlined within the Patient and Carer Experience Strategy and a range of pharmacy-related activities.

The ENHT has taken the following actions to improve the score, and so the quality of its services by:

- Continuously taking action in response to feedback
- Implementing local initiatives within the clinical divisions in light of local feedback

Indicator 5 - Recommending the Trust (Staff)

The Trust participates in the annual national staff survey where staff are asked "*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*"

69% of staff surveyed 'strongly agreed' or 'agreed' with this statement.

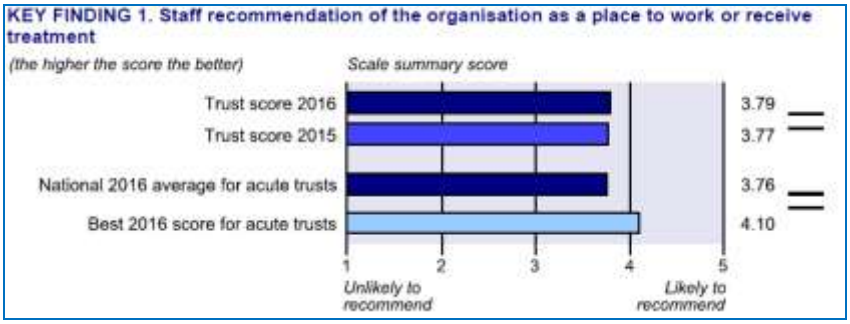
	Recommending the Trust	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2014	2015	2016			
a	% of staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends	67%	67%	**69%**	69% Acute Trusts	95% Liverpool Heart and Chest Hospital NHSFT	45% North Essex Partnership University NHSFT

(Source: National Staff Survey 2016)

The ENHT considers that this data is as described for the following reasons. The Trust continues to engage, develop and recognise staff as described in Part 3, section 3f, of this report.

The ENHT has taken the following actions to improve this score, and so the quality of its services, by implementing the initiatives outlined in the People Strategy and engaging staff through its culture programme. Section 3f describes some of the initiatives underway to increase staff involvement, wellbeing and development thereby supporting improvements to patient care.

The National Staff Survey report presents data so that it is possible to view the Trust scores compared with the previous year and against other Trusts. It can be seen in the chart below that the Trust score slightly improved compared to 2015 and is slightly higher than the national average.



Indicator 6 - Family and Friends Test (Patients)

After completing treatment or being discharged from a service, patients will often be invited anonymously to complete the Family and Friends Test (FFT). This is a single question "*How likely are you to recommend our service to friends and family if they needed similar care or treatment?"*

Five options are given:

Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely

Responses are grouped as follow:

Would recommend = % of 'extremely likely' and 'likely' responses
Would not recommend = % of 'unlikely' and 'extremely unlikely'

The information is collected via paper/ electronic surveys or text messages. The results are shared amongst Trust staff and uploaded into the national data collections for publication on NHS Choices. During 2016/17 105,636 FFT responses were received and the monthly responses are displayed on each ward for patients and the public to see which brings about local ownership.

	Family and Friends Test	**ENHT Previous Period**		**ENHT Current Period**	**National Current Period**	**Best Performer**	**Worst Performer**
		Dec 2016	Jan 2017	Feb 2017			
a	Friends & family test—score of inpatient	96%	97%	97%	96%	100% Various	76% Sheffield Childrens NHSFT
b	Friends & family test—score of patients discharged from the accident & emergency department	81%	82%	83%	87%	100% Liverpool Womens NHSFT	48% North Middlesex University NHST

(Source: NHS England, Friends & Family Test data)

Very impressed with the dedication, professionalism and general friendliness of the nurses despite pressures in staffing and challenges they face on the ward daily. The nursing staff are also caring and very supportive and they would go out of their way to accommodate any request from family members to listen sympathetically and ease my concerns.
Barley Dec-16

Having to wait less time to get through all the doors so we can spend more time with the little one. Less time for handover or handover being done in another room.
Neonatal unit Dec-16

Inpatients & Day Case

97% Recommend the Trust (NHS England, Feb 2017)	In February 2017: 1,743 in-patients said they would be extremely likely to recommend the Trust 11 in-patients stated they would be extremely unlikely to recommend the Trust The England average for recommending the Trust during this time was 96% (excluding independent sector providers).

Accident and Emergency

83% Recommend the Trust (NHS England, Feb 2017)	In February 2017: 1,103 emergency department attendees said they would be extremely likely to recommend the Trust 111 emergency department attendees stated they would be extremely unlikely to recommend the Trust The England average for recommending the Trust during this time was 87% (excluding independent sector providers).

The FFT score of 83% reflects the challenges faced by the Trust in delivering emergency services at a time of severe demand. However the slight improvement compared with the score in 2015/16 reflects some of the improvements made to expedite flow through the department from arrival to discharge or admission.

The place was clean, the staff were wonderful, kept me up to date with what was happening and told me what was wrong with my daughter, and even had cups of tea, which is a lovely touch when you haven't been able to sleep for a few days; it's not normally available unless you go out to find a machine. Well organised, relaxed staff and very helpful. Thank you.

ED, Lister Dec-16

Not enough seats, I was involved in a car accident, had nowhere to sit. Only one doctor on for everyone. Got seen quickly for an x-ray but very long and painful wait for the results.

ED, Lister Dec-16

The ENHT considers that this data is as described for the following reasons. The Trust is implementing the initiatives outlined within the Patient and Carer Experience Strategy and is working with community partners to improve the flow of patients through the emergency department.

The ENHT has taken the following actions to improve the score, and so the quality of its services by:

- Developing staff as per the culture programme, as research shows that happy staff deliver better services
- Continuously taking action in response to feedback
- Revising care pathways and processes, such as in the Emergency Department, so that patients have an even better experience

Maternity & out-patients

The family and friends test is also undertaken within maternity and the out-patients department. Results are given below.

	Would recommend				
	Antenatal	Birth	Post-natal	Community Midwifery	Outpatients
Trust target	93%	93%	93%	93%	94%
Q1 Apr--Jun-16	93.79	95.41	87.14	100.00	95.44
Q2 Jul-Sept-16	93.06	96.95	89.77	83.33	95.38
Q3 Oct-Dec-16	94.16	94.79	86.06	100.00	94.69
Q4 Jan-Mar-17	96.61	97.41	89.35	80	95.75

Indicator 7 - Venous Thromboembolism

Thrombosis is a blood clot occurring inside a blood vessel. A venous thrombus is a blood clot that forms within a vein. A deep vein thrombosis (DVT) is a blood clot in the deep veins of the leg. Occasionally a small segment of this clot may break and travel in the blood stream to the lungs where it may lead of a pulmonary embolism (PE). Such clots may develop for a number of reasons eg. being still in bed. All in-patients should be assessed for their risk of VTE and where necessary be prescribed an appropriate anti-coagulant (blood thinning drug).

	Venous Thromboembolism (VTE)	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		July-Sept 2016	Oct-Dec 2016	Jan-Mar 2017			
a	% of patients who were admitted to hospital and who were risk assessed for VTE	96.57%	98.01%	Due May			

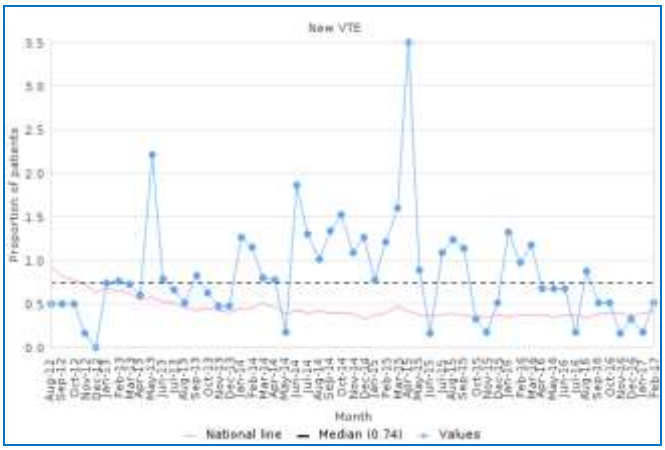
(Source: NHS England, VTE risk assessment data)

The ENHT considers that this data is as described for the following reasons. There is a robust data collection process which ensures completeness of data. Pharmacy staff are fully engaged in working with doctors to promote the assessments being undertaken.

The ENHT has taken the following actions to improve this percentage, and so the quality of its services, by:

- Ongoing instruction / training on VTE assessment
- Making results available for specialty level review
- Monitoring the completion of assessments at ward level with compliance information displayed on ward boards

The NHS safety thermometer shows that the incidence of new (hospital acquired) VTE has been below the median throughout the year (except August) with incidence either slightly above or below the national line.



Throughout the year the Thrombosis Committee has overseen actions aimed at reducing the incidence of hospital induced blood clots. This work has centred around education, production of guidance, review of medications and changing practices in light of learning from those who have acquired a hospital acquired blood clot. The medication chart, which contains the risk assessment, has been revised to simplify its completion.

Indicator 8 - Clostridium Difficile

Clostridium difficile is a bacterium that can affect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others. C. difficile infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics.

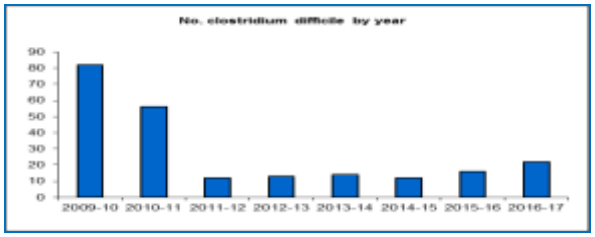
(NHS Choices)

	Clostridium Difficile	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2013/14	2014/15	2015/16			
a	The rate (per 100,000 bed days) of cases of C.difficile infection reported within the Trust in patients aged >= 2	6.2	5.7	**7**	14	0 Various hospitals	66 Royal Marsden Hospital

(Source: www.gov.uk statistics/C difficile)

More recent data from Public Health England (PHE) for 2016/17 to March shows the rate of reported infections per 100,000 bed days as 10.27 (based on reporting 22 cases by this point). This is the 6th (of 19) best performing Trust in the East of England (average 12.39) and lower than the England average at 11.06.

During 2016/17 there were 22 reported cases of hospital acquired C.difficile in the year, ten of which have been successfully appealed, and a further under discussion.



The ENHT considers that this data is as described for the following reasons. The Trust continues to promote high standards of hygiene and appropriate antibiotic usage. There have been reported delays in taking stool samples for testing.

The ENHT has taken the following actions to improve this rate, and so the quality of its services, by:

- Strict hand hygiene control (96.26% compliance) and adherence to infection control care bundles
- Application of the antibiotic stop policy
- Undertaking root cause analysis investigation of each case to identify causes and use this information for learning and sharing across the organisation
- Focusing upon timely collection of stool specimens

Careful antibiotic prescribing must be undertaken to help prevent the incidence of clostridium difficile. The Trust participated in a CQUIN scheme to reduce antibiotic use by 1% (measured by daily dose per 1000 admissions); and a scheme to review antibiotic usage 72 hours after initial prescription.

✓ Compared to baseline data 2013/14 antibiotic usage in 2016/17 reduced by 18%.
✓ 93% of antibiotics reviewed in quarter 4 (against a plan of 90%), with the aims of all other quarters also met

A new antimicrobial stewardship ward round started in February, focusing on patients with gastroenterology conditions where there is a high use of certain antibiotics.

Indicator 9 - Number of Patient Safety Incidents

A patient safety incident is an unintended or unexpected incident which could have or did lead to harm for one or more patients. Common examples include falls and pressure ulcers.

	Number of Patient Safety Incidents	**ENHT Previous Period**		**ENHT Current Period**	**National Current Period**	**Highest Performer**	**Lowest Performer**
		Apr – Sept 15	(Oct 15-Mar 16)	(Apr 16-Sept 16)			
a	The number of patient safety incidents reported within the Trust	2799 *(2961)*	3968 *(4176)*	3446 *(3527)*	-	-	-
b	The rate of patient safety incidents reported within the Trust (per 1000 bed-days)	26.61 *(28.15)*	36.41 *(38.32)*	31.76 *(32.51)*	-	71.81 North Devon Healthcare	21.15 Luton & Dunstable Hospital
c	Number of severe harm or death (Acute Trust – non specialist)	17 *(18)*	23	27	-	4 0% Thameside Hospital	92 1.7% United Lincolnshire Hospitals
d	Percentage of severe harm or death (Acute Trust – non specialist)	0.6%	0.6%	0.8%	0.4%		

(Source: NHS Digital Indicators/NHS Outcomes framework/Domain 5)

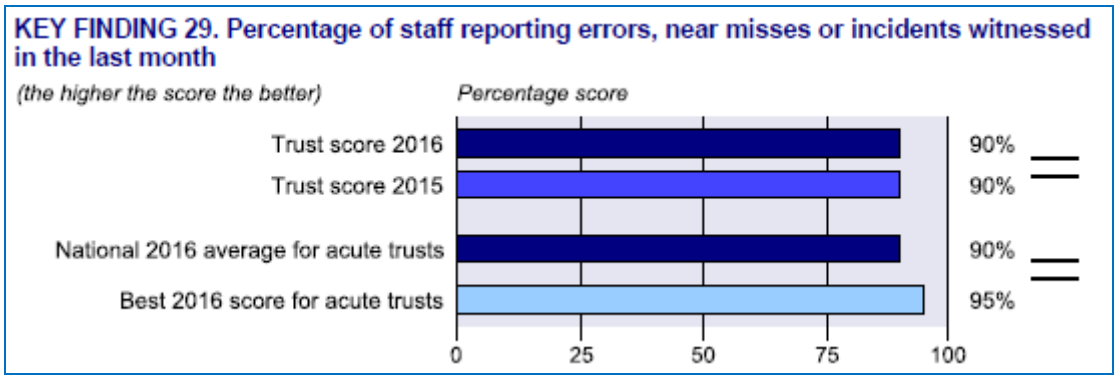
Staff report patient safety incidents via an electronic reporting system. Managers review the incidents detailing the action taken where relevant. Trend data can be extracted from the electronic system which is used to target preventative initiatives or to identify wards or departments where more support is required to address any emerging problems.

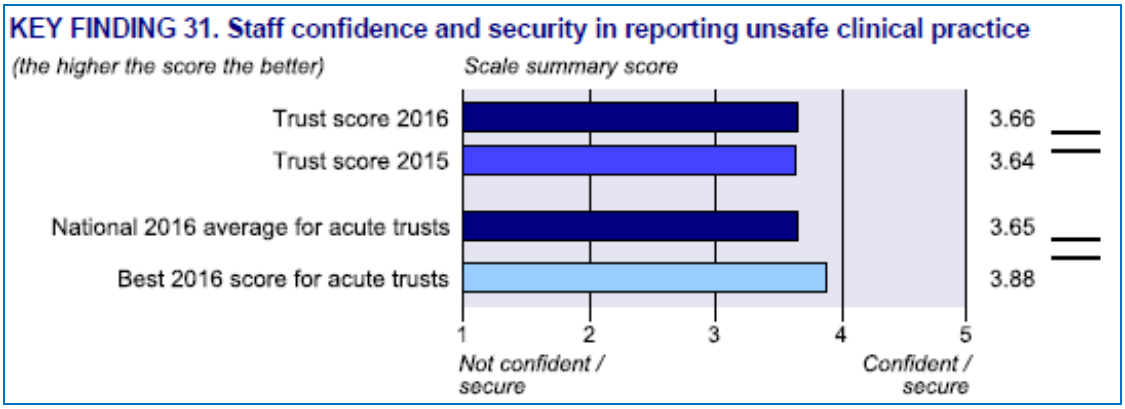
The ENHT considers that this data is as described for the following reasons. Staff report incidents on an electronic system and whilst surveys indicate staff are confident to do so there is an ongoing concern about signing incidents off in a timely way. This causes a delay in sending data to the national system hence a lower reporting rate is shown than is actually the case. The number of incidents reported are shown in brackets () but not all signed off in time to meet the national capture deadlines.

The ENHT has taken the following actions to improve these scores, and so the quality of its services, by:

- Continuing to support staff in dealing with any concerns
- Providing ongoing training
- Providing monthly reports to divisions about the sign-off status

The national Staff Survey (2016) indicates that staff report incidents in line with national averages and feel confident to do so.



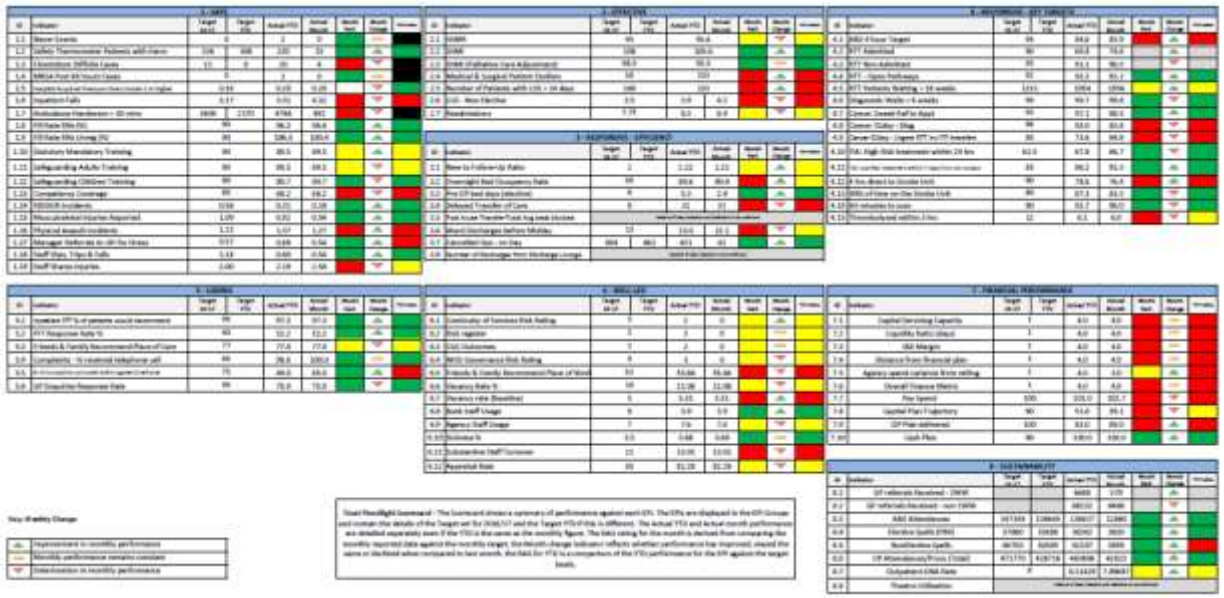


Part 3

3a	Review against selected metrics • Safety • Clinical effectiveness • Patient experiences
3b	Duty of Candour
3c	Sign up to Safety
3d	Staff survey
3e	Care Quality Commission inspections
3f	Our staff
3g	Performance against national requirements

3a Review against selected metrics

The Trust Board routinely reviews a selection of metrics at each of its meetings. An overview, known as the Floodlight, is given below for illustrative purposes.



This shows the ‘at a glance’ performance in relation to five areas which includes the components of quality – safety, experiences (caring) and effectiveness.

The metrics include national and local indicators, some of which have ‘stretch targets’. Such stretch targets aim high to force the organisation to make big improvements. Although desired, it is not always possible to reach these targets which is why a number of indicators above are shown as ‘red’.

Patient safety

Indicator	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Never events	1	1	4	**2**	0	✖
MRSA Bacteraemia	2	5	0	**2**	0	✖
Number of inpatient falls	988	919	861	**867**	<818	✖
Number of in-patient falls resulting in serious harm	16	14	13[1]	**15**	<=24	✓
Number of preventable hospital acquired pressure ulcers	45	54	26	**27**	<=36	✓

In the 2015/16 report this figure was reported as 11
Source: Datix internal incident reporting & information held by local teams

Never events

A never event is an incident that should never happen if the correct procedures are in place and being followed to prevent an occurrence.

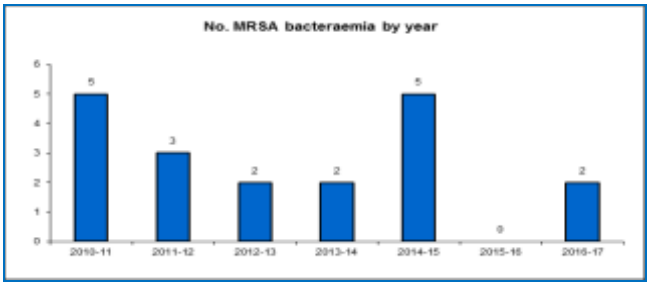
In 2016/17 the Trust reported 2 never events:

- A wrong side bearing was placed into a knee during surgery. A failure to realise the bearings were 'sided' coupled with inadequate checks prior to placement meant that surgery was completed before the error noted. The department has introduced specific checking responsibilities and reviewed the role of company representatives within the theatre environment.
- A patient fell out of a window despite restrictors being in place. The restrictors were compliant with regulations but could not withstand the force applied against them.

MRSA

Methicillin Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that is resistant to many widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections resulting in patients staying in hospital for a long length of time.

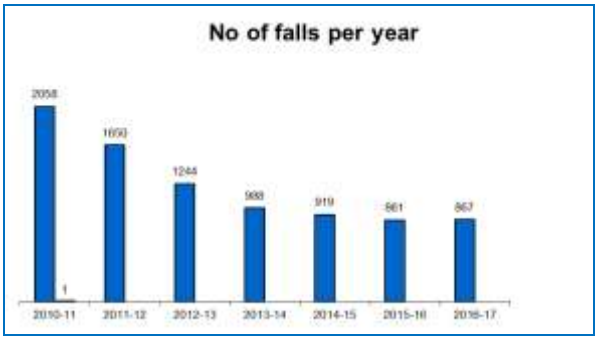
In 2016/17 the Trust had a target of achieving zero avoidable MRSA Bacteraemias. These are bloodstream infections from the MRSA bacterium. There have been two hospital associated MRSA bacteraemias in the year including one pre-48 hour case which was found to be a contaminant.

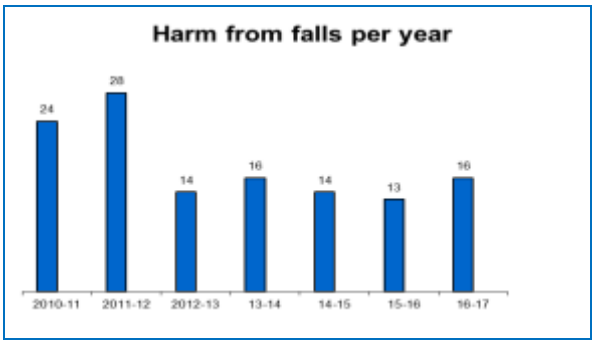


Actions underway are the same as those described in the section on clostridium difficile.

Falls

A 5% falls reduction target was planned against the 2015/16 figure. During the year 867 patients fell. This represents a 0.69% increase compared with 2015/16 and an increase per 1000 bed days by 0.12.





There were 152 falls that resulted in harm representing a 7.31% reduction when compared to 2015/16. Of these 15 patients suffered severe harm and one patient died as a result of a fall. Upon investigation it was identified that the patient who died had a severe blood coagulation abnormality which increased the risk of bleeding into the brain following trauma.

Actions underway to help prevent falls include:

- Baywatch system of observing cohorted patients at high risk of falls
- Safety huddles which facilitate staff to identify and manage key patient risks on a daily basis
- Participation in a falls collaborative organised by NHS Improvement, starting with pilots on a small number of wards and focus on an improvement plan

Where a patient has fallen and this has resulted in severe harm such as a fractured hip or head injury the incident is investigated as a serious incident. The findings from the investigations are routinely shared amongst the clinical teams to ensure that risk mitigation measures are put in place. All falls-related serious incidents are discussed routinely at the bimonthly Falls, Fragility and Bones Group to decide whether the findings/learning from individual investigations warrant an amendment to the trusts falls prevention strategy.

Pressure Ulcers

There have been 15 grade 2 and 12 grade 3 unclassified avoidable hospital acquired pressure ulcers reported during 2016-17. The majority of these (13/27) relate to heels.

Actions underway to help prevent pressure ulcer development include:

- Pressure ulcer prevention study days
- Production of a film to promote use of the intentional rounding tool
- Review of equipment available in relation to heels
- Alteration and re- launch of the heel care flowchart

Also relating to patient safety…

Safeguarding Adults

- ✓ A ‘flag’ on the patient administration system helps to identify patients with a learning disability so they can be supported more effectively during their attendance or admission
- ✓ 90.9% (March) of all Trust staff were compliant with Adult safeguarding training, surpassing the 90% aim
- ✓ QEII, Hertford County Hospital and Ophthalmology continue to work with the Health Liaison Team towards achieving Purple Star accreditation

Safeguarding Children

✓ 91.2% (March) compliance with child protection training (aim >=90%)

✓ Processes implemented and plans to improve data collection for referrals to mental health services and children's services to inform service

Electronic referrals

✓ Radiotherapy referrals are paperless thus ensuring robust audit trails and reducing the chance of error

Clinical effectiveness

Indicator	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Length of stay (non-elective)	3.91	3.53	3.50	**3.9**	<=3.5	✗
Number with length of stay > 14 days				**145**	<100	✗
Cancelled operations (on the day)	0.62%	1.41%	1.71%	**467**	<=504	✓
Medical and surgical outliers (PCM)				**115**	<50	✗

Source: Information accessed from local teams

The indicators described in this section are all inter-related whereby improvements in one are required to support improvements in the others. For example a reduced length of stay will increase the bed availability for those requiring surgery, thus reducing on the day cancellations due to a lack of beds.

Length of stay

Length of stay is optimised when care pathways and care bundles are introduced so that care is given in a prescriptive manner aligned with best practices.

A care pathway, also known as an Integrated Care Plan, is a plan of optimum care to be delivered from arrival to discharge. It describes the tests, treatments and monitoring to be undertaken at certain points during the admission; and by whom. It aims to standardise care where possible so people routinely receive the same optimum treatment and staff become familiar with delivering it.

A care bundle is a specific group of actions that need to be undertaken within an agreed timeframe to maximise chance of survival or to optimise treatment. An example is the Sepsis care bundle – known as the sepsis 6 – where 6 aspects of care must be delivered together within one hour of suspected diagnosis. The omission of one aspect will reduce the chance of overall success.

Care Bundles, either standalone or as part of an Integrated Care Plan, are now in place for the following diagnostic groups:

- Pneumonia
- COPD
- Congestive cardiac failure
- Stroke
- Acute MI
- Decompensated cirrhosis.

The newest care bundle is that for Decompensated Cirrhosis which is a medical emergency with a high mortality rate. The care bundle comprises a practical, evidence-based guideline designed to be used from the point of admission (within 6 hours), including a checklist of important aspects of Chronic Liver Disease management.

Within Respiratory services the use of the COPD care bundle continues to be encouraged and data is now submitted as part of a national real-time audit. As part of the STP project the Trust is working with WHHT and PAH to agree a standard pathway for pneumonia to reduce the variation in management.

Trust discharge planning teams are also actively working with community health and social care partners to support the needs of those requiring additional help after discharge.

Cancelled operations

The number of 'on the day' cancellations that have occurred during 2016/17 is 467 against a plan of below 504.

Hospital initiated cancellations are due to a failure of the hospital's infrastructure such as a lack of beds, equipment failure, missing medical records, sterile services issues or staff absence. Patient cancellations are where it is not possible to operate on a patient as they have failed to attend, have cancelled at short notice or are not medically fit for surgery.

The theatre process redesign work is intended to improve theatre efficiency thereby maximising the use of theatre time. In addition better bed management and the prevention of admission and re-admission will all help to reduce the number of cancellations.

Outliers

Patients are admitted ideally on a ward where their care and treatment can be provided by specialists with expert knowledge of their condition. For example the needs of a patient with heart problems is best cared for in the coronary care unit. Where a patient is placed on a ward within a different specialism this is known as 'outlying'. Although care and treatment is still provided the specialist teams are not as readily available so patients potentially may not receive the most timely or optimum care.

The Trust is committed to reducing the number of outliers; and to support this the number of outliers is now tracked on a monthly basis. The data available is still in its infancy and developments during 2017/18 will help to ensure the data is robust and meaningful.

All outlying patients are reviewed by a dedicated medical outlier team within the Trust although more therapy support will be required in the future. It is the aim of the team to review the patients daily before 12 Noon and to ensure discharge planning and multidisciplinary teamwork is maximised.

Outlier medical patients get similar medical input to patients on medical wards, i.e. consultant ward rounds Monday – Thursday with Friday covered by physician of the day rota. Specific additional support is provided by support teams such as those providing diabetes and dementia care. Heart failure and acute kidney injury teams actively support patients throughout the Trust.

Also relating to effectiveness of care…

- ✓ The Trust continues to work towards 7 day working, aiming to comply with the four national priorities by March 2018. These are: Time to Consultant Review; Access to Diagnostics; Access to Consultant-directed Interventions and On-going Review.

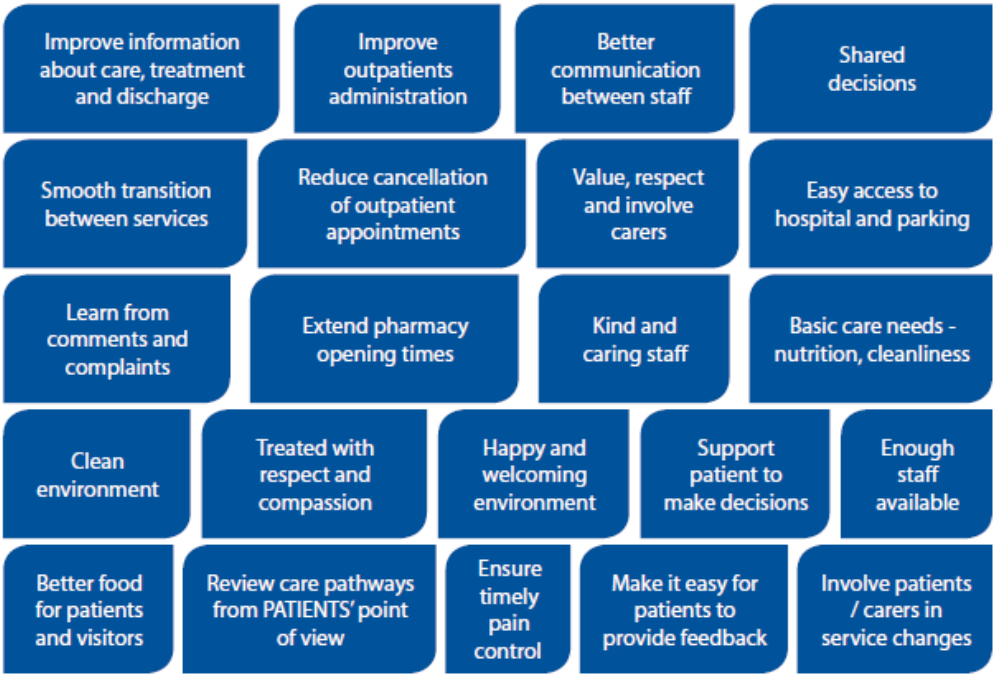
✓ Patients who have Robot Assisted Radical Prostatectomy were found to have better treatment when compared with patients undergoing Open Radical Prostatectomy and that the cost of treatment was less.

Patient experiences

The Trust's Patient and Carer Experience Strategy (2015-19) has three ambitions:

- To improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care
- To improve the information we provide to enhance communication between our staff, patients and carers
- To meet our patients' physical, emotional and spiritual needs while they are using our services, recognising that every patient is unique

A summary of the strategy is represented in the diagram below.



Patient experiences indicator set

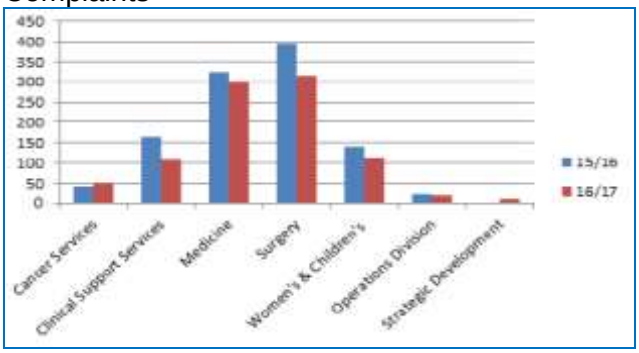
Indicator	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Number of complaints	864	1181	1095*	**924**	<previous year	✓
Number of PALS concerns	1728	2306	3279	**3195**	N/A	-
Complaints per level of activity - per 100 bed days (Before 2015/16 this was per finished consultant episode)	0.9%	1.32%	0.5% (New methodology)	**0.41% (Q1-3)**	N/A	-
Complaints – response within agreed timeframe	49%	59%	54%	**48%**	>75%	✗

*The 2015/16 report stated 1072 complaints were recorded. This has been revised in light of supplementary information.
Source: Datix internal system & Information held by local teams

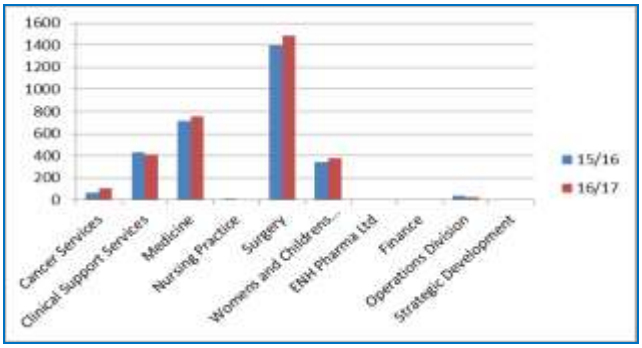
Complaints and PALS concerns

The number of complaints and PALS concerns is showing a reduction compared with the previous year.

Complaints



PALS Concerns



Given that activity has increased over the year it is encouraging that fewer complaints have been received.

✓ Data on complaints per 100 bed days which takes into account changing activity levels suggests an improving picture compared to 2015/16.

Complaints response times

When a complaint is received a member of the complaints team telephones the complainant and agrees an appropriate timeframe within which to complete a response. This is then measured. The timeframe has been met on 48% of occasions against a plan of >=75%.

Investigators are given 15 days to provide a report but often where the complaints are complex or where more than one department or professional is involved the investigation can be very time consuming. Case Handlers within the complaints team meet with key clinical personnel to support the investigation and more recently a standardised report template has been introduced to support obtaining thorough answers.

Each division receives a monthly spreadsheet detailing the number of complaints that are open for each specialty. This supports local ownership and monitoring. In addition, a review of the staff assigned to undertake the investigations has been undertaken to ensure the right people are involved; and a training programme has been delivered to enable ward sisters to more fully understand the process of undertaking a complaints investigation which will help to expedite the investigation and ultimately the response rate.

Below are some examples of what has happened as a result of complaints.

You said…	**We did…**
Delays in medication dispensing meant patient was delayed being discharged.	Apology given that a different way of working at the weekend means that prescriptions are sent to Pharmacy for dispensing. The Pharmacy team are exploring the dispensing prescriptions from the wards at the weekends to minimise delays
Cancellation of procedure / communication concerns.	Apology that family were not told sooner. Explanation given of why it may be necessary to cancel a procedure. As a result of the complaint the procedure for the scheduling of lists will be reviewed.
Complainant queried the refusal of Fentanyl. Concerns over care	Doctor was reluctant to give a controlled drug as the care plan the patient brought to the Emergency

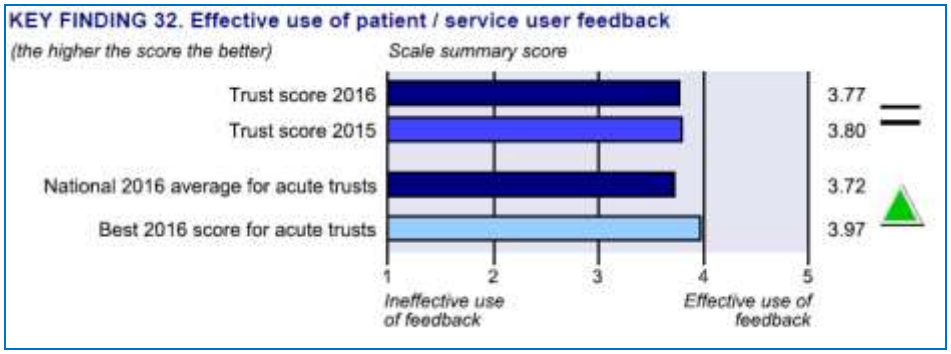
plan not being on patient's file / electronic records.	Department had not been produced on Trust headed paper. The care plan has been re-written, printed on headed paper and laminated. The patient and staff now have copies.
Complaint regarding a delay in the Emergency Department, lack of communication and "unhelpful lazy" staff.	Explanation that many new processes had recently been put in place, including improved staffing due to recruitment, changing processes within the Emergency Department and improving the care pathway to ensure that patients who need to be admitted are given beds sooner, thus freeing up beds and trollies for the patients who need them while they are waiting to be seen. The concerns relating to attitude and behaviour of a member of staff have been discussed with the individual and training has been arranged.

Gathering feedback

The Trust values the views of our patients, their families/ carers and the public to help us better understand what they think about our hospitals, staff and services so that we can make improvements. Examples of how we seek and listen to service users are:

- Local and national surveys (paper and electronic)
- Letters of thanks
- Complaints and Patient Advice and Liaison Service (PALS) enquiries
- Comments posted on the NHS Choices website
- Engagement activities including consultation work on service planning
- 'Patient Stories' shared with the Trust Board

The National Staff Survey (2016) shows the Trust as being better than average in its effectiveness of using feedback from service users.



It was my 2nd time as a day patient from the doorman right the way through to the surgeon there amazing companionate I wish more hospitals were like this I highly recommend this hospital well done to everyone wishing you a great future x

General Surgery, January 2017

Very poor communication no doctor return calls if it wasn't for the nurses we would not know anything about my dad no discussion regarding dads further care about moving him to a care home sister on the ward very un approachable would not talk to us I could go on not acceptable for a NHS hospital.

December 2016

Dementia

A Clinical Nurse Specialist (CNS) oversees the development of services for people with dementia and offers advice and support to staff looking after them. Hospital environments can

increase anxiety for suffers of dementia and the Trust continues to develop its services to care for them:

- A Dementia/Delirium care plan, aimed to identify and meet the care needs of patients with dementia and people suffering from delirium, has been trialled on the elderly care wards. A roll-out to all wards is planned for 2017/18
- The new patient administration system (Lorenzo) has been set up with a specific section for dementia assessments. Once the system goes live in July it will help the CNS to identify inpatients quickly and be able to offer them and staff support
- Dementia Strategy Multi-disciplinary meetings are held every 3rd Thursday of the month. They aim to discuss and implement better patient care and dementia awareness
- Dementia champion meetings are held every three months. It is an opportunity for the CNS to support staff on wards and provide up to date information within the Trust
- A series of educational Student Nurse forums have been held and Student Nurses regularly shadow the CNS to see how dementia patients are supported

✓ It is an exciting time for dementia within the Trust as we've been approached by Dementia UK to become a host organisation for an Admiral Nurse. Admiral Nurses are specialist dementia nurses who work in partnership with people affected by dementia and their families by embracing evidence-based relationship-centred care. With the support of Dementia UK the Nurse can receive up to date training, support and work closely with other Admiral Nurse's in the community. This will help support patients and carers going home in the community and hope to prevent hospital admissions too.

National in-patient survey 2016 (update when available in May)

xxx patients responded to the survey, with a xx% response rate (xx% nationally). The results since 2013 are shown together with how the Trust scores compared with the national averages.

Question group	2013	2014	2015	2016	National range (2016)
Emergency / A&E department	8 =	8.1 =	8.4 =		
Waiting lists & planned admissions	8.6 =	8.6 =	8.6 =		
Waiting to get to a bed	6.9 =	6.9 =	7.1 =		
Hospital & ward	7.8 =	7.7 ↓	8.1 =		
Doctors	8.2 =	8.1 =	8.4 =		
Nurses	8.1 =	8.2 =	8.1 =		
Care & treatment	7.2 =	7.4 =	7.5 =		
Operations & procedures	7.8 ↓	8.2 =	8.1 ↓		
Leaving hospital	6.9 =	6.9 =	6.8 =		
Overall views & experiences	5.1 =	5.4 =	5.3 =		

Electronic surveys

The Trust uses electronic devices, called Meridian, to record the views of patients during their stay with us. Examples of pie charts produced by the Meridian system are shown throughout this report.

In 2016/17 almost 12,000 people undertook the electronic inpatient survey. The scores for each of these questions is shown in the table below with the highest scores relating to privacy

and dignity; the lowest to noise at night and food. The scores can be generated for specific wards and time periods and are used by the relevant departments to make improvements.

Rank	Question No.	Question	Score	Questionnaires
1	20	Did you feel you were treated with respect and dignity while you were in the hospital?	97.01	11919
2	21	During your time in hospital, did you feel well looked after by hospital staff?	96.14	11909
3	18	Do you think the hospital staff did everything they could to help control your pain?	92.82	11878
4	13	When you had important questions to ask a **nurse**, did you get answers that you could understand?	90.88	11863
5	8	Did you get enough help from staff to eat your meals?	90.84	11934
6	6	In your opinion, how clean was the hospital room or ward that you were in?	89.76	11938
7	12	When you had important questions to ask a **doctor**, did you get answers that you could understand?	88.33	11862
8	17	Do you feel you got enough emotional support from hospital staff during your stay?	87.24	11889
9	11	Were you involved as much as you wanted to be in decisions made about your care and treatment?	83.71	11884
10	10	Were you ever bothered by noise at night from hospital staff?	83.67	11910
11	16	Did you find someone on the hospital staff to talk to about your worries and fears?	82.19	11883
12	14	In your opinion, were there enough nurses on duty to care for you in hospital?	80.44	11879
13	15	Do you know which nurse is in charge of looking after you? (this would be a different person after each shift change)	76.11	11860
14	19	How many minutes after you used the call button did it usually take before you got the help you needed?	71.15	11907
15	7	How would you rate the hospital food?	65.62	11937
16	9	Were you ever bothered by noise at night from other patients?	65.01	11899
17	5	As you would not recommend this service could you please tell us why?	N/A	11955
18	4	As you would recommend this service, could you tell us what we did well?	N/A	11955
19	2	What was good about your stay?	N/A	11398
20	3	What would have made your experience better?	N/A	11233
21	1	How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	N/A	11928

You Said… We Did

All wards have a patient experience notice board where they display a range of information about the ward's performance. This includes listening to feedback and acting upon it – so called 'You Said – We Did'. Examples of some actions taken by staff are given below.

Learning From Your Experience - Examples of 'You Said – We Did' Actions

October - December 2016

Ward/Dept.	You Said	We Did
Acute Medical Unit Assessment	We need better communication with the doctors about timings of what is going to happen and when.	Reminded all staff to keep patients and relatives updated on all treatment plans and decisions so everyone is clear what is happening and when.
Short Stay Unit	Patients can get a bit noisy sometimes which is disruptive.	Where possible we will aim to move patients if they are distressed or disruptive to others, although sometimes this is not possible as space is limited.
Short Stay Unit	We would like our families to be able to visit more often.	We are rolling out 'John's Campaign' welcoming visitors on the ward between 9am-9pm and enabling carers to stay with their loved ones at any time. We have two fold up beds available for carers staying overnight on the ward.
Midwife Led Unit	I was kept waiting for a bit on arrival at the MLU.	We try to make everyone on MLU feel welcome as soon as they arrive with us and ensure that they are reviewed as soon as possible. However if there is likely to be a delay we will ensure that women are informed and know when they are likely to be seen.
Midwife Led Unit	Left a bit too long without any information after delivery.	We understand the importance of leaving a new family to bond and rest after birth and we will do our best to support and guide on an individual basis. If women or their partners have any concerns the call bell is available 24 hours a day and staff are happy to answer any questions or give advice.
Consultant Led Unit	A shorter time between triage and transfer to the CLU	We endeavour to ensure that there are no delays in transferring women to ensure they are cared for in the right place. At times, when activity is high there may be a delay in transfer, we will ensure that women are kept informed of what is happening.
5A	Wanted to be kept up to date by doctors.	We endeavour to keep patients informed of their progress and test results. Depending on the type of test, some results can take longer to be processed. We have reminded our staff to keep patients updated on progress whilst in our care.

Also relating to patient experiences…

Purple Star Award

✓ The Trust's diabetic eye screening team has earned a Purple Star for supporting people with learning disabilities. Awarded by Hertfordshire County Council's Purple Star strategy team, it is earned for the delivery of high quality services that have been adjusted reasonably for adults with learning disabilities eg. promotion and use of the Purple Folders, production and use of accessible information and demonstration of awareness of safeguarding concerns.

Patient/Carer Stories

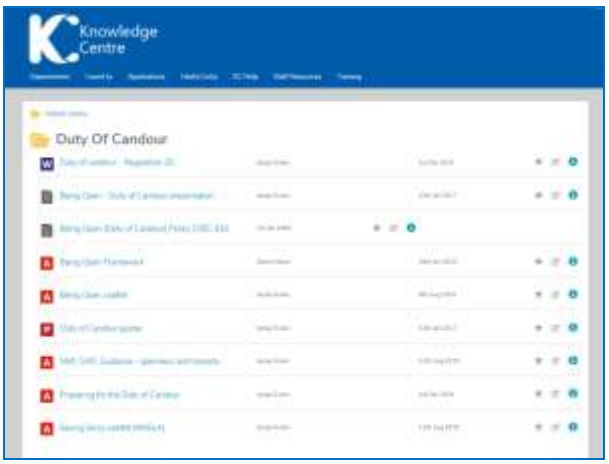
✓ Trust Board meetings start with a patient story, often told by a patient attending the meeting. The Board welcomes such information to understand better what it is like to be a patient/ family member in our hospitals.

3b Duty of Candour

This is the duty to 'be open' with people when something goes wrong leading to significant harm. The duty is to explain what has happened; to offer a sincere apology; and to involve the patient / family in what will happen next.

Some examples of how the Duty is promoted include:

- Training at induction and during mandatory updates for doctors
- Forced fields on the incident reporting system for staff to state how they have been open when things have gone wrong
- Written communication with patients/ families when a serious incident has occurred
- Investigation reports include a specific section on communication with the patient/ family
- Meetings with patients/ families to discuss incidents
- Incident training includes the importance of family discussions
- Liaison with families as part of investigations



Information for staff is available in one place on the Trust's intranet

For many years patients/ families have been offered, and taken up, the opportunity to meet with staff to discuss the findings of a serious incident investigation report.

During 2016/17 a new process was established whereby families are invited to meet with the patient safety and investigation teams prior to the start of a serious incident investigation. This allows patients/ families to be more involved with the investigation and enables their views and concerns to be considered early on. Such an approach is helpful to investigators who can obtain answers to concerns at the earliest opportunity and include them in the report. More importantly, the views of patients/ families are considered early and the meeting offers an opportunity to answer any immediate questions.

The value of these meetings is demonstrated by the views of two families involved:

"I would like to thank you for organising the meeting, which I thought went well. I have come away in the knowledge that by drawing the trusts attention to our own experiences we may help other families in the future. Please extend my thanks once again to Dr Hughes for his honest and thorough report"

"Very soon after the mistake was apparent I was visited by a senior pharmacist and by the young pharmacist involved. I was kept informed of investigation progress whilst still in hospital and a full explanation was also given to my family. Later, after my discharge from hospital, as the investigation progressed I and my daughter were invited to meet with the investigators face to face so that I could express in my own words how I felt at the time of the error and subsequently. It was very important to me that I was allowed to do so. I am fully reassured that a proper investigation was carried out and that measures have been taken to help prevent a similar incident in the future."

3c Sign up to Safety

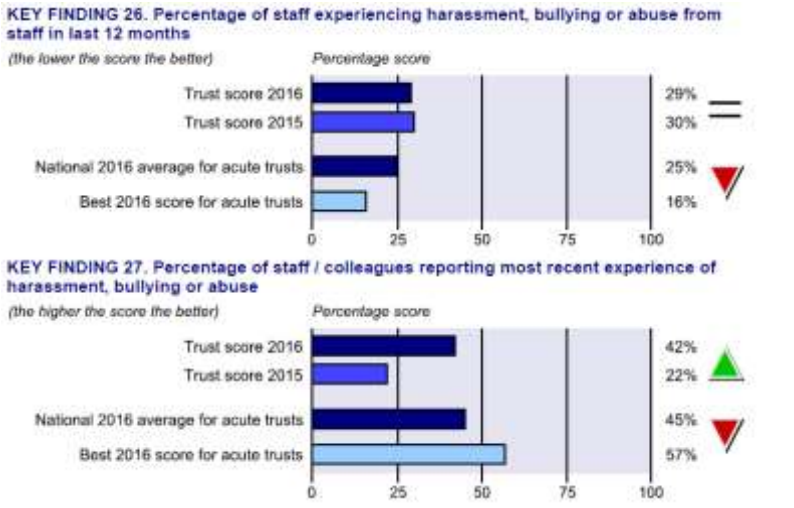
Sign up to SAFETY LISTEN LEARN ACT	Sign up to Safety is a national initiative to improve safety by identifying improvement projects and implementing them locally; but also sharing learning nationally via web links and conferences. The Trust's safety initiatives are closely aligned with: • The Improving Patient Outcomes Strategy • The Trust's culture programme • Plans to enhance collaboration with partners • Plans to enhance the Duty of Candour

3d Staff survey

Harassment and bullying

Although showing improvements since 2015, the 2016 NHS staff survey highlights a continuing concern with bullying and harassment at the Trust.

Percentage of staff…	Trust 2014/15	Trust 2015/16	National
Reporting they had experienced harassment, bullying or abuse from patients/ relatives/ public	29%	**28%↑**	27%
Reporting they had experienced harassment, bullying or abuse from staff	30%	**29%↑**	25%
Who had experienced harassment, bullying or abuse had reported it	22%	**42%↑**	45%
Who had never suffered violence from patients/ relatives or public	89%	**89%=**	85%
Who had never suffered violence from staff	98%	**97%↓**	98%



Slight improvement in experiencing bullying compared to 2015 but rated in the **worst 20% of Trusts** in 2016

Significant improvement in reporting episodes of bullying compared to 2015 but rated in the **worst 20% of Trusts** in 2016

Source:
National Staff Survey 2016

Below is a summary of the initiatives, as detailed in the staff newsletter *Your Voice* (Sept 2016) to reduce bullying.

We refuse to tolerate any form of Bullying and Harassment from our staff.

The Trust are committed to ensuring that none of our staff experience bullying and harassment at work and that staff have the opportunity to raise concerns as soon as possible through a number of different forums.
(Please see staff support section on page 7)

We have been working over the last year to remove bullying and harassment from the Trust and improve the ways we can support our staff;

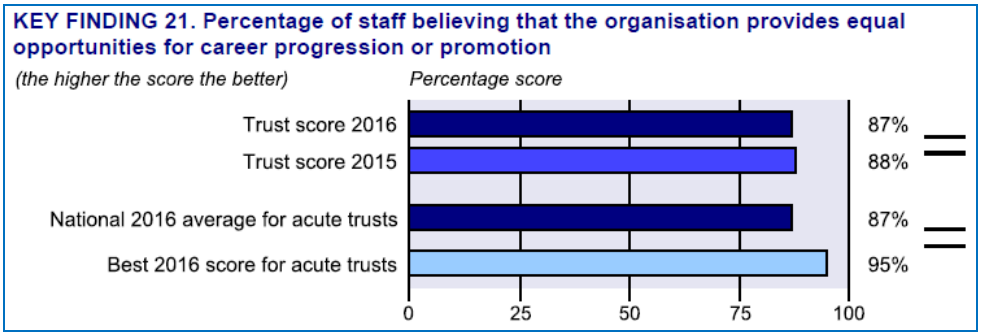
- Zero Tolerance campaign to bullying and harassment
- Staff are encouraged to speak up without fear.
- An anonymous concerns-raising platform – Speak in Confidence
- Employee relations advisory service (ERAS)
- Use early intervention techniques
- Raising the awareness of bullying and harassment
- Educating staff and managers on the impact of bullying and harassment
- Managers using their emotional intelligence when dealing with Bullying and Harassment cases
- Managers encouraged to have difficult conversations with team members when appropriate
- Raising the importance of tackling bullying and harassment with the executive team
- Bullying and harassment survey (Duncan Lewis report)
- CORE management skills training for the Trust's line managers
- Drop-in surgeries run by the ERAS team for staff
- A focus on reducing vacancy rates (which impact on stress and pressure felt by staff)
- Continue to drive improved compliance for new appraisal process which focuses on assessing behaviours and values
- The availability of the employee assistance programme
- Mediation is also used in cases of bullying and harassment. HR staff will be undertaking an intensive training course on mediation skills in September 2016
- We deal with cases informally
- Executive walkabout and Ask Nick sessions

In addition, training programmes offered by the Employee Relations Advisory Service for managers include Difficult Conversations and Dealing with Conflict.

Supported by the culture programme and the initiatives to reduce sickness and vacancies detailed in Section 3f it is intended that staff will work as part of a stable workforce in a culture that is nurturing and developmental. These initiatives collectively aim to reduce the incidence of bullying.

Equal opportunities

The 2016 Staff Survey indicated the Trust has an *average* score at 87% for *staff believing the organisation provides equal opportunities for career progression or promotion.* This is a slight overall reduction compared with the previous year. When looking in detail at the responses by ethnic group we can see there is a disparity felt by staff within the black and minority ethnic (BME) groups albeit to a lesser extent than reported nationally. It is encouraging to note, however, that there has been some improvement in the scores reported by the BME staff groups.



			Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	89%	88%	90%
		BME	81%	76%	79%

The Trust took the opportunity to include additional questions in the national survey on *Leadership & Career Development* and *Organisational values.* As an optional module there are no national comparisons but it does provide some rich data and an opportunity in the future to measure the effectiveness of the LEND leadership model and the Leadership & Management Development Pathway described in Section 3f. Of note:

- Over 70% of staff feel they have the capability to become a leader in their area of work
- 53% of staff feel that the person they report to creates opportunities for their professional growth
- Just under 60% of respondents feel that there are opportunities for them to develop their career in this organisation, and a similar number feel able to access the right learning and development materials when they need to.

The Trust is now engaging staff in developing actions to make further improvements.

3e Care Quality Commission inspections

October 2015

The Care Quality Commission (CQC) carried out an inspection as part of its routine comprehensive inspection programme from 20-23 October 2015.

The Commission rated the Trust as '**requires improvement**' overall but judged Hertford County Hospital and Children's Community Services to be '**good**'. The Bedford and Harlow renal units were inspected but not rated. The Trust was rated '**good**' for caring.

The ratings for the services assessed are given in the tables below.

Our ratings for Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Requires improvement	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for QEII

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Our ratings for Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Our ratings for Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate
End of life care	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Chemotherapy	Good	Good	☆ Outstanding	Requires improvement	Requires improvement	Requires improvement
Radiotherapy	Good	Good	Good	Good	Good	Good
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community health services for children, young people and families

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Throughout the year staff have continued to progress actions to improve services. Their action plans are reported and monitored via Development Board meetings and updates are routinely sent to the CQC. Some examples of improvements are given below:

- Increased awareness sessions regarding Mental Capacity Assessments
- Risk register reporting and oversight has improved
- Disability Champions have been identified at Mount Vernon Cancer Centre and more appropriate seating for people with disabilities has been purchased
- Strengthening of systems to ensure that patients who require urgent transfer from Mount Vernon Cancer Centre to other hospitals have their needs met to ensure their safety
- Movement of paediatric clinics to ensure they are in child-appropriate environments
- Review of maternity triage so that women requiring the services are seen in a more appropriate and timely way

- Rotation of community midwives to work in the maternity unit to maintain skills and confidence
- Review of the emergency department triage process

May 2017

The CQC carried out an unannounced, focused inspection on 17 May 2016 to review concerns found during their previous comprehensive inspection. The inspection focused on the adult emergency department (ED) and Bluebell Ward, part of the children's and young people's service. Although services were inspected they were not rated.

The CQC saw that significant improvements had been made since the last inspection such as:

- Staff were caring and compassionate towards patients and visitors within the emergency department; and patients and those close to them felt involved in their care
- The new triage process within the ED appeared to be efficient and safe
- Improvements to hand hygiene and overall cleanliness
- Systems were in place to monitor patients at risk of deterioration in the ED and on Bluebell Ward
- The risk assessments reviewed, including falls and pressure area risk assessments, were generally completed appropriately and reflected patients' needs
- Staffing levels met patients' needs at the time of the inspection and there had been an improvement in the number of staff that were trained to care for a child with complex needs

However, further improvements were identified such as meeting targets in the ED around triage and 4 hour waiting times. In addition further improvements were required relating to the knowledge around Duty of Candour, local induction of temporary staff and training around advanced life support. The actions relating to all recommendations have been built into the action plans and monitored as above.

Internal Audit

An audit of Care Quality Commission (CQC) processes was undertaken as part of the approved internal audit plan for 2016/17, particularly focussing on the development and monitoring of action plans following the CQC inspection. The audit noted:

- There is a strategic and tactical overview of the CQC process provided through a senior management structure
- Testing was undertaken on a sample of completed actions in respect of medicine, mandatory training, childrens' and maternity and surgery to confirm that these had been actioned and were supported by appropriate evidence. These were all found to evidence/ support the delivery of the actions and no issues were identified.

It was reported that not all fields within the action plans had been updated fully but otherwise the report stated…

"the Board can take substantial assurance that the controls upon which the organisation relies to manage the identified risks are suitably designed, consistently applied and operating effectively".

3f Our Staff

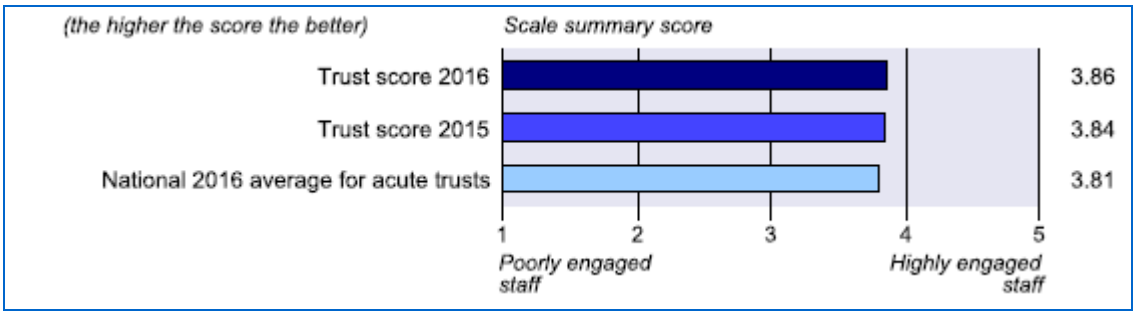
"We want to be known as an organisation where our people feel engaged, valued and supported and empowered to deliver excellent patient care and services they are proud of." *(People Strategy 2014-19, page 3)*

Staff indicator set

Key Indicators	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Staff engagement	3.76	3.71	3.84	**3.86**	N/A	
Appraisal completions	45.33%	68.33%	80.45%	**81.75%**	>=85%	=
Sickness rate (annualised)	3.41%	3.55%	3.55%	**3.65%**	<=3.5%	✘
Turnover	10.71%	12.91%	12.8%	**12.96%**	<=11%	✘
Vacancy rate	5.65%	7.11%	9.72%	**5.42%**	<=5%	✓

Staff engagement

The National Staff Survey 2016 demonstrates that staff engagement has improved further during 2016/17 and is **above average** compared with other Trusts.

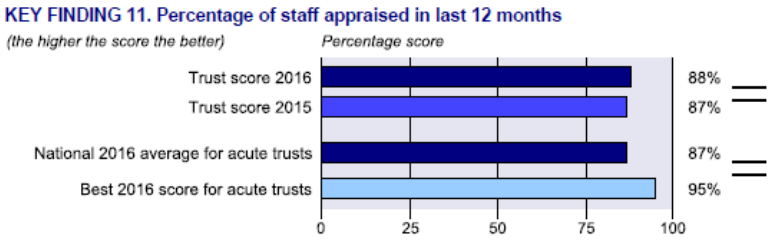


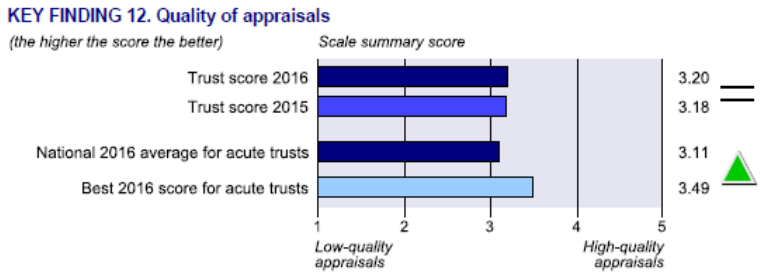
The table below shows how the Trust compares with other acute trusts on each of the questions making up the 'staff engagement' score.

	Change since 2015 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	• Average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Highest (best) 20%
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	✓ Increase (better than 15)	✓ Highest (best) 20%

These findings reflect the efforts undertaken to involve staff in service development as part of the improvement plans together with the increase in staff development opportunities.

Appraisals
81.75% (March) of staff have received an appraisal against a target of 85%. Appraisals are aligned with incremental dates and staff may not receive their pay progression without being compliant with appraisals and mandatory training. Managers approve the switching off of automatic pay progression for non-compliant staff.





Continued improvement in appraisals conducted compared to 2015 and rated the **same as the national average**

Continued improvement in the quality of appraisals rating **above average**

Source:
National Staff Survey 2016

Sickness Absence
To reduce sickness absence below 3.5% staff and managers are being supported to optimise health at work and prevent work related ill health and injury. Examples of some of the initiatives underway are:

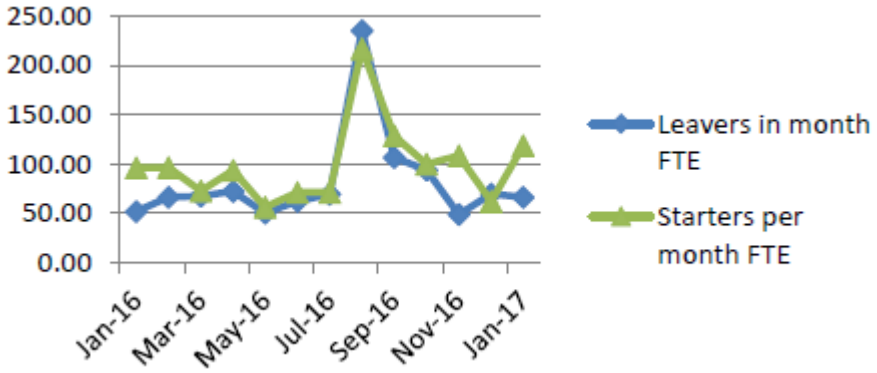
- Absence Assist – liaison service which manages staff absence
- Employee Relationship Advisory Service (ERAS) – in-house team supporting staff when they have matters of concern; supporting the management of staff suffering long term sickness
- Review of nursing absence which makes up the largest percentage of sickness absence and support for ward managers to manage this
- Early access to occupational physiotherapy for staff with musculoskeletal conditions as part of the health and wellbeing plans
- The Health at Work Service has promoted the 'Time to Talk' campaign which is encouraging people to be open about their mental health. Two events were held in February to promote the campaign; encourage use of the ERAS; offer advice on stress management and promote lunch time walks
- The Health at Work team offer mental health first aid lite training

Turnover and vacancies
The Trust aims to reduce the vacancy rate to below 5%. Also, to support the People Strategy and the Safer Staffing agenda a number of innovative attraction, recruitment and retention projects have been established. Examples include:

- Flexible working project commenced in January 2017 with four wards piloting self-rostering as a preferred method of flexible working across clinical teams
- Increased access and opportunity for leadership development (see 'culture programme' below)
- 'Never lose a nurse' campaign with drop in surgery style sessions

- Improving the speed of pre-placement health clearances to expedite the recruitment process
- Cohort recruitment, including international recruitment campaigns for registered nurses
- Continuing to advertise on local radio, social media and e-jobs boards, as well open days and evenings to increase awareness of vacancies
- Launch of the ENHanced Recruitment Campaign to increase awareness of flexible working and pension contribution choices. The pilot scheme which was initiated to attract agency workers back to working for the Trust will continue until 31 July 2017; after which its success will be evaluated
- Conducting exit interviews to understand the reasons for leaving. Analysis of January leavers indicates this is largely related to retirement (32%), relocation (18%), enhanced job opportunity (13%) and family/ personal reasons (8%).

The graph below shows the turnover levels during the year.



The target of achieving the Tust wide vacancy rate of 5%-6% is expected to be achieved in the second quarter of the financial year 2017/18.

Culture Programme

The Culture Programme, known as LEND, aims to improve staff engagement. This is being achieved by embedding a strong leadership culture, leading to improved patient and staff experience and improved customer satisfaction with services.

- Quarterly sessions for line managers to explore Trust developments and to consider their role and contributions
- Skills development including the management pathway

Leadership & Management Development Pathway

In January, an expanded pathway was launched. This is a set of programme and practice opportunities for all roles at all levels to develop confidence, competence and motivation to care effectively and compassionately for our community.

The expanded pathway includes programmes such as:

- Skills for Leaders
- Building Effective and Agile Teams
- Quality and Service Improvements

	Aspiring leaders	Leaders		Experienced Leaders	
Who	Non-management roles, interested in developing and becoming future leaders (suggested for Bands 1-5)	Supervises a team, reports to the team /department manager (suggested for Bands 3-5)	Leads a team / department (includes nurse team leaders, managers, doctors / dentists in training) (suggested for Bands 6-7)	Experienced in leading a department or team of people (includes nurse team leaders, managers, doctors / dentists in training) Interested in exploring leadership further and its career-long importance (suggested for experienced Bands 6-7)	
Programmes	**Aspiring Leaders** 1 day course covering the development of your personal leadership skills and leading by example (PIVOT and LEND)	**Effective Supervisor Programme** 3 workshops over 3 months covering key supervisory skills and portfolio of reflections	**Effective Manager Programme Part 1 – Core Management Skills** 3 days for NEW and existing managers covering core management and people skills **Effective Manager Programme Part 2 – In practice** 3 workshops over 4 months PLUS each delegate has: observed appraisal, observation of service, work shadowing	**Coaching - An approach to leadership** 2 day programme introducing the concepts and practice of coaching which will support the establishment of a coaching culture and as an approach to leadership. Strong practical and experiential programme supported by relevant models and concepts.	**Leadership Awareness - You and your approach to leadership** 2 day programme that explores and raises awareness of the concept and challenges of leadership. Interactive and thought provoking, exploring personal ideas of leadership as well as practical techniques - create a career long interest in developing your personal leadership capacity.
On-the-job development and practice	Activities to build experience - e.g. work shadowing, recommended meetings, secondments, follow up learning	Activities to build experience - e.g. work shadowing, recommended meetings, secondments, follow up learning	Activities to build experience - e.g. work outside of specialist area, secondments, involvement in projects, follow up learning	Activities to build experience - e.g. involvement in change and improvement, work shadowing, work outside of specialist area, secondments, follow up learning	
	ENH library services and evidence based resources are free for all Trust staff. Contact librarylister.enh-tr@nhs.net for information on how the library team can support your learning. http://www.enherts-tr.nhs.uk/gps-professionals/library/our-resources/				
Other training development practice	**Additional development - liaise with your manager/mentor to find out what is available for your role and profession**				
	Trust leadership development		**Regional or national leadership development**		
	Appraisal skills for managers - Half day		NHS Leadership Academy programmes, for example - The Stepping Up programme for aspiring BAME leaders, NHS Graduate Management Training Scheme		
	Recruitment and Selection Skills - 1 day				
	ERAS Policy training on: Sickness Absence, Work Life Balance, Capability, Dignity and Respect at Work and Grievance, Dealing with Conflict and more to be released in 2017		Regional Mary Seacole Programme		
	Health@Work Service - Mental Health First Aid Lite training - Half day		1:1 Coaching via NHS Beds & Herts or regional coaching networks		
	LEND Leadership sessions and LEND team updates		1:1 Mentoring via NHS regional mentoring network		
	Bespoke team interventions tools and advice		CPD funded courses at University of Hertfordshire, including Skills for Clinical Leadership		
	Briefing/debriefing - building an organisation				

Next Step - Leadership and Management Development Pathway - Part B on next page

The 2016 Staff Survey indicates that the quality of non-mandatory training offered and delivered by the Trust has improved since 2015 and is amongst the best nationally.

Quality of non-mandatory training has improved since 2015 and is **amongst the best 20%** of Trusts

Source:
National Staff Survey 2016

Staff surveys

Staff surveys are undertaken annually as part of a national programme. A selection of some of the national staff survey results are given below with the position showed compared with the national averages. Findings from the survey are also given later when aligning them to the Trust values. The full set of staff survey results is shown in Appendix 1.

Question	Trust 13/14	Trust 14/15	Trust 15/16	Trust 16/17	Comparison with national	National 16/17
Role makes a difference to patients	90%	92%	92%	**91%**	**Above average**	90%
Level of satisfaction with work and care	81%	77%	4[1]	**4.02**	**Above average**	3.96
Good communication with managers	27%	26%	32	**33**	**Average**	33
Quality of non-mandatory training	Not collected		4.09	**4.12**	**Best 20%**	4.05
% staff experiencing discrimination at work		11%	12%	**12%**	**Below average**	11%

[1] change in measurement

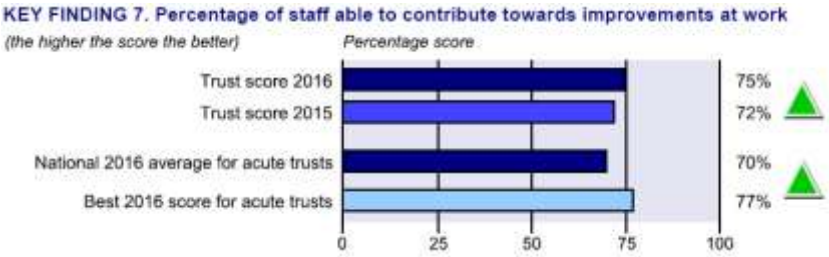
There has been no significant deterioration since the 2015 survey. Significant improvements since the 2015 survey include:

- Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse [note – although improved this indicator remains worse than average]
- Percentage of staff feeling unwell due to work related stress in the last 12 months
- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
- Percentage of staff able to contribute towards improvements at work
- Organisation and management interest in and action on health and wellbeing

Aligning the national staff survey results with Trust values

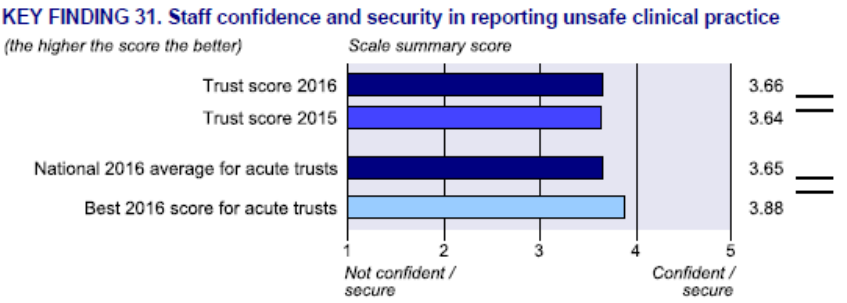
We put our patients first

We strive for excellence & continuous improvement



We value everybody

We are open and honest



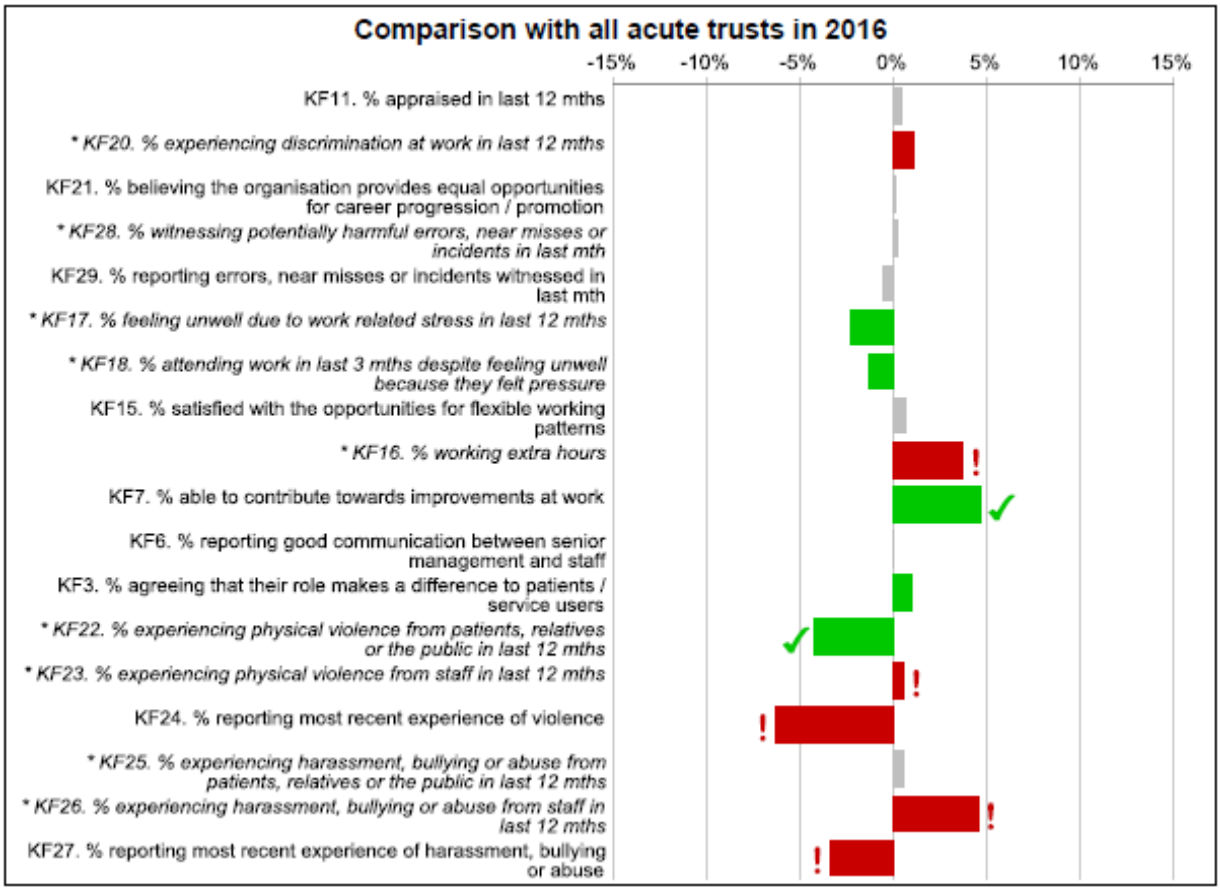
We work as a team

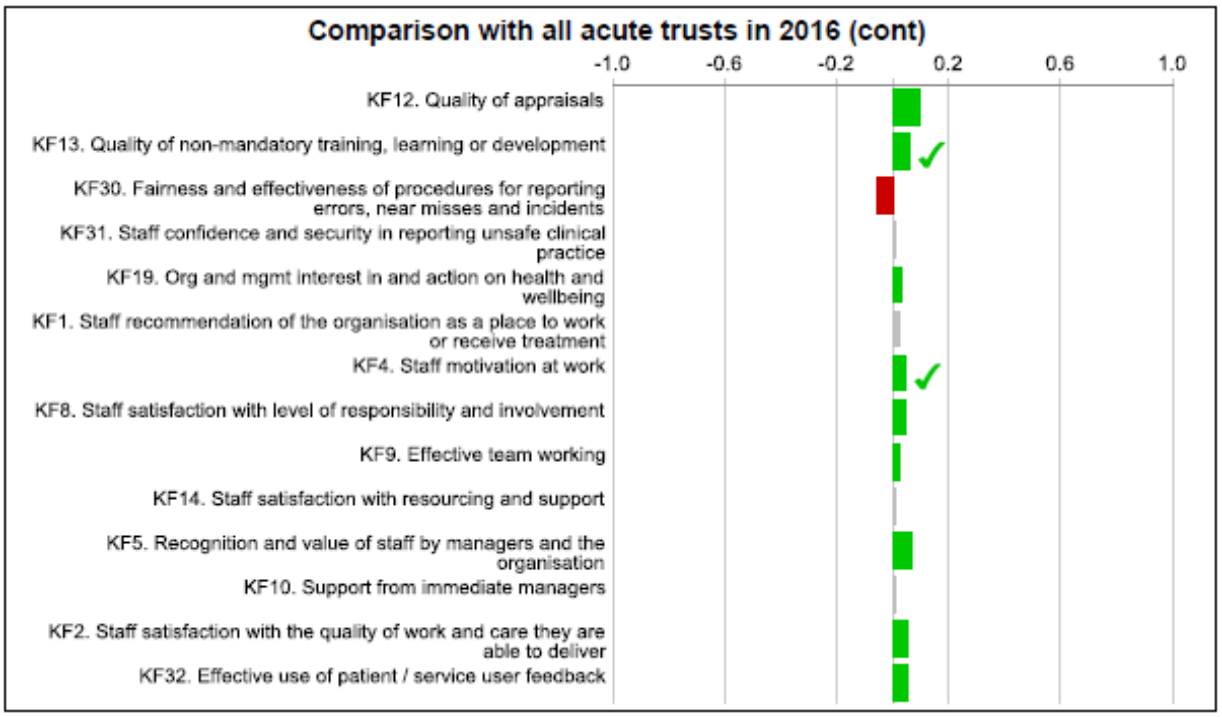
3g Performance against national requirements

		14/15	15/16	16/17 YTD	Plan for 16/17	Met
Referral to treatment times	Max 18 weeks from referral in aggregate – patients on incomplete pathways	94.2%	92.7%	**92.2%**	>=92%	✓
Access to A&E	Four hour maximum wait in A&E	92.3%	85.2%	**84.6%**	>=95%	✖
Cancer access – initial treatment	62-day urgent referral to treatment of all cancers	81.4%	76%	**73.6%**	>=85%	✖
Clostridium difficile	Rate of infection per 100,000 bed days	12	16	**22**[a]	<=11	=

Source: Single Oversight Framework (NHSI), Risk Assessment Framework (Monitor)
[a] 10 cases have been successfully appealed, with one further under discussion

Appendix 1 - National Staff Survey 2016





KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Annexes

Annex 1 Statements from stakeholders

Annex 2 Statement from auditors

Annex 3 Statement by the Directors

Appendix E

LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

2016/17 QUALITY ACCOUNT/REPORT Appendix to the Annual Report

Draft

26 April 2017

To Auditors and Stakeholders (27th April 2017)

Contents **Page**

i). What is a Quality Account

ii). About our Trust

1. A Statement on Quality from the Chief Executive

2. Report on Priorities for Improvement in 2016/17

3. Priorities for Improvement in 2017/18

4. Statements related to the Quality of Services Provided

5. A Review of Quality Performance

6. Statement of Directors' Responsibilities in respect of the Quality Report

7. Comments from Stakeholders

8. Independent Auditors Assurance Report

9. Glossary of Terms

Appendix A – Clinical Audit Reports

Appendix B – Trust Committee Structure

What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an **annual Quality Account**. This is a report that informs the public about the quality of the services that we deliver. They are published annually and are available to the public.

Quality Accounts aim to increase public accountability and drive quality improvement. They do this by requiring organisations to review their performance over the previous year, publish their performance and identify areas for improvement. Quality accounts will also inform you about how an organisation will make those improvements and how they will be measured.

A review of our quality of services for 2015/16 is included in this account alongside our priorities and goals for quality improvement in 2016/17 and how we intend to achieve them. This report summarises how we did against the quality priorities and goals that we set in 2015/16.

How is the 'quality' of the services provided defined?
We have measured the quality of the services we provide by looking at:

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

About our Quality Account

This report is divided into seven sections.

- The first section contains a statement on quality from the Chief Executive and sets out our corporate objectives for 2017/18.

- The second section looks at our performance in 2016/17 against the priorities that we set for patient safety, clinical effectiveness and patient experience.

- The third section sets out our quality priorities and goals for 2017/18 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.

- The fourth section includes statements related to the quality of services that we have provided and includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.

- The fifth section is a review of our quality performance and includes performance against national priorities and local indicators. It also provides examples of how we have improved services for patients.

- The sixth section of the report includes a statement of Directors' responsibility in respect of the quality report.

- The seventh section contains comments from our external stakeholders.

Some of the information in the Quality Account is mandatory; however most is decided by our staff and Foundation Trust Governors.

About Our Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 90,000 admitted patients, nearly 400,000 outpatients and Emergency Department attendees and we delivered over 5,300 babies.

We serve a diverse population most of whom are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile. There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 Luton Annual Public Health reports states that in many cases, Black and Minority Ethnic (BME) communities have poorer health outcomes when compared to the overall population and these are linked to infant mortality, access to services due to awareness, language and cultural barriers, early onset dementia and diabetes. The Index of Multiple Deprivation 2010 also indicates that Luton is becoming more deprived.

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

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

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

Division	**Specialties**	
Medicine	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	Plastic Surgery ENT Cancer Services Medical Oncology Ophthalmology
	Urology	Oral & Maxillofacial Surgery

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

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

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

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

Part 1

1. A Statement on Quality from the Chief Executive

Improving clinical outcome, patient safety and patient experience remain the core values of the L&D. This can be seen by reading our corporate objectives and understanding the progress that we are making year on year delivering sustained improvement.

During the year, we have continued our focus on quality improvement initiatives. We received our CQC Report in June 2016 which rated the Trust as 'Good'. This was an excellent result and the Inspection Report did not mandate any must do actions for the Trust. There were some improvements identified that the Trust has taken forward and this is reported within this Quality Account.

We launched our Advancing Quality and Patient Safety Framework at our Engagement Event in December 2016 where over 2000 staff were engaged in delivering our plans. This will be further developed throughout 2017/18.

As in previous years we consistently delivered against national and local quality and performance targets. We continued to be one of the best performing hospitals in the country for the waiting time targets in A&E and we achieved the 18 week and cancer performance. We also maintained a low number of C Diff with 8 cases.

Our quality priorities set out for 2016/17 have been embedded into our systems and processes and we made considerable progress. We

- Maintained over 90% compliance with the 3 day anti-biotic reviews in all clinical areas.
- Maintained a high focus on mortality and further improved on the mortality review processes and we have started to see the HSMR reduce towards the end of 2016/17.
- Have made exceptional progress in the reduction of hospital acquired pressure ulcers from 11 grade 3 and 4 in 2015/6 to just three in 2016/17.
- Maintained a falls rate of below the national average and a reduction in the number of falls that resulted in harm.
- Maintained a cardiac arrest rate below the national average and continued to learn from each incident to further strengthen our processes.
- Improved our stroke audit compliance scores considerably with plans in place to improve further.
- Implemented a number of end of life care measures to further improve communication and training across healthcare.
- Achieved an improving outpatient experience with a reduction in short notice appointments rescheduled and a reduction in patients who do not attend their appointments.

This Quality Account also focuses on how we will deliver and maintain our progress against our key quality practices in the coming year. These priorities have been developed from our own intelligence of where we need to improve, commissioning quality goals (CQUIN) and our CQC report.

Pauline Philip
Chief Executive
24th May 2017

Corporate Objectives 2017/18

This document updates our 2014-2019 Strategic Plan and our 2017/19 Operational Plan. Progress against the plan is reported in the Annual report.

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

1. **Deliver Excellent Clinical Outcomes**
    - Year on year reduction in Hospital Standardised Mortality Ratio in all diagnostic categories

2. **Improve Patient Safety**
    - Year on year reduction in clinical error resulting in harm
    - Year on year reduction in Hospital Acquired Infection

3. **Improve Patient Experience**
    - Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance

4. **Deliver National Quality and Performance Targets**
    - Deliver sustained performance with all CQC outcome measures
    - Deliver nationally mandated waiting times and other indicators

5. **Implement our New Strategic Plan**
    - Deliver new service models:
        - Emergency Hospital (collaborating on integrated care and including hospital at home care)
        - Women's and Children's Hospital
        - Elective Centre
        - Academic Unit
    - Implement preferred option for the re-development of the site.

6. **Secure and Develop a Workforce to meet the needs of our Patients**
    - Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.
    - Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes.
    - Deliver excellent in teaching and research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

7. **Optimise our Financial Plan**
    - Deliver our financial plan with particular focus on the implementation of re-engineering programmes

Part 2

2. Report on Priorities for Improvement in 2016/17

Last year we identified three quality priorities. This section describes what we did and what we achieved as a consequence. All of these priorities continue to be relevant and will be further developed during this current year.

We had key priorities each for patient safety, patient experience and clinical outcome. Our remaining priorities are detailed in the annual plan.

Priority 1: Clinical Outcomes

Key Clinical Outcome Priority 1

- **Improve the management of patients with acute kidney injury (AKI)**

Why is this a priority?
AKI is a sudden reduction in kidney function. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. It is a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. This was a key priority for the Trust last year and we focused on implementing a Trust wide electronic system to improve detection, developed an AKI management care bundle and further improved AKI diagnosis and treatment.

What did we do?
- We provided training and education for junior doctors in the management of patients with AKI.
- We have continued to emphasise the importance of timely recognition of a patient with AKI, and have set the standard of four hours from arrival to recognition.
- We have continued to use an alerting system set up in our results reporting system to notify clinicians that a patient has renal impairment. We explored updating this system in line with the upgrade of the Laboratory Information Management System planned for 2017/18.
- We have continued to utilise a care bundle approach to provide junior doctors with guidance as to what action to take following identification a patient has AKI. As part of that innovation we have implemented a 'Door to Treatment time' of six hours. We have reviewed our bundle in line with the Patient Safety Alert and made modifications to ensure the Trust is compliant with the Alert.
- We provide GP's with information about their patient's presenting with AKI, and suggest a plan of care to optimise and monitor patient's renal recovery post discharge.
- We have revised the standard fluid chart, and devised a 'Red, Amber, Green' (RAG) rated Early Warning System for monitoring patients intake and output, which will provide guidance for when to escalate for medical intervention.

How did we perform?
- We continued to actively support early recognition and optimal management of all patients presenting with AKI and acquiring AKI as part of their in-patient disease process. The average compliance with 'Door to Recognition Time' has been 87% over the last year. The average compliance with 'Door to Treatment Time within 6 Hours' was 92%.
- We provided GPs with a plan of care to monitor and optimise renal recovery for those patients with Stage 2 & 3 AKI – which are the most serious forms of renal impairment.

Compliance with providing GPs with a plan of care at discharge has been 70% over the past year.
- The new fluid charts innovations are in the pilot stage.

Key Clinical Outcome Priority 2

- **Improve the management of patients with severe sepsis**

Why is this a priority?

Sepsis is a common and potentially life threatening condition where the body's immune system goes into overdrive in response to infection. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis. Early detection and effective management of patients presenting with sepsis will reduce morbidity and mortality.

Improving the management of patients with severe sepsis, septic shock and red flag sepsis has been a CQUIN 2016-17, both for in-patients and for patients presenting to the Emergency Department with sepsis.

What did we do?

The Trust has utilised NICE guidance published in July 2016 and revised screening tools and recommendations for optimal management of patients presenting with Sepsis in the Emergency Department and developing Sepsis as part of their in-patient disease process.

The screening tools and updated management recommendations have been implemented both in the Emergency Department and throughout all in patient areas of the Trust.

Sepsis Champions have been nominated in all clinical areas to lead the Sepsis Improvement work in the Divisions and individual Directorates. Clinical Champions are supporting the audit of compliance with timely Screening, Antibiotic administration, and antibiotic reviews after three days.

How did we perform?

- Compliance with appropriate sepsis screening (audit) for emergencies and ward –based patients, and 3 day antibiotic reviews has been above 90% in all clinical areas.
- Timely compliance with antibiotic delivery for patients presenting with severe sepsis and septic shock (audit) for emergencies and ward –based patients, is showing compliance with the CQUIN targets to date.

Key Clinical Outcome Priority 3

- **Improve our approach to mortality surveillance, identifying and reducing avoidable deaths**

Why is this a priority?

The Trust's 12 month rolling HSMR remains statistically high, but the monthly trend has seen five consecutive months of improvement within expected ranges. It is likely that the 12

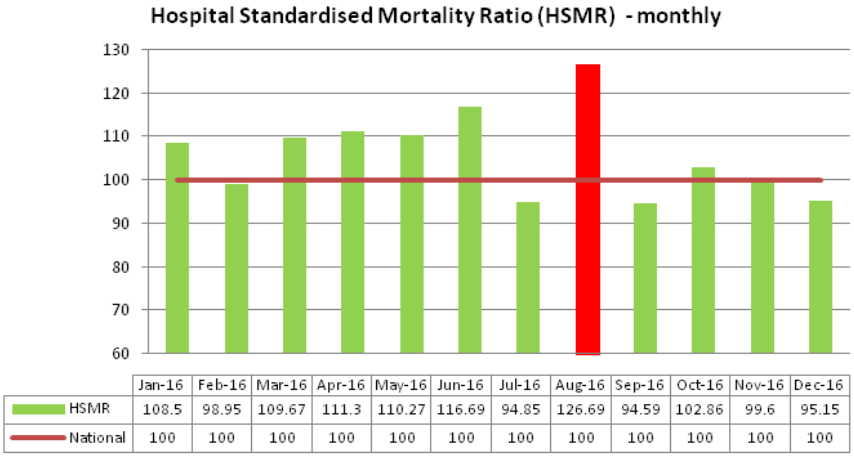
month HSMR will remain elevated until the particularly high values seen in January, April and May 2015 fall out of the indicator. This monitoring and reduction of our HSMR remains a critical priority in the year ahead.

What did we do?

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

How did we perform?

The Trust has seen an improvement in the HSMR for the 12 months ending December 2016. The value is no longer statistically significantly high for the last four months of the year. The Trust has introduced daily screening of all deaths using a standardised format and any deaths that trigger a request for a more detailed review are forwarded to the appropriate consultant and the outcome is reported through local Governance meetings and the Trust's Mortality Board.



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
HSMR	108.5	98.95	109.67	111.3	110.27	116.69	94.85	126.69	94.59	102.86	99.6	95.15
National	100	100	100	100	100	100	100	100	100	100	100	100

Key Clinical Outcome Priority 4

- **Reduce our antibiotic consumption**

Why is this a priority?

Anti-Microbial Resistance (AMR) has risen over the last 40 years with inappropriate and overuse of antimicrobials being a key driver. The number of new classes of antimicrobials coming into the market has reduced in recent years, whilst at the same time total antibiotic prescribing has increased by 6%. Widespread antimicrobial resistance increases the prospect of fewer effective treatment options for infections where antimicrobials can be life-saving and significant increased risk attached to standard surgical procedures.

What did we do?

There are two parts to the quality priority CQUIN for 2016/17:

a) To achieve a reduction in both the total amount of antibiotic consumption and in 2 categories of broad spectrum antibiotic consumption compared to 2013/14.

In order to achieve the targets several different workstreams were initiated with the intention of ensuring improvements were initiated and embedded into ongoing antimicrobial stewardship practice.

Workstreams included:

- Monthly analysis of antimicrobial usage such as piperacillin/tazobactam, meropenem, co-amoxiclav, ciprofloxacin and cefuroxime for directorates (General Medicine, General Surgery, A&E and DME), identification of areas with variation against guidelines in antimicrobial prescribing and tracking the link between use of these antibiotics and incidence of *C.difficile* infection.
- Feedback of analysis to Clinical Governance meetings with recruitment of junior doctors to carry out further audits on antibiotic usage. (Management of Urinary Tract infections).

b) To drive forward improvements in the number of antibiotic prescriptions reviewed within 72 hours with the aim of achieving more than 90% prescription review.

Although the standard has been set at this level, we are committed to a programme of continual improvement of care. An action plan has been developed which includes a range of improvements.

The action plan includes:

- An extensive drive to educate the doctors, nurses and pharmacy staff, the importance of documenting the indication and reviewing antibiotics and using narrow spectrum antibiotics by following the Start Smart then Focus (SSTF) initiative. (Presentations, posters, a stand during the World Antibiotic Week, patient safety newsletters and encouraging doctors to carry out audits).
- Pharmacy staff attending the white board rounds (which was implemented on the 19th September 2016) where patients' antibiotics are reviewed on a regular basis by pharmacists chasing up course lengths and changing to oral. Pharmacists document the indication and doctors are also encouraged to document review and changes when appropriate. The impact of this initiative is being measured.

Success Criteria

- Although the Trust seems to be on target for Total Antimicrobial consumption and Piperacillin/Tazobactam, the data for Quarter 4 which covers the second part of the winter pressures is yet to be submitted for analysis.
- The target for the carbapenems was not achievable as usage in the year 2013/14 was very low.
- The Trust has consistently achieved over and above the standards for all 4 Quarters (91%, 95%, 97% and 98.3%).

Priority 2: Patient Safety

Key Patient Safety Priority 1

- **Ongoing development of the Safety Thermometer, improving performance year on year**

Why was this a priority?

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism during their working day.

This is a point of care survey that is carried out on 100% of patients on one day each month across the whole of the NHS. One of its most unique aspects is the concept of a 'harm free care' measure, the proportion of patients who are free from any of the harms measured. Using a composite measure such as this provides us with a more positive view of the care we deliver, and ensures that we move away from thinking about harms in a siloed way (www.safetythermometer.nhs.uk).

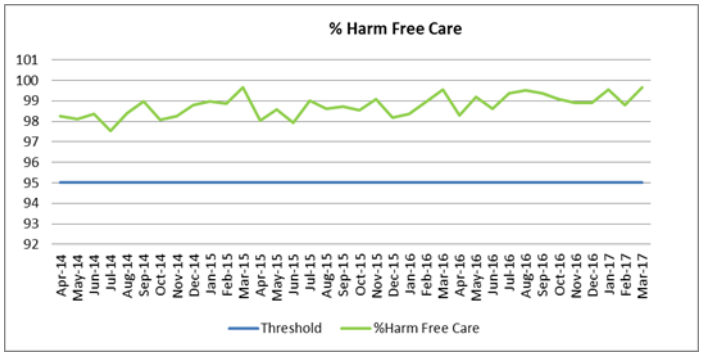
Safety Thermometer prevalence data supplements our more detailed incidence data and other intelligence about harms, to direct quality improvement initiatives and monitor the effectiveness of actions put in place.

What did we do?

During 2016/17 we continued to participate in the NHS Safety Thermometer, measuring the prevalence of any new harms incurred during a person's inpatient stay. Ward staff were supported to review their results each month and discuss their findings at the Quality Performance Review meetings with the Director of Nursing. The data from Safety Thermometer is considered alongside Trust incidence data and the learning that resulted from investigations into patient safety incidents. Episodes of patient harm were analysed using root cause analysis with the support of the appropriate specialist nurses. The detailed analysis supports the identification of learning and enables teams to implement actions to prevent recurrence. Learning is shared through the Ward Sisters forums and through the patient safety newsletter.

How did we perform?

During 2016/17 we successfully achieved harm free care of over 98% of our patients, and for six months of the year, we achieved more than 99% harm free care. In January, the harm free care score peaked at 99.54%, which was a real credit to the endeavours of all our staff who kept patients safe at a time when the Trust was extremely busy.



Pressure Ulcers - The Trust has made exceptional progress in the reduction of hospital acquired, avoidable pressure ulcers over the past year. During 2016/17, there were a total of two Grade 3 pressure ulcers compared with 11 in the previous year – a reduction of 82%.

For grade 2 pressure ulcers, 26 were acquired this year compared with 96 in the previous year – a reduction of 73%.

We understand these great successes to be attributable to a number of initiatives:

- A sustained, robust training programme for all nursing staff which has undoubtedly raised the profile and importance of having a relentless focus on skin inspections and skin care for our patients.
- A tissue viability risk assessment and care plan has been incorporated into the newly updated nursing documentation booklet which helps to streamline the process.
- An *Incontinence Associated Dermatitis Pathway* has been introduced, along with the introduction of two new barrier products.
- A *Heel Protection Pathway* has been introduced, along with the switch to new improved heel protectors.
- Nasal cannulae for the delivery of oxygen therapy have been switched for a product which includes ear protection. This has led to a reduction in pressure damage to patients' ears which was a particular problem for patients on long term oxygen therapy.
- The Tissue Viability Team continues to have a very high profile in the clinical areas and this enables swift intervention when any issues or learning are identified.

Falls - During 2016/17 the safety thermometer audits identified 11 patient falls over the year where harm was sustained. The harm ranged between low harm (nine patients) and severe harm (two patients). This is an improvement on 2015/16 where we reported 21 falls with harm on the safety thermometer.

The falls nurse, in partnership with the senior leadership team and Matrons, keeps falls incidence constantly under review. During the year, it has been noted that the number of patients suffering harm from a fall has reduced. One Serious Incident was raised following a fall resulting in a fractured hip and robust root cause analysis undertaken. The majority of falls result in no harm or low harm to patients.

During the year the trust implemented new nursing documentation which now incorporates the multifactorial falls risk assessment recommended by NICE and the Royal College of Physicians. The Trust is piloting a new approach to enhanced observations for patients who are at higher risk of harm.

Catheter Related Urinary Tract Infections (CAUTI) – the aim for this year was to ensure that no more than 16% of inpatients had a catheter in situ. Whilst this aim was not achieved, there was a small reduction with an average of 17.75% per month. Usage is largely determined by the acuity of patients at the time of the prevalence study. The Continence Nurse Specialist (CNS) has continued to work closely with ward teams to ensure that a robust process is in place to evaluate every catheter on a daily basis. The Continence CNS has established a closer working relationship with the infection control team and now has direct use of the ICNET system (an infection control IT system) to enable better identification of CAUTI'S , so that training can be targeted to areas where problems are being identified. During 9 months of the past year, there were no CAUTIs reported, with an average of prevalence of 0.5% for the remaining months.

Venous Thromboembolism (VTE) – VTE is an important patient safety issue nationally. Hospital Associated Thrombosis can result in significant mortality, morbidity and healthcare costs. The two primary aims of the Trust are to ensure that patients are appropriately assessed for their risk of developing a thrombosis, and ensuring that appropriate prophylaxis is prescribed and administered reliably. We monitor our achievement of appropriate assessment and during 2016/17, we screened more than 95% of patients (the national aim is 95%) in all but one month (93.5% in May). For every patient who is identified as having thrombosis, a review is undertaken to assess whether the thrombosis is Hospital Associated

and if so, whether it was preventable. The learning from robust Root Cause Analysis investigations is shared and used to inform our quality improvement work. Two key themes to have emerged recently relate to the development of thrombosis in patients with lower limb injuries who are not admitted to hospital; and those patients who develop thrombosis despite receiving prophylaxis who have a raised Body Mass Index. The Trust follows national evidence based guidance; however, for these two groups of patients, this is not reliably preventing thrombosis.

Key Patient Safety Priority 2

- **Improve the management of the deteriorating patient**

Why is this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians' may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2015 -16 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration.

What did we do?

We continued to conduct reviews into all cardiac arrests to identify any learning points
As part of the review process we have monitored:

- Compliance with observations protocols for deteriorating patient
- Compliance with the correct process for escalating concerns
- Whether Medical response was timely
- Critically analysing the decisions made by medical staff prior to the arrest to identify whether management was optimal to prevent further deterioration. In addition we have monitored the setting of appropriate ceilings of care, and the use of Personal Resuscitation Plans and where appropriate and Do Not Attempt Resuscitation (DNAR) orders.

As a result of the reviews a number of cases have required serious incident case reviews or directorate level investigations, and action plans put in place to minimise re-occurrence of any issues identified. Where it has been deemed following review of the case that there is local learning only, then clinical areas have been requested to devise a local action plan to address any issues.

To achieve improvements in the use of appropriate setting of Personal Resuscitation plans and DNAR orders, the University of London Partnership (UCLP) have supported the Trust in providing training and education to medical staff. This training has included guidance in having difficult conversations, and the legal and ethical position regarding DNAR Care Plans. Case scenarios have been used to illustrate key learning points.

How did we perform?

We have continued to maintain our average cardiac arrest rate below the National Average rate. We have continued to conduct reviews into all cardiac arrest to identify any learning points.

Key Patient Safety Priority 3

- **Further development of stroke services**

Why is this a priority?

Central to the Trust strategy to become a 'Hyper-Acute Emergency' hospital, is to deliver optimum stroke care through further investment in our 'Hyper-Acute' stroke Unit. Following an increase in therapies staffing and an additional two Stroke Physicians, 2016 will focus on the recruitment of additional speech and language staff and a senior Clinical Nurse Specialist to improve nurse leadership and ensure all performance targets are met. Data capture for SSNAP will be improved to ensure that all activity and key clinical interventions are accurately recorded. More ambitiously, the senior nursing team in conjunction with the new specialist nurse will design a revised educational programme to train nurses in key competencies. Multi-agency working will focus on further developing our repatriation policy to improve direct access to the unit.

What did we do?

How did we perform?

The unit's overall SSNAP score has improved from a performance score of an E to a C. Table one demonstrates how there has been a trajectory of improvement throughout the year.

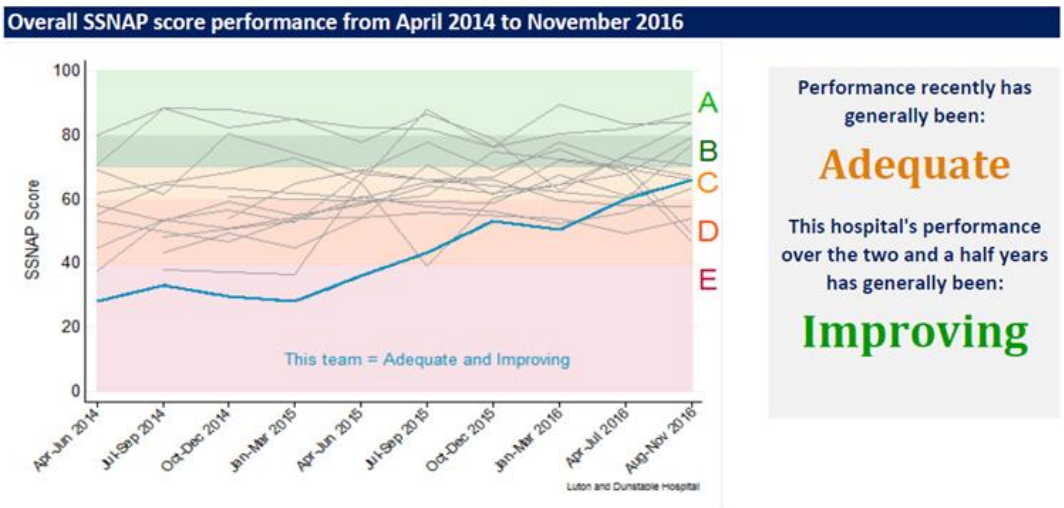


Table One

Table two demonstrates how we now discharge more patients within the first 3 days after stroke and significantly less patients stay for 30+ days compared with stroke units nationally. Our length of stay is also three days shorter than the national stroke unit average.

Luton and Dunstable Hospital - SSNAP Executive Summary

Activity and length of stay

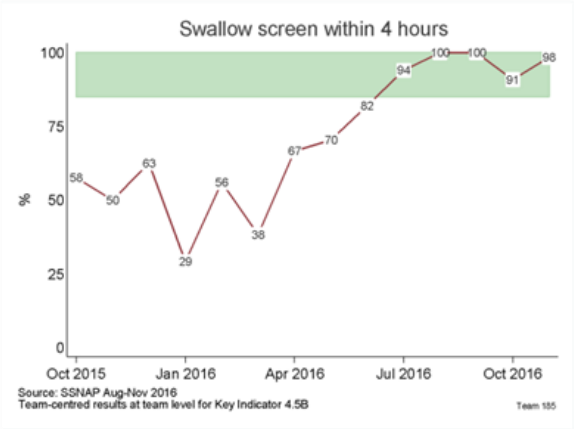
In August-November 2016 this hospital treated 260 patients, of which:

256 patients were first admitted to this hospital 4 patients were transferred in from another hospital

Length of stay:	For all routinely admitting teams nationally N=27,507	For all patients treated at this team N=260	For patients discharged/transferred alive from this team N=233
0-3 days	40.3% (11,087 patients)	42.7% (111)	41.6% (97)
4-7 days	20.3% (5,580 patients)	17.3% (45)	18.0% (42)
8-21 days	21.4% (5,886 patients)	26.2% (68)	27.5% (64)
22-30 days	5.3% (1,446 patients)	4.2% (11)	4.3% (10)
31+ days	12.8% (3,508 patients)	9.6% (25)	8.6% (20)
Mean	*14.0 days*	*11.0 days*	*10.8 days*

Table Two

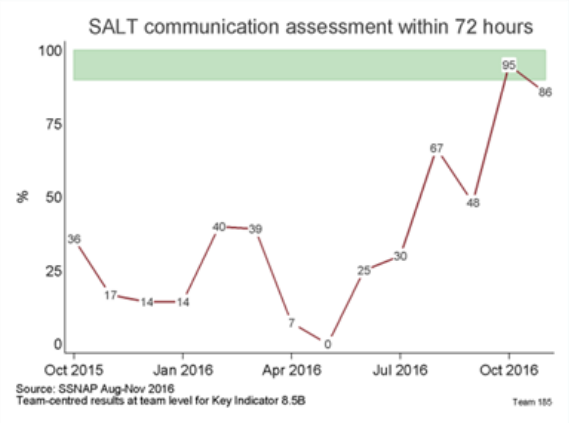
As a result of investment in staff and targeted service development, there have been significant improvements in the quality of care offered to stroke survivors. This includes our stroke specialist nurse having been appointed, resulting in substantial improvements in assessments being completed in a timely manner (figure 1) and patients receiving stroke specialist nursing care (figure 2).



(Figure One)

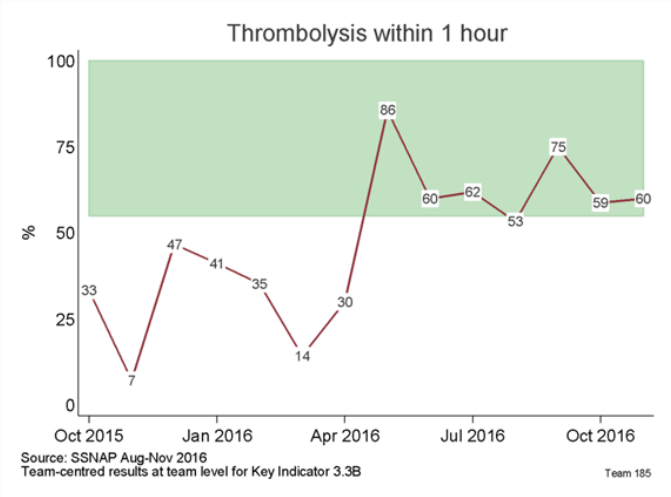
(Figure Two)

There has also been a stroke therapy service manager appointed who has been responsible for improving: Physiotherapy; Occupational Therapy; Speech and Language Therapy; and Dietetics. Physiotherapy and Occupational Therapy for the unit continues to be rated as Excellent (OT) and Good (PT). Locum SLT staff have been used during the recruitment process of appointing two specialist speech and language therapists. Although results have not translated into SSNAP publication, due to the lag in data, figure three demonstrates the early improvements SLT are now offering to the patients. Therapists are also working together to improve the patient experience and discharge pathways with figure four demonstrating improvements in goal setting.



(***Figure Three)*** ***(Figure Four)***

Finally, the appointment of the additional consultant posts and respective projects, has resulted in improvements both in scan times and the percentage of patients having thrombolysis treatment within the one hours target (figure five).



In summary, the appointment of new staff in conjunction with a drive in service development projects, and work across the stroke MDT has resulted in significant improvements. However, we accept there is more work to be done. We continue to work on specific challenges such as stroke specialist nursing recruitment, pathways and priorities to ensure our patients arrive on the unit and stay there, and to further improve the overall unit from a C to a B or an A. This year has been a success for stroke at the Luton & Dunstable Hospital and trajectories suggest further improvements are possible.

Priority 3: Patient Experience

Key Patient Experience Priority 1

Why is this a priority?

Improving End of Life Care (EOLC) is a priority if we are to ensure the best possible quality of care for our patients and their families. The Trust's strategy for improving the care our patients receive at the end of life is based on two key documents; NHS England's *'Actions for End of Life Care 2014-16'* which sets out NHS England's commitments for adults and children emphasising that not only living well but also dying well is a key quality priority. The narrative for 'person-centred coordinated care' (Every Moment Counts) produced for NHS England by National Voices in 2014, in conjunction with its partners, sets out critical outcomes and success factors in end of life care, support and treatment, from the

perspective of the people who need that care, and their carers, families and those close to them.

What did we do?

End of life care continues to be a key priority for the Trust. The most sensitive and difficult decision making that our clinicians have to make continues to be around recognition of the dying phase. However it is recognised that such decision making remains a challenge. Engaging patients and their families where possible, putting them at the centre of their care remains a key priority. The following actions were undertaken:

1. *Improved communication*
   The programme has been on improving communication across Luton with all stakeholders involved in the management of End of Life Care. The focus is on referring all patients in the last 18 months of life to MCCT (My Care Communication Team)/PEPS, a central point that coordinates care and provides a 24 hour helpline. Working towards a truly collaboration approach by sharing information to ensure care is timely, ensuring patients achieve their preferred place of death by enabling Trust staff access to advanced care plans.

2. *Implemented the Amber Care Bundle*
   The Amber Care Bundle provides a systematic approach to managing the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in 1-2 months. This contributes towards patients being treated with greater dignity and respect, enabling patients to achieve their preferences and also having a positive impact on multi-professional team communication and working.

3. *Complete a training programme*
   The team have continued to develop strategies to enhance Palliative Care/EOLC training across the Trust to ensure the best care and experience is delivered. These have included the introduction of ward champions, and the development of a package of training as part of the EOL CQUIN. To enable staff access a course entitled, “An introduction to Palliative Care” has been introduced, this will be delivered monthly. Courses in communication and Advanced Care Planning are also being introduced this year. In addition to this the palliative team are providing regular input with:
   - Medical Colleagues via Grand Round, Department and Clinical meetings
   - Ad Hoc sessions in Statutory Training as requested
   - Regular sessions with medical students
   - “Last 48 Hours” with Nursing Preceptors.
   - EOLC with new overseas nurses
   - 1-1 sessions on wards
   - Ward Team meetings
   - Department meetings with AHPs
   - 1-1 sessions with ward champions
   - Nursing and medical students ‘shadowing’ members of the team
   - Educating and training ward staff who are managing palliative care patients.
   - Providing written materials in the palliative resource folders on each ward
   - E-Learning opportunities available to all on the Intranet
   - A competency course has been designed by the End of Life Care Nurse aimed particularly at Ward Champions but appropriate for any professional wanting to enhance their EOLC competencies
   - Volunteers Companionship – This has been introduced offering support for patients and families.

How did we perform?

- EOLC received a rating of 'Good' from the CQC inspection team. This demonstrates the considerable improvements that had been made across the Trust since the last inspection and the commitment from all staff to implement the improvement plan that is monitored through the Trust EOLC Strategy group.
- Completed a comprehensive training programme to ensure staff have received training informing them of the benefits of referring to MCCT/PEPS, the target for eligible staff to be trained has been met.
- Met the target set to increase referrals to increase referrals to MCCT/PEPS.
- Implemented Amber Care Bundle on wards 14, 15, 16, 17, 18 and wards 10-12 are planned for Spring 2017.
- Discussions are underway to provide Trust staff access to System One, the community patient electronic record which enables key people to access important advanced care plans and preferred place of death information.

Key Patient Experience Priority 2

- **Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium**

Why is this a priority?

Patients with Dementia and Delirium can have complex care needs. This care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge.

What did we do?

- Continued to screen in patients over 75yrs on admission to hospital. This enabled further cognitive screening and investigations to be carried out or recommended to GP's.
- Continued to utilise the butterfly symbol as an identifier, which alerts staff to special needs. Now using labels in the Emergency Department and Outpatients Department to identify additional needs.
- Utilised the Psychiatric Liaison Service (PLS) for inpatient assessment and reviews where appropriate to identify Delirium and cognitive impairment.
- Introduced a cognitive assessment in medical proforma to enable recognition of Delirium and appropriate management and prevention.
- Continued with in house Dementia training programme aligned with national framework for skills and knowledge for our staff.
- Took part in the national audit of Dementia with the Royal College of Psychiatrists Reports to be published in 2017.
- Purchased distraction trolleys for all ward areas to standardise distraction equipment for patients and facilitate social interaction.
- Initiated signage improvements.
- Carers pack now provided to carers of people with Dementia offering contact support and sign posting.
- Continued to seek and review feedback from service users (patients & Carers) to improve service delivery.
- Utilised complaints to provide a framework of improvements to services across the site.

- Introduced a vulnerable adult nurse to work alongside safeguarding and dementia thus providing some resilience to the Dementia service for carers and staff on the wards.
- Developed a nursing discharge summary letter to standardise discharge information to care homes for the person with Dementia aligned with NICE QS 136.

How did we perform?

- Following complaint and patient experience feedback we have initiated a surgical pathway review for patients with dementia.
- Newly diagnosed in-patients are referred by PLS to Dementia CNS- improved networking and collaborative working.
- Monthly monitoring contract figures for screening and referral continue to be achieved.
- Used feedback from a carer to develop a training video of carer/patient experience.
- Trained two further Dementia Champions to facilitate 'Dementia Friends' sessions across the Trust.

Patient Experience Priority 3

- **Key Completing the Roll Out of Partial Booking across the Trust**

Why is this a priority?

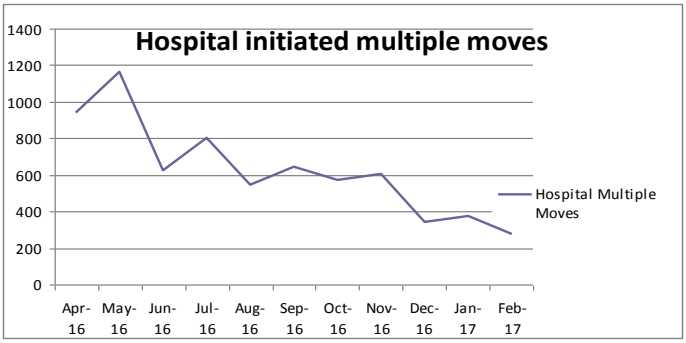
Outpatients successfully piloted partial booking in several specialties in Medicine and Surgery over the course of 2015/16. The initiative demonstrated benefit for clinicians, business managers and most importantly for our patients. The new appointment system facilitated substantial benefits in terms of improved waiting list management and service capacity planning, reducing the multiple rescheduling of patient appointments and helping to reduce DNA rates in these specific specialty areas.

What did we do?

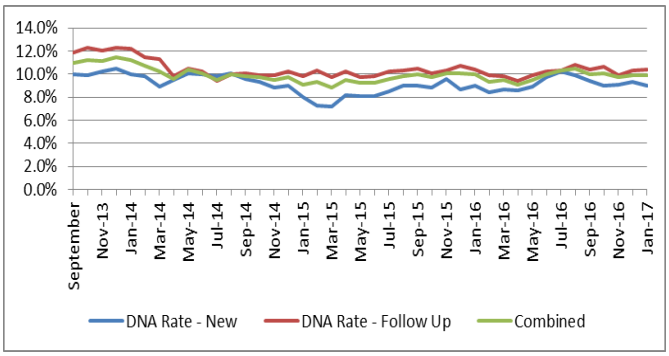
The roll out of partial booking has continued in 2016/17, with a significant number of additional specialties, representing 87.5% of the whole Trust, which are now live and benefiting from improved waiting list management. Each area is managed by a specialty specific pathway co-ordinator working with the relevant service leads. Those specialities most recently added include diabetes and endocrinology, Care of the Elderly, cardiology, paediatrics, stroke services and Oral Maxillo-Facial Services. It is anticipated that the roll out plan will be concluded by the end of May 2017, with four more specialties planned to go live.

How did we perform?

There has been a significant reduction in hospital initiated multiple rescheduled appointments, as patients in partial booking specialties are no longer future dated beyond six weeks, improving patient experience.



Trust follow up DNA rates have reduced due to a combination of partial booking and the expansion of the outpatient appointment reminder system.



3. Priorities for Improvement in 2017/18

Improving clinical outcomes, safety and experience for our patients while delivering value for money is key to the Trust's overarching quality strategy. To meet the short term challenges that we face, we have developed a number of ambitious Trust-wide quality priorities. These are based on local as well as national priorities including the need to ensure ongoing CQC compliance and to implement the recommendations from our own internal review of the Francis, Berwick and Keogh reports.

An additional focus on transforming our workforce to deliver our new ways of working and quality priorities will be performance managed across clinical divisions to ensure improvements. The Trust is recognises that this transformation of services will be challenging and the overall plan and key risks for achieving these quality priorities will be monitored by the Trust Board's Quality Committee.

We have key priorities each for clinical outcome, patient safety and patient experience

Priority 1: Clinical Outcome

Key Clinical Outcome Priority 1

- **Improve our approach to mortality surveillance, identifying and reducing avoidable deaths**

Why is this a priority?

The Trust had an extensive focus on hospital mortality during 2016/17 which was reflected in a comprehensive programme of work. A report was commissioned for an independent review into the Trusts HSMR performance in February 2016 by Dr Bill Kirkup CBE. the report was supportive of the work undertaken to date and made further recommendation which was added to the programme.

Overall the program included, the review of all deaths using a standardised Mortality tool; improving the access to specialist palliative care; establishing Mortality and Morbidity meetings in all of the Divisions and changes to coding. The Mortality Board monitors the progress of the programme and ensures learning is shared across the Trust.

During the latter part of 2016/17, the HSMR has reduced to below the national average demonstrating that the actions that we have been taking are making and impact. However, the number of crude deaths in the first two months of 2017 has been higher than expected and could see the HSMR rise again. This monitoring and reduction of our HSMR remains a critical priority in the year ahead.

What will we do?

The Trust Mortality Board will oversee the delivery of:

- A Mortality Policy that sets out the Trust's approach to mortality review, the monitoring of progress and the way learning is shared.
- Using external benchmarks, the Trust will complete on-going reviews for trends and correlations with other Trust clinical information.
- Reviewing all deaths in line with National Guidelines.
- Improvement in our benchmarked mortality to the upper quartile of performance.

Work with the Clinical Commissioning Groups and Local Authorities to improve the acute support available to end of life patients resident in care homes to avoid unnecessary admissions to hospital within the last few days of life.

Delivering a model of clinical care that has continuity of care towards needs based care is key principle that may impact on mortality and length of stay. This is a quality priority for 2017/18 and is (see Patient Safety Priority 2)

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Improving HSMR performance
- Reduction in the number of patients from care homes who die within 72hrs of admission.
- Roll out of Needs Based Care within Medicine and DME (see Patient Safety Priority 2)

Key Clinical Outcome Priority 2

- **Reduce the impact of serious infections (Antimicrobial Resistance and Sepsis)**

Why is this a priority?

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these, it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. This quality improvement initiative (which is also a National CQUIN scheme), is aimed at embedding NICE guidance to improve sepsis management. Furthermore, the approach taken to combine a responsive approach to the detection and treatment of sepsis needs to be balanced with a rigorous approach to the stewardship of antibiotics. Antimicrobial resistance has increased in recent years and the Chief Medical Officer believes that it is a major risk for healthcare. Without a reversal of the trend, we may find we have no drugs to treat serious infections in the future. The approach to these two key areas for improvement is taken from the viewpoint that the issues of sepsis and antimicrobial resistance are complementary and that developing and implementing a joint improvement scheme (CQUIN) will support a coherent approach towards reducing the impact of serious infections.

What will we do?

The Trust will build on the work undertaken throughout 2015 and 2016 with a particular focus on:

- Continuing to deliver and improve upon the timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Continuing to deliver and improve upon the timely treatment of sepsis in emergency departments and acute inpatient settings

- To continue to deliver upon the 24-72 hour review of antibiotics for patients with sepsis who are still inpatients at 72 hours and to continue to improve upon the quality of those reviews
- Ensure that Trust guidelines and protocols continue to meet best practice standards
- To reduce total antibiotic consumption per 1,000 admissions in three domains:
    - Total antibiotics
    - Carbapenems
    - Piperacillin-tazobactam

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- To consistently screen 90% or more of the relevant patients for sepsis.
- To deliver antibiotics within one hour of identification of sepsis to at least 90% of those patients.
- To undertake an empiric antibiotic review between 24-72 hours in at least 90% of patients with sepsis.
- To reduce antibiotic consumption by at least 1% for total, carbapenems and pipericillin-tazobactam during the year compared to 2016 consumption data.

Key Clinical Outcome Priority 3

- **To improve services for people with mental health needs who present to Accident and Emergency**

Why is this a priority?
People with mental health problems are three times more likely to present to AA&E than the general population. Nationally, more than 1 million presentations are currently recorded as being directly related to mental ill health. Furthermore, evidence has shown that people with mental ill health have 3.6 times more potentially preventable emergency admissions than those without mental ill health and that the high levels of emergency care use by people with mental ill health indicate that there are opportunities for planned care to do more. A large majority of the people with most complex needs who attend AUE the most frequently are likely to have significant health needs including physical and mental comorbidities and may benefit from assessment and review of care plans with specialist mental health staff and further interventions from a range of health and social services. This is a National priority and a CQUIN has been developed to support cross-provider working to deliver improvements in care to this group of patients by providing enhanced packages of care from the most appropriate services.

What will we do?

- The Trust will work in partnership with East London Foundation Trust, the provider of our mental health services and a range of other partners including ambulance service, primary care, police, substance misuse services, 111
- A group of patients who attend A&E most frequently will be reviewed in order to identify those who would benefit from assessment, review and care planning with specialist mental health staff

- Appropriate models of service delivery will be considered and adopted in order to provide specialist input for people who frequently attend A&E with primary mental health problems
- To co-produce, with the patients, a care plan and ensure that these are shared, with the patient's permission, with partner care providers across the system
- Review and refine the IT systems to ensure that information about the conditions of our patients is more accurately collected in order to help target improvements to the most appropriate patients
- Develop a method to assess patient satisfaction and experience of the new services

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- To reduce the number of attendances for the group of frequently attending patients by 20% over the next year, amongst the patients who would benefit from mental health and psychosocial interventions
- To have collected patient experience feedback in order to further develop the service

Key Clinical Outcome Priority 4

- **To provide services to patients experiencing frailty in line with best practice**

Why is this a priority?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this quality improvement initiative is to implement best practice guidance to enable us to take action to prevent these adverse outcomes and help people live as well as possible with frailty. Appropriate services, delivered effectively to this group of patients will support a reduction in length of stay, reduced morbidity and mortality and a better experience for patients and their carers. Furthermore, the initiative will support the delivery of the Trust priority to deliver Continuity of Care and improve the flow of patients admitted as emergencies to the hospital.

What will we do?

- To establish models of care and service delivery in line with standards set by the British Geriatric Society "Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings"
- Identify and develop/provide the resources required to deliver a high quality service
- Establish referral criteria and care pathways
- Ensure that there is rapid access to appropriately trained and skilled staff to undertake a comprehensive, early assessment and care planning in order to deliver early intervention by the multidisciplinary team
- Ensure that clinical navigation is embedded within the service delivery plan

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- That a frailty service is operational and receiving appropriate referrals
- That patients and their carers are satisfied with the service and that feedback is used to help further improve and develop the service
- A reduction in the number of frail patients being admitted to hospital via A&E or EAU
- A reduction in the length of stay for patients with frailty
- An increase in the proportion of patients with frailty who, following comprehensive assessment and care planning, are able to be discharged to their usual place of residence
- A decrease in the proportion of patients with frailty who are admitted to hospital for an overnight stay

Priority 2: Patient Safety

Key Patient Safety Priority 1

- **Improving Continuity of Care and delivering Needs Based Care model**

Why is this a priority?

The delivery of 7 day consultant led services and early senior review and decision making for patients admitted to hospital as an emergency has been a significant area of quality improvement for the Trust, with significant increases in consultant presence out of hours and at the 'front-door' of the hospital over the last few years. However, as our model for emergency care has gradually evolved, an unintended consequence has been an increase to the number of consultants that have sequential input into a patient's care. It is not unusual for a patient admitted to a medical specialty as an emergency to receive care from a number of different consultants during their hospital stay. This can lead to confusion for the patient and their family as to what is happening, difficulties in co-ordinating the plan where the owning consultant is not following it through, and does not make it easy for senior medical staff to closely monitor a patient's progress and assess the effectiveness of treatment. By improving the continuity of consultant care for an individual patient, we will improve patient experience, reduce length of stay and minimise the clinical risk of patient management plans being handed over between senior clinical staff multiple times.

Within the range of emergency admissions to hospital, there will be some patients who will benefit from being cared for by physicians with a particular specialist interest, such as stroke, cardiology or respiratory. There are other patients who may be admitted with a straightforward medical issue, such as an infection or after a fall, but have very complex needs perhaps because of underlying long term conditions, poly-pharmacy, or extensive social or support needs. These patients require care from a senior general medical physician, with support from a wide range of professionals, and carefully managed transitions between hospital and usual place of residence. Getting the patient to the right specialty team as early in their admission as possible is really important to avoid unnecessary investigations, support the patient to be managed at home wherever possible and to enable rapid and targeted treatment and intervention without having to wait for advice from another specialist.

What will we do?

The Medical Division have been working on developing a model of Needs Based Care since late 2015, and has already embedded ambulatory care pathways, which are now running 7 days, and opened a cardiac ward for patients to be admitted under cardiologists where appropriate, rather than being admitted under a general physician who would then seek advice from a cardiologist. This has shown a dramatic reduction in length of stay for patients with cardiac diagnosis, and the initial data review suggested that this change was saving up to 15 medical beds. The next steps for implementation of Needs Based Care are to;

- Deliver admission for patients directly to respiratory specialists 7 days a week
- Complete works to the lifts in the medical block to facilitate specialty ward moves and create a larger flexible EAU bed base at the front of the hospital
- Complete the design of the complex and general medical senior medical model to enable movement to full needs based care for all specialties

In terms of facilitation of increased continuity, there are three transitions of care to be considered:

- When a patient with a long term medical condition comes into hospital, they should be cared for by a consultant who has been managing their outpatient care with their GP
- When a patient is admitted to hospital, they should have the same consultant for as much of their stay as possible, with no avoidable handovers.
- When a patient comes into hospital for a second time, they should return to the care of the consultant who discharged them, so that the treatment and plan can be reviewed in the context of the patient's prior admission

It is our intention to remodel the way the consultant care of inpatients is delivered to maximise consultant continuity for patients against each of these three elements of the pathway. This will require changes to consultant timetables, to enable ongoing care of patients rather than the traditional 'on-ward, off-ward' patterns of work.

Furthermore, by implementing length of stay reductions through delivery of the Red to Green initiative and focussed management of patients with length of stay in hospital of over 7 days, we will reduce the number of patients that are not admitted to the right bed first time, and so will reduce avoidable handovers that result from patient movement between wards.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Reduction in the number of consultant handovers within an inpatient episode
- Increase the % of patients discharged by the same consultant for a related re-admission
- Increase the % of patients discharged by their named outpatient consultant where applicable
- Reduction in length of stay for emergency medical patients
- Improved patient satisfaction regarding communication and involvement in decision making around their care

- Fewer non-value adding days to patient hospital stays due to improved co-ordination of the treatment plan

Key Patient Safety Priority 2

- **To reduce the incidence of falls amongst patients staying in hospital**

Why is this a priority?

Over the past five years, the Trust has shown a year on year improvement in the prevalence of falls with harm but the incidence of falls (rate per 1000 bed days) has remained relatively static. Whilst the Trust has a lower incidence of falls than the national average, we are committed to refocusing our multidisciplinary team efforts in order to reduce our rate of falls. When a patient has a fall in hospital, the effect can be both physically and psychologically detrimental and in many cases may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the efficiency of delivery of services to patients by less effective use of beds. Research has shown that when staff such as doctors, nurses and therapists work more closely together, they can reduce falls by 20-30% (RCP 2016). The Trust plans to build upon the work already undertaken to strengthen our approach to the prevention of falls thereby improving patient safety and experience.

What will we do?

- Ensure that the membership of the Falls Steering Group is in line with the recommendations of the RCP
- Continue to embed the multifactorial risk assessment in practice for all patients aged 65 and over and for those aged 18-64 who are have a clinical risk factor for falling.
- Educate staff, audit practice and undertake targeted improvement work to ensure that the best practice guidelines of NICE and the Royal College of Physicians is consistently implemented for all our patients.
- Complete the roll-out of the new Falls Prevention Leaflet which has been published for patients in hospital and their families and carers
- Implement the recommendations following the most recent bed rails audit
- Continue to review assistive technology to enhance the delivery of safer care for patients at risk of falls
- Undertake a review of the bed stock to ensure that there are appropriate numbers and types of beds
- Undertake focused quality improvement initiatives to reduce the number of falls associated with use of bathrooms and toilets
- Continue with the review and implementation of best practice standards for enhanced care for our most vulnerable patients
- Implement, as a priority, the frailty best practice standards
- Continue to investigate and analyse themes and trends from falls to inform the implementation of appropriately targeted actions for improvement

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria:

- The Falls Steering Group has membership and engagement in line with RCP recommendations

- A reduction in the rate of falls to a consistent rate of less than 4 per 1000 bed days
- A reduction in the rate of falls specifically associated with patient use of toilets and bathrooms
- Patients, their families and carers routinely receive and are asked to read the Falls Prevention Leaflet
- The Trust falls prevention action plan is regularly updated to include the learning from the analysis of falls

Key Patient Safety Priority 3

- **Improve the management of deteriorating patients**

Why is this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as “Failure to Rescue”. This in turn leads to further deterioration in the patient’s clinical condition and potential death. Although the Trust’s average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2016-17 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, there is a need to continue in our improvements to deliver more sensitive, appropriate care at the end of a person’s life. It is vital that for those patients, nearing the end of their life, that appropriate, timely decisions are made and care plans put in place to provide compassionate dignified care when aggressive treatment or resuscitation are not appropriate.

What will we do?

- Continue to embed the implementation of the Treatment Escalation Plans
- Continue to deliver training and support to clinical teams in the assessment of patients nearing the end of their life and in having effective, sensitive conversations with the patient and their family or carers.
- Continue to audit the observation and treatment of patients who deteriorate and implement learning from the findings.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria:

- Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline.
- To continue to sustain improvements all along the deteriorating patient pathway ensuring:
    1. Timely and appropriate observations
    2. Timely escalation of concerns to medical staff
    3. Timely medical response times,
    4. Improvement in timely and appropriate decision making by medical staff.

- Patients nearing the end of their life are appropriately assessed and provided with a careplan to ensure the most appropriate care delivery

Key Patient Safety Priority 4

- **To reduce the incidence of medication errors for inpatients**

Why is this a priority?

Every step in the processes associated with the use of medicines has the potential for failure to a varying degree. Medication safety is therefore, the responsibility of all staff and most effective when underpinned by a culture of openness and honesty when things go wrong. It is vital that we learn and use our developing understanding of medication safety incidents to most effectively deal with the causes of failure. The reporting, analysis of and learning from medication safety incidents is vital even where no harm has occurred to a patient. This allows the best quality learning to take place as the 'what', 'how' and 'why' things went wrong, so that effective and sustainable solutions can be put in place to reduce the risk of similar incidents occurring.

Research evidence (NHS England 2014) indicates the following medication error rates in the medicine use process nationally:

- Prescribing error rate in hospital, 7% of prescription items;
- Medicine administration errors in hospital, 3 - 8%;
- Dispensing error rate in hospitals, 0.02 - 2.7% of dispensed items;

Drug incidents accounted for 7% of all incidents reported on the Trust's patient safety incident reporting system during 2016/17, 95% of which caused no harm or low harm. However, there is opportunity to increase reporting rates of medication incidents following an apparent reduction in reporting during some parts of the year.

Since being chosen as one of the pilot sites for the 'Safer Patient Initiative' over a decade ago, significant progress has been made through an organisation-wide approach to patient safety and medication safety. The findings of the Francis Report also resulted in measures being put in place to address areas of concern relating to medicines use. The Trust Medication Safety Review Group (MSRG) reviews medication error reports each month, identifying themes and ensuring multidisciplinary, trust-wide learning is shared. This priority, aims to refocus attention across all professions to maximise the opportunities afforded by learning for quality improvements to further drive up our safety in medicines management.

What will we do?

- Improve the patient safety reporting system (DATIX) to more effectively support the medication safety agenda
- Continue to embed the culture of reporting, investigating and learning from medication safety incidents
- Monitor and identify trends and themes in medication related incidents e.g. audit of missed and omitted doses
- Targeted quality improvement work to reduce incidence of the most prevalent error types
- Focus on reducing errors associated with the use of high risk medicines
- Ensure that Trust practices are fully in line with NHS Improvement Patient Safety Alerts

- Promoting safe medication use on the wards through new ways of working (MDT) e.g. board rounds, safety briefs, huddles
- Ensure that the dissemination of lessons learned from medication errors through various mechanisms is consistent and robust. This will be achieved by using a range of communication channels e.g. newsletter, IT screensavers, clinical governance meetings, prescribing error sessions
- Further promote good leadership and a culture of openness (duty of candour) amongst clinical staff and between staff and patients
- Continued education and training to highlight the role of all healthcare professionals in medication safety

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria:

- A reduction in the rate of medication errors due to errors in prescribing
- A reduction in the rate of medication errors due to administration errors
- A reduction in the incidence of missed or delayed doses

Priority 3: Patient Experience

Key Patient Experience Priority 1

- **Improve the experience and care of patients at the end of life and the experience for their families**

Why is this a priority?

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. The last two years have seen improvements in communication with patients and families, improved symptom management and spiritual care, investment in training and education and reduction in inappropriate cardiac arrests through more timely decisions regarding DNACPR. This year, the focus will be on working with our community colleagues and our commissioners to ensure patients achieve their choice of 'place to die' and that this is achieved in a timely manner.

What will we do?

- Continue to build and develop the Palliative Team raising the profile of specialist palliative care expertise and the new EOLC Nurse role.
- Continue to present to clinical meetings across the multidisciplinary teams in order to promote the EOL Individualised Care plan and embed the national guidelines of palliative care. In particular helping to identify the dying patient and foster appropriate, timely conversations around EOL.

- Continue to promote “small things make a difference”- i.e. introduction of new linen patient property bags.
- Continue to strengthen the EOL Strategy Group making it a robust steering group for the delivery of palliative care standards we can be proud of.
- Supporting our staff on the wards and promoting our ethos that palliative care is everyone’s business from the cleaner to the consultant.
- Improve communication through additional and improved leaflets available to our patients.
- Palliative Care champions have been identified on each ward and equipping them to be advocates and role models of palliative care.
- Work with our chaplaincy team to improve the delivery of good spiritual and religious care to this cohort of patients, family and friends.
- Continue to audit of the EOL Individualised Care Plan and enhancing its correct use.
- Gather feedback on patient and carers experience.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Improved performance in the national ‘Care of the Dying’ audit
- Improved performance in the further local audits of the EOL Individualised Care Plan
- A reduction in incidents and complaints through the End of Life Steering Group
- Continued improved feedback from patients and carers

Key Patient Experience Priority 2

- **Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium**

Why is this a priority?

Patients with Dementia can have complex care needs. These care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their care pathway, provide good quality patient care and experience whilst they are attending hospital and communicate effectively with primary care in order to more effectively address their specific needs and provide a better quality experience. Service user feedback provided by the Alzheimer’s Society has shown that there is an opportunity to improve the experiences of the person with dementia and their carer who attend our out-patient departments. The Trust is committed to focusing on this element of patient experience for the coming year.

What will we do?

This has been a key quality priority for the Trust for some years with improvements in timely assessment, referral, treatment and support for carers. 2017 will focus on delivering improvements in the care and experience for the person with dementia and their carers who are using our out-patient services:

- Develop a process to ensure that people living with dementia who are referred to our outpatient services are identified before their attendance to enable special needs and requirements to be met

- Work in close partnership with primary care colleagues in order to improve referral pathways and sharing of information
- To provide additional focused training and support for all staff working within outpatient settings across the Trust to enable them to better address the needs of people with dementia and their carers
- Embedding the use of the butterfly symbol to support easy identification of people with dementia to facilitate continuity of care
- The impact of the environment on the person with dementia will be recognised as a fundamental influence on the wellbeing and experience. Opportunities to make improvements to the environment such as signage, layout of consulting rooms and distraction facilities will be the focus of a quality improvement initiative

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- The reported experiences of patients and their carers will be improved
- The reported experiences of staff working in the outpatient setting is that they feel more confident, skilled and knowledgeable in caring for people living with dementia and their carers
- Staff report higher levels of satisfaction in the service that they are able to provide for these patients and carers

Key Patient Experience Priority 3

- **Ensure proactive and safe discharge in order to reduce length of stay**

Why is this a priority?

There is considerable national evidence for the harm caused by poor patient flow. Delays lead to poor outcomes and experiences for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies.

Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend – between 2013 and 2015, recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million beds days. For older people in particular, long stays in hospital can lead to worse health outcomes and can increase their long term care needs.

This is a national issue and, as such, local A&E Delivery Boards are being asked to implement key initiatives to address some of the major underlying issues causing delayed discharges. The National CQUIN scheme builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways.

What will we do?

- Map and streamline existing discharge pathways across acute, community and NHS care home providers, and roll-out protocols in partnership across the whole system.

- Develop and agree, in partnership with our commissioner, a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver a reduction in length of stay
- To upgrade our IT system and train staff so that the Emergency Care Data Set can be collected and returned with the required additional data and improved accuracy
- To embed the implementation and roll-out of Red Days and Green Days in order to identify wasted time much earlier in the patient's journey
- To use the intelligence offered by the Red and Green Days analysis to focus quality improvements aimed at reducing the issues which cause delays
- Undertake daily SITREP meetings and daily escalation meetings to review
- To review the synergies and opportunities afforded by the use of the Productive Ward "Planned Discharge" module to be used alongside the programmes of improvement activities that are currently in progress

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Red and Green Days is part of business as usual and used consistently to assess the value of each patient's day
- By the end of the year, a 2.5% increase in the number of patients discharged to their usual place of residence within 3-7 days who were admitted via non-elective route and are aged 65 and over
- There will be no increase in the readmission rate as a result of the decrease in length of stay

Key Patient Experience Priority 4

- Improving experience of care through people who use services

Why is this a priority?

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. Patients and their carers are at the heart of what we do and seeking a better understanding of and responding more effectively to their experiences is a core element of how we deliver our services.

Furthermore, the NHS Five Year Forward View says that 'we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services'1 (2014). The concept of patient leadership is emerging as one important new way of working collaboratively with patients and carers. 'One new concept – patients as leaders – is beginning to gain popularity'2 (Kings Fund 2013). Nationally, initiatives are emerging which places high priority on involving patient leaders in the endeavours of NHS organisations to secure better information from service users and to support

In addition to this priority for our patients experience, it is also a priority to improve the experiences of staff. The 2016 national staff survey results showed our Trust to be in the lower 20% of Trusts in England for effective use of patient/service user feedback. Our key priority therefore needs to be to ensure that we increase the opportunities to gain feedback

from our patients and carers, that we seek to increase the usefulness and quality if the information we gather and that we increase the scale and pace of quality improvement initiatives which are directly responding to our patient experience feedback.

What will we do?

- Embed the use of iPads on wards and in departments to collect feedback from more patients
- Implement a texting service to seek feedback from patients visiting A&E, outpatients and those who have delivered a baby in hospital
- Supplement the FFT question routinely asked on discharge, with a range of questions to provide a better understanding of patient experience
- Ensure that ward and departmental managers receive regular reports of their feedback in a format that is easy to understand, share with their teams and use with their teams to drive improvements
- Ensure that patient experience findings and related quality improvements are a standard agenda item on Departmental and Divisional Governance and Board meetings with the expectation that actions to respond are discussed and agreed
- Ensure that the findings of patient experience surveys are widely publicised for staff and patients/visitors so that everyone has easy access to information which shows what the feedback is and how we are using it
- For our top four languages, ensure that patient experience surveys are translated and offered to those patients for whom those are their preferred spoken language
- Explore the use of Patient Leaders to further enhance our capacity and capability in the collection of patient experience feedback, in line with the NHS England Patient Leader initiatives
- Establish a Patient Experience Board to lead and monitor progress with the patient experience strategy
- Maximise the opportunities to make direct links between staff experience and patient experience
- Continue to build on a culture where patient and carer experience is everybody's business

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

Success Criteria

- Patient experience feedback is displayed alongside staff experience feedback
- Patient experience feedback and quality improvement action plans is a standing item on the agenda of meetings in all divisions
- Staff see and believe that the Trust acts on concerns raised by patients
- Staff receive regular updates on patient/service user experience in their department
- Feedback from patients/service users is used to make informed decisions within departments
- There will be an increase in the number of patients providing feedback to the Trust
- The teams will have access to an enhanced range of feedback which they use to tailor local quality improvement initiatives

Key Patient Experience Priority 5

- **To support the continued delivery of care to patients nearing the end of their life within residential and nursing homes**

Why is this a priority?

People nearing the end of their life who are living in nursing or residential homes are sometimes brought into hospital because of a failure in provision in the community. 30% of patients stay in hospital for less than one day and a significant number die within 48 hours of admission because they are patients who are at the end of their life. These two groups of patients particularly have the potential to receive more appropriate care if it were able to be delivered within their place of residence. Evidence suggests that staff within nursing homes and residential homes are often reluctant to call an ambulance because they are aware that the patients' needs could be adequately provided for within the community had the appropriate services been consistently available. The effect is that people may be dying in hospital unnecessarily and that some beds are being used for less appropriate admissions. The service we aim to provide will provide an alternative to calling for an emergency ambulance when intervention in the home would effectively prevent the patient transfer.

What will we do?

- Work in partnership with SEPT and CCS to create a clinical outreach team to ensure 24 hour cover, seven days per week who are able to provide care and treatment to patients within residential or nursing homes
- To provide support to the staff within the nursing and residential homes in order to maintain continuity of care for patients within their usual place of residence
- To build on the strengths of the Hospital at Home and Clinical Navigation Teams to build a team who can rotate into roles in order to deliver a responsive service
- To work with the primary care providers and ambulance service to ensure that appropriate screening and referral criteria are established and implemented to enable an effective, safe referral pathway to be put in place

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- The outreach service is in place providing interventions in nursing and residential homes which result in an avoided admission to A&E
- The service will not be limited by postcode but will be available for any home from where the patient would otherwise have been conveyed to the Luton and Dunstable Hospital A&E department

4. Statements related to the Quality of Services Provided

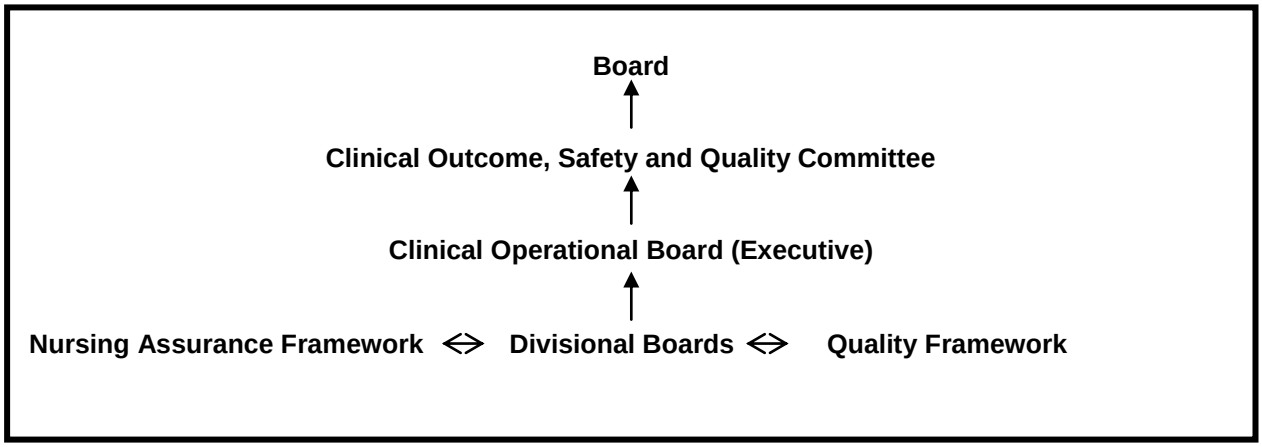
4.1 Review of Services

During 2016/17 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes. The Board of Directors considers performance reports quarterly including progress against national quality and performance targets. The Board also receives reports from the Clinical Outcome, Safety and Quality sub committee. Quality is managed by the Divisional Boards and the Clinical Operational Board providing assurance to the Clinical Outcome, Safety and Quality Committee. These reports include domains of patient safety, patient experience and clinical outcome. During 2016/17 the Executive Board commissioned a number of external experts and external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- External reviews of two Serious Incidents
- Mortality review received by Dr Bill Kirkup
- Support from the Institute for Health Improvement to support our Advancing Safety and Quality Framework

In addition, the Board receives reports relating to complaints and serious incidents.

Quality Assurance Monitoring



The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2016/17.

4.2 Participation in Clinical Audits and National Confidential Enquiries

During the period the Trust was eligible to participate in 34 of the 52 National Clinical Audits that met the Quality Accounts inclusion criteria.

The Trust participated in 33 (97%) of the eligible national audits

The audit that we were eligible to participate in but did not was:

- National Ophthalmology Audit - due to software issues. Business Case for the Electronic Patient Records system called Medisoft submitted

Clinical audits are a mixture of National and local priorities which each directorate is responsible for as part of their Clinical Audit Forward programme. The data collected for Quality accounts includes mandatory audits on the National Clinical Audit and Patient Outcomes Programme which directorates must participate in. Other audits whether local or national may not have been deemed as high priority or reflects the audits which directorates have prioritised.

Details are provided within the table 1 below.

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All patients with diagnosis of MI	Will be completed ahead of deadline (July 2016)
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible No			
Bowel Cancer (NBOCAP)	Royal College of Surgeons	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	All (100%)
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	100%	Jan - Dec 2015 - 162 cases submitted
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All ITU Admissions	396 Cases (100%)
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes	Eligible No			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
	Research (NICOR) Adult and Children				
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All PCI	270 Cases
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	Data collection in progress. 100% (153 cases will be submitted by June 2016)
Elective Surgery (National PROMs Programme)	Health & Social Care Information Centre	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	Total cases submitted 43 (Primary Hip Replacement:7, Primary Knee Replacement: 14, Groin Hernia: 20, Varicose Veins: 2
Emergency Use of Oxygen	British Thoracic Society	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	30+30+1	15
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians of London	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	30	100%
Inflammatory Bowel Disease (IBD) programme	IBD Audit managed by Royal College of Physicians ***Transitioning to***	Eligible Yes	Apr 2015 - Mar 2016	20	20

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
	IBD Registry managed by the British Society of Gastroenterology	Participated Yes			
Major Trauma Audit	The Trauma Audit and Research Network (TARN)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All cases	158 Cases submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All cases	100%
National Audit of Intermediate Care	NHS Benchmarking Network	Eligible Yes Participated No*			
National Audit of Pulmonary Hypertension	Health & Social Care Information Centre (HSCIC)	Eligible No			
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	Cardiac Arrests	122 (additional x20 to be entered)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Royal College of Physicians 3 audits	Eligible Yes Participated Yes x2 N/A x1	Apr 2015 - Mar 2016	All	100%

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	Eligible Yes Participated Yes (partially)	Apr 2015 - Mar 2016		
National Complicated Diverticulitis Audit (CAD)	The National CADS project	Eligible No			
National Diabetes Audit - Adults	Health and Social Care Information Centre (HSCIC) 4 audits	Eligible Yes Participated Yes x 2 N/A x 1 No x 1	Apr 2015 - Mar 2016	All eligible cases	100%
National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	98%
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	Heart Failure Diagnosis	257 Cases Ongoing data entry
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Eligible Yes Participated	Apr 2015 - Mar 2016	All	100%

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
		Yes			
National Ophthalmology Audit	Royal College of Ophthalmologists	Eligible Yes Participated No*			
National Prostate Cancer Audit	Royal College of Surgeons of England (Clinical Effectiveness Unit)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Vascular Registry	Royal College of Surgeons of England	Eligible No			
Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	All (100%)
Oesophago-gastric Cancer (NAOGC)	The Royal College of Surgeons of England (Clinical Effectiveness Unit)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All newly diagnosed UGI cancer patients receiving treatment will be submitted.	Not yet concluded.
Paediatric Asthma	British Thoracic Society	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases during November 2015	74 cases (100%)
Paediatric Intensive Care (PICANet)	University of Leeds	Eligible No			
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) 3 audits	Eligible No			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases
Renal Replacement Therapy (Renal Registry)	UK Renal Registry	Eligible No			
Rheumatoid and Early Inflammatory Arthritis	Northgate Public Services	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All cases of early arthritis	22
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians 2 audits	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All Stroke cases	100%
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	Eligible No			
UK Parkinson's Audit	Parkinson's UK	Eligible Yes Participated Partly Yes*	1st April 2015 and 31st March 2016	DME and Neurology	100%
Vital signs in children (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated	1st April 2015 and 31st March 2016	50-100 cases	50 cases submitted - data to Jan 2016

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
		Yes			
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	All (100%)
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	Reported in section 4.3
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) - University of Manchester	Eligible No			
Adult Asthma	British Thoracic Society	Eligible No			
Chronic Kidney Disease in primary care	Informatica Systems Ltd	Eligible No			
Non-Invasive Ventilation - Adults	British Thoracic Society	Eligible No			
Paediatric Pneumonia	British Thoracic Society	Eligible No			

Local Clinical Audits

In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of seventeen local clinical audits were completed during the reporting period which were project managed by the Trust's Clinical Audit Department (Appendix A).

4.3 National Confidential Enquiries

	Topic/Area	Database/ Organiser	% return*	Participated Yes/No
1	Mental Health	NCEPOD	100%	Yes
2	Acute Non Invasive Ventilation	NCEPOD	75%	Yes
3	Chronic Neurodisability	NCEPOD	17%**	Yes
4	Young People's Mental Health	NCEPOD	67%**	Yes
5	Cancer in Children, Teens and Young Adults	NCEPOD	0%**	Yes
4	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

* The number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry
** This study is still open and returns being made

4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2016/2017 and who were recruited during that period to participate in research approved by a Research Ethics Committee was **658.** This research can be broken down into **171** research studies (**148** Portfolio and **23** Non-Portfolio).

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

4.5 Goals agreed with Commissioners of Services – Commissioning for Quality and Innovation

A proportion of Luton and Dunstable University Hospital income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Luton and Dunstable University Hospital NHS Foundation Trust and NHS Luton as lead commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. During 2016/17, a number of CQUIN schemes were agreed – some of which were national schemes and the remainder, locally agreed quality improvement initiatives.

Indicator Number	Indicator Name	% of the Value
1a	Staff Health and Wellbeing: Introduction of health and wellbeing initiatives	0.25%
1b	Staff Health and Wellbeing: healthy food for NHS staff, visitors and patients	0.25%
1c	Staff Health and Wellbeing: improving the uptake of flu vaccination by frontline clinical staff to 75%	0.25%
2a	Sepsis Timely identification and treatment for sepsis in emergency departments	0.125%
2b	Sepsis Timely identification and treatment for sepsis in acute inpatient settings	0.125%

Indicator Number	Indicator Name	% of the Value
3a	Cancer 62 Day Waits Urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first treatment within 62 days	0.2%
3b	Cancer 62 Day Waits Root-cause analysis on all long waiters and a clinical harm review for a positive diagnosis	0.05%
4a	Antimicrobial Resistance and Antimicrobial Stewardship Reduction in antibiotic consumption per 1,000 admissions	0.2%
4b	Antimicrobial Resistance and Antimicrobial Stewardship Empiric review of antibiotic prescriptions	0.05%
5	Development of Shared Decision Making for Patients Requiring Same Day Urgent Care	0.7%
6	System wide Palliative Care and End of Life	0.2%
7	Integrated care for complex patients South Bedfordshire	0.2%

The Trust monetary total for the associated CQUIN payment in 2016/17 was £4,800,000 and the Trust achieved 88% of the value.

4.6 Care Quality Commission Registration

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

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

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

No enforcement action has been taken against the Trust during the reporting period April 1st 2015 and 31st March 2016 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

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

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

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

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

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

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

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016.

Our ratings for Luton and Dunstable Hospital

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

The CQC Inspection Report did not mandate any actions for the Trust however it did highlight a number of areas for further improvement. Each Division was asked to undertake a detailed review of the inspection report and develop an action plan paying particular attention to the "Requires Improvement" ratings within Medicine and Critical Care.

Progress against specific action plans is monitored through the various Divisional Governance processes and oversight of compliance and progress is monitored through COSQ. Any key areas have also been included in our Quality Priorities for 2017/18.

Medicine

1. A number of the key areas highlighted for improvement formed part of the Trust's quality priority for 2016/17. These included the timely administration of antibiotics for patients with sepsis and completion of VTE assessments. Ongoing audits are in place to monitor progress and have demonstrated an improvement in performance.
2. Another of the key areas for improvement was the medical model of care within Acute Medicine and Elderly Medicine. The report highlighted the number of Consultant handovers that resulted in a lack of continuity of care. The Trust has committed to an ambitious programme that will see the Trust move from an Age Based to a Needs Based Care model that has continuity of care as its key principle. This work will continue in 2017/18 and will be considered across all specialties and forms one of the Quality Priorities for 2017/18.
3. A comprehensive Stroke Action Plan was further developed to incorporate feedback from the CQC report. The actions have been aggressively progressed with significant improvements across all the component parts. This is also monitored at each meeting of the Board of Directors to monitor compliance.
4. Mandatory training compliance, particularly for conflict resolution, safeguarding children level 3 and infection control has improved with clear expectations and monitor processes in place.
5. The report raised some concerns with the Inconsistency in the recording of medicine administration and delays in dispensing discharge medication**.** The Trust has invested in an electronic prescribing system that has removed the inconsistency in recording medicine administration and this has been rolled out to the majority of clinical areas. A pilot project was run that used pharmacists on ward rounds to write take home medications which resulted in a reduction in the discharge delays. A business case has been prepared to support the roll out across all wards.
6. The rising Trust HSMR was a key area of concern raised by the Trust to CQC in the preparation for the Inspection. Within the Inspection Report a number of recommendations were made to support the ongoing work on the Trust in relation to this matter. At the time of the Inspection Mortality was discussed as part of governance meetings within Medicine. However, the Division agreed to ensure that these have more focused attention and quarterly Mortality Meetings are in place where case reviews are shared and learning takes place. Mortality meetings are held in all Divisions within the Trust. The Mortality Board oversees the review of deaths across the Trust, monitors trends and receives reports from any alerts raised through the Dr Foster benchmarking system. We have also maintained HSMR as a Quality Priority for 2017/18.
7. Delays to discharge were highlighted as an area for further improvement. A Discharge Hub has been developed to provide a focus on understanding the delays within the patient pathways and expediting and escalating any delays in patient progress through the pathways or barriers to discharge. Daily meetings with Executive level oversight are in place to monitor progress. Reducing length of stay will form part of our Quality Priority for 2017/18.

Critical Care

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

This immediate response was commended by the CQC.

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

1. Electronic prescribing and pharmacist rounds in critical care were introduced and the recruitment of a practice development nurse improved training opportunities.
2. A blood gas analyser was made available on HDU and the training was put in place accordingly.
3. Clinical management model has changed making it easier for staff to know who had clinical ownership of the patient.

A number of improvements remain in progress

1. Discharging patients from the Unit during working hours remains challenging due to the high bed occupancy across the clinical specialties. Every effort is made to step patients down from Critical Care during working hours however it is not always possible. The Critical Care Outreach team has been expanded to provide 24/7 cover for the wards. This mitigation is in place to support the late transfer out of patients whilst work is ongoing to reduce length of stay and bed occupancy.
2. The importance of HDU contributing to the ICNARC database was raised within the report. This is planned for 2017/18
3. It is recognised best practice to offer a Rehabilitation of the Critically Ill Patient follow up clinic to patients who have treated in Critical Care. Unfortunately this service is not currently commissioned by the CCG however the Trust is working with the CCG to agree how we might be able to deliver these clinics.

Other Service Improvement

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

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

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

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

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

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

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

Children and Young People electronic prescribing system has been implemented in paediatrics. The Surgical and Paediatric teams have worked together to agree a process that ensures a Paediatric nurse is present in theatre and this post is currently open for recruitment as at April 2017.

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

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

Transforming Quality Leadership 'Buddy' System
During 2016/17, we re-launched a programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation are assigned a 'buddy' area and are required to complete a cycle of visits across the domains and escalate any issues. The process involved Executive leadership across the domains with champions supporting the implementation. All clinical areas across the Trust are included in the programme.

This process provides board to ward reviews and also supports staff to raise concerns and issues to the management team. This programme developed into a revised quality monitoring framework to provide assurance of ongoing compliancy against the CQC Core Standards.

4.7 Statements on Relevance of Data Quality and Action to Improve Data Quality

The accuracy and completeness of the data we use to support the delivery of high quality care is of the utmost importance to the Trust.

The Trust has been making progress with data quality during the year 2016/17. There are many processes carried out by the Information Team, which identify data quality issues.

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

- CCG challenges
- Monthly and weekly Outpatient data quality reports sent out to users e.g. attendance not specified
- Theatre reports

- Inpatient reports
- Referral reports
- Benchmarking analysis – SUS dashboards
- Data Quality Improvement Plan
- Data Accuracy checks
- Completeness and Validity checks
- A&E not known GP checks
- A&E wait - arrival – departure times

During 2016/17 we have taken the following actions to improve data quality:

- Developed the role of the Senior Data Quality Analyst and confirmed recruitment of a Data Quality Analyst to support the role.
- Continued our extensive programme of data quality checks and initiatives involving staff and managers at all levels
- Added additional Data Quality Procedures to improve on areas e.g. overnight stays on day wards and incorrect neonatal level of care.
- Increased the use of automated reporting to increase the visibility of any data quality problems and expanded our contacts within the departments
- Continued to work with Commissioners to monitor and improve data quality pro-actively in key areas.

NHS Code and General Medical Practice Code Validity

Luton and Dunstable University Hospital NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS number was:

- 99.4% for admitted patient care; 99.8% for outpatient care and 95.9% for A&E care.

The percentage of records in the published data which included the patient's valid General Medical Practice was:

- 100% for admitted patient care; 100% for outpatient care and 100% for A&E care

Action Plan for Data Quality Improvement for 2017/18

Information Governance

- **Data Quality Accuracy Checks -** Maintain the number of audits on patient notes.
- **Completeness and validity checks -** Remind staff about the importance of entering all relevant information as accurately as possible via Email and liaising with IT Applications Training Team for individual ad hoc refresher training.

1) CCGs Challenges

- Continue to work with Outpatients, IT & Divisions to improve other areas of known data issues (Admission Method vs A&E Attendance)
- Continue to communicate with users the importance of recording the current GP at time of attendance or admission.
- Continue to improve the NHS Number coverage
- Continue to monitor Multiple Firsts and highlight areas that are consistently creating first appointments

2) Outpatients

- Continue to produce weekly and monthly lists identifying those patients with an attendance status of 'not specified'. Also work with the Outpatients, IT and Divisions to reiterate the importance and financial impact of not recording information accurately
- Continue Regular Outpatient Data Quality meetings.

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

4) Waiting List
- Continue Regular Waiting List Data Quality meetings.

5) Theatres
- Changes in General Management has resulted in the current DQ reports stopping and new Theatres reports to be considered with the department and Finance

6) Referrals
- Continue to send out referrals to users to rectify the referral source and highlight within the Outpatient Data Quality Meeting the importance of the source being entered

7) Patient Demographics
- Continue to monitor and update Invalid Postcodes, DBS errors and missing NHS numbers. Highlight within DQ meetings the importance of QAS and up to date GP information.

8) A&E
- Continue to improve the NHS Number coverage
- Continue Regular Outpatient Data Quality meetings.

9) SUS dashboards
- Work with Divisions to improve the completeness of the fields where the National Average is not being met
- Use the dashboard to identify areas that require improvement (e.g. Ethnic Group Collection in Outpatients and NHS Number in AE needs to improve

Other Data Quality meetings

The Information Team are holding regular data quality meetings with A&E, Theatres, Inpatients and Maternity (still to be confirmed).

Clinical coding error rate

The Luton and Dunstable University Hospital NHS Foundation Trust was subject to an audit during 2016/17, carried out in by an established coding agency.

An error rate of 9.5% was reported for primary diagnosis coding (clinical coding) and 6.6% for primary procedure coding. This demonstrates good performance when benchmarked nationally and achievement of level 2 attainment in the Information Governance Toolkit.

Information Governance toolkit attainment levels

The Luton and Dunstable University Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2016/17 was 69% and was graded as satisfactory.

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes within an organisation.

Part 3

5. A Review of Quality Performance

5.1 Progress 2016/17

A review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness indicators selected by our stakeholders. These indicators were selected in 2009/10 through a survey and the most popular indicators were selected. We have continued to follow the selected data sets and any amendments have been described below the table.

Performance Indicator	Type of Indicator and Source of data	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	3	3 ***	1	1	N/A	The Trust has a zero tolerance for MRSA. During 16/17 there was an isolated case.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	96*	106*	112*	108.7*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	19	10	11	8	N/A	Demonstrating an stable position. Remains one of the lowest in the country
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	30	19	11	3	N/A	Demonstrating an excellent position.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	4	3	2	4	N/A	Maintaining low numbers
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.6	1.6	1.04	1.4	1.6	Maintaining good performance below the national average
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.6 days	3.4 days	3.2 days	3.2 days	N/A	Maintaining the LOS

Performance Indicator	Type of Indicator and Source of data	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	National Average	What does this mean?
Rate of falls per 1000 bed days	Clinical Effectiveness Trust Board Report	4.87	4.25	4.32	4.06	5.5	Maintaining good performance.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (n)	Clinical Effectiveness	84.7%	79.5%	69.4%	78.3% (to Nov)	Target of 80%	This has continued to be a challenge and the Trust has a robust action plan in place to improve performance.
% of fractured neck of femur to theatre in 36hrs (n)	Clinical Effectiveness Dr Foster	82%	75%	78%	62%	N/A	Significant impact of Novel Oral Anticoagulants (NOAC's) which preclude surgery for 48 hours after the last dose. Some delays due to lack of Trauma capacity
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	76*	79*	69.7*	70.79*	100	This is demonstrating the Trust as a positive outlier and improved performance on the previous year.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	91*	109*	112.8*	89.56*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Readmission rates*: Knee Replacements Trauma and Orthopaedics (n)	Clinical Effectiveness Dr Foster	4.7%	6.7%	7.2%	7.09%*	N/A	There has been a slight increase. A review of Trust data has been undertaken and no concerns were identified.
% Caesarean Section rates	Patient Experience Obstetric dashboard	25.7%	27.8%	28.3%	32.9%	25%	The Trust is a level 3 NICU and received high risk patient transfers
Patients who felt that they were treated with respect and dignity**	Patient Experience National in patient survey response	9.0	8.9	9.0	Available after Inpatient Survey May 2017	Range 8.5 – 9.7	Demonstrating an improving position

Performance Indicator	Type of Indicator and Source of data	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	National Average	What does this mean?
Complaints rate per 1000 discharges (in patients)	Patient Experience Complaints database and Dr Foster number of spells for the year	7.01	7.12	6.29	6.64	N/A	The Trust continues to encourage patients to complain to enable learning.
% patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	7.9	7.8	7.4	Available after Inpatient Survey May 2017	Range 7.0 – 9.3	Demonstrating a slightly poorer position but still within range.
Venous thromboemolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95%	Achieved >95%	Achieved >95%	Achieved >95%	N/A	Maintaining a good performance.

(n) Denotes that this is data governed by standard national definitions

* Denotes calendar year

** Patients who felt that they were treated with respect and dignity is now reported in place of % patients who would rate the service as excellent, very good or good (in-patients). This is no longer asked within the national annual in-patient survey.

*** Public Health England Healthcare Acquired Infection Surveillance Group identifies the number of MRSA bacteraemia "allocated" to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.

5.2 Major quality improvement achievements within 2016/17

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

Improving Quality

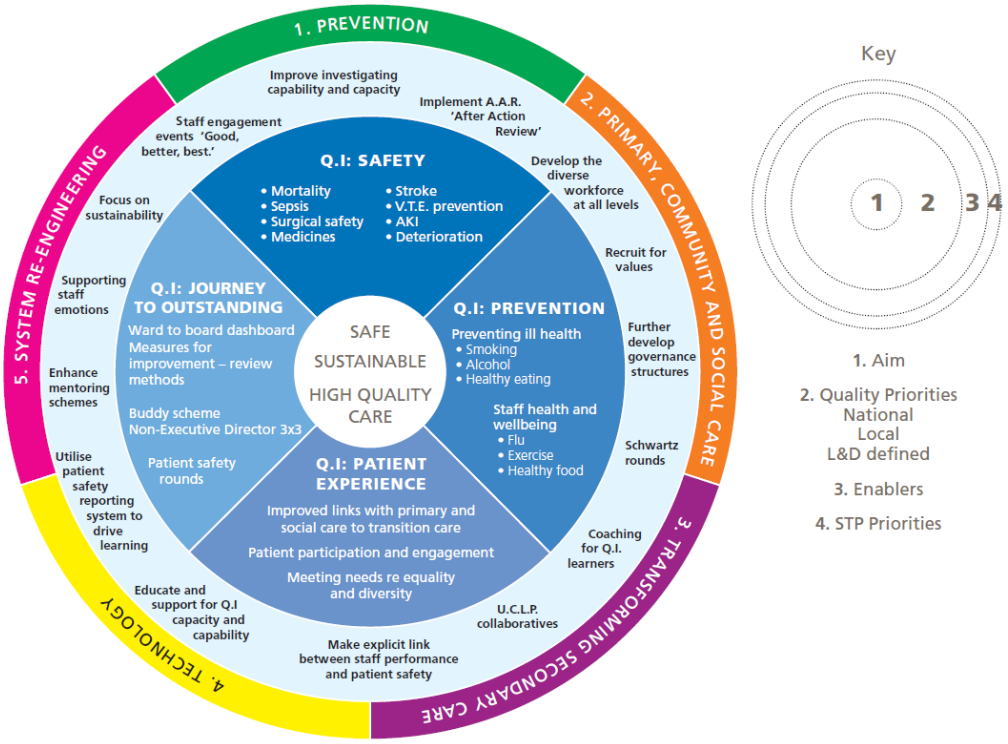
The CQC report was published in June 2016 and although the CQC Inspection Report did not mandate any actions for the Trust it did highlight a 'requires improvement' for safety.

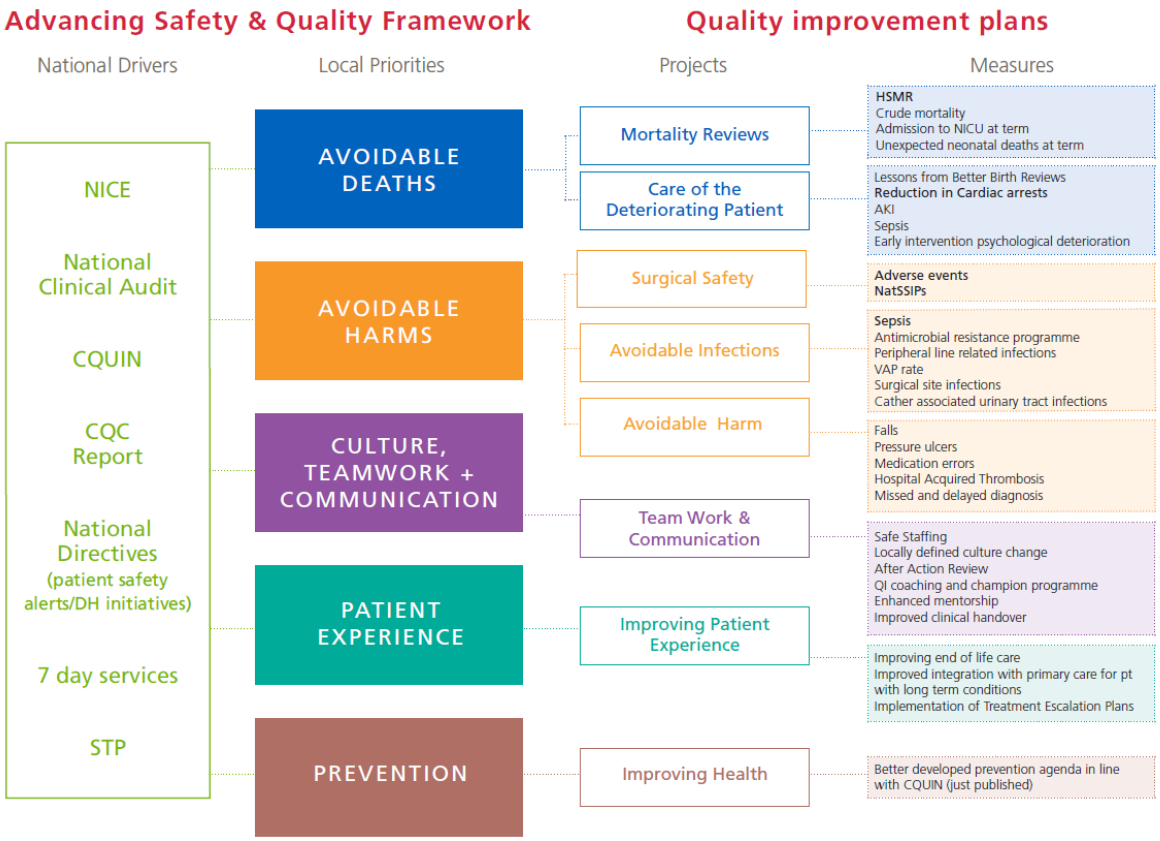
As part of the Trust commitment to patient safety we:

- Took some immediate steps to improve the environment for patients within the High Dependency Unit

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

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





Our Quality Impact Assessment process

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

The CIP / QIA processes:

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

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

The triangulation of quality with workforce and finance

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

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

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

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

Our Quality Improvement Implementation

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

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

A number of developments are already underway including:
Schwartz Rounds: a review has been undertaken and a plan made to continue with further development over the next year.

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

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

Utilise patient safety reporting system to drive learning: an extensive quality improvement programme is underway to redevelop and redesign the incident reporting system to create a system that is more streamlined and user friendly for both reporters, incident investigators and for those responsible for reviewing trends, themes and sharing the

learning. The Head of Clinical Risk and Governance now manages the complaints team which will afford a more robust approach to triangulating the learning from incidents, complaints, claims and litigation.

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

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

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

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

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

Engagement Events – 'Good Better Best'

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

Raising Concerns and Freedom to Speak Up Guardian

We have continued our focus on encouraging our staff to raise any concerns. In October 2016 we appointed a new Freedom to Speak Up Guardian. The new role was presented to over 2000 staff at the Trust Engagement Events. The role has a dedicated email and

telephone number to be able to access confidentially. A report is made to the Board of Directors and an oversight of the process is reviewed by the Audit and Risk Committee.

5.3 Friends and Family Test

The organisation continues to participate in the Friends and Family Test (FFT), submitting information on a monthly basis to NHS England. We are also able to view other Trust's scores which enable us to benchmark our scores against both regional and national scores. We use the FFT to provide us with real time feedback from our patients and carers. The information continues to be reviewed for trends and themes across the organisation and at ward and department. There were no particular trends or themes noted from the information collected.

Response rates to the FFT have increased steadily throughout the year and various ways of collecting the data hep to improve the number of responses. Not only do patients and their carers have the opportunity to complete response cards, we have also introduced iPADs making the information quicker to collect and analyse. We also rely on the link on our website and calls made from the Patient Experience Call centre. Volunteers have been extremely valuable in helping us to collect this data spending time on the wards and in clinics. Some areas have had a bigger challenge in collecting the data and where this is the case we have provided extra support to help improve their scores.

The FFT question has remained unchanged:

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

And we continue to collect information from the same clinical areas as last year for adult and paediatric services. Those are;

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

A quarterly report of the patient experience feedback is reviewed at the Clinical Outcomes, Safety and Quality Committee and by the Patient and Public Participation Group.

Tables 1-4 show the percentage recommend scores across all areas of the Trust. These statistics are reported monthly to NHS England.

2016/17 has seen variable response rates for Friends & Family Test. In March 2017 the Trust achieved a response rate of 24.3% for inpatients which is an improvement from 18.5% in 2015/16.

The latest data published by NHS England and shows the Trust remains comparable to the national average for response rate and recommend percentage. There was a slight reduction in response rate in Q3 but otherwise no significant difference was seen. We are assisted by volunteers who visit the inpatient wards to collect data. We continue promote the importance of the Friends & Family Test, in order to monitor and manage improvements in patient experience and a Friends & Family Test Masterclass was held with all the ward sisters to raise the profile and understand the importance of the feedback from patients and how to use their feedback to make improvements.

Comparison	Total Responses	Total Eligible	Response Rate	Percentage Recommend	Percentage Not Recommend
England excluding independent providers (Q1)	215,706	866,254	24.9%	96%	2%
Trust (Q1)	1,207	4,473	27.0%	96%	2%
England excluding independent providers (Q2)	213,961	874,563	24.5%	97%	1%
Trust (Q2)	1145	4,502	25.4%	97%	1%
England excluding independent providers (Q3)	223,106	904,437	24.7%	95%	2%
Trust (Q3)	1,233	5,626	21.9%	96%	1%
England excluding independent providers (Q4)	201,533	827,936	24.3%	96%	2%
Trust (Q4)	1100	4533	24.3%	96%	2%

Table 1 Inpatients Percentage Recommend Scores 2016/17

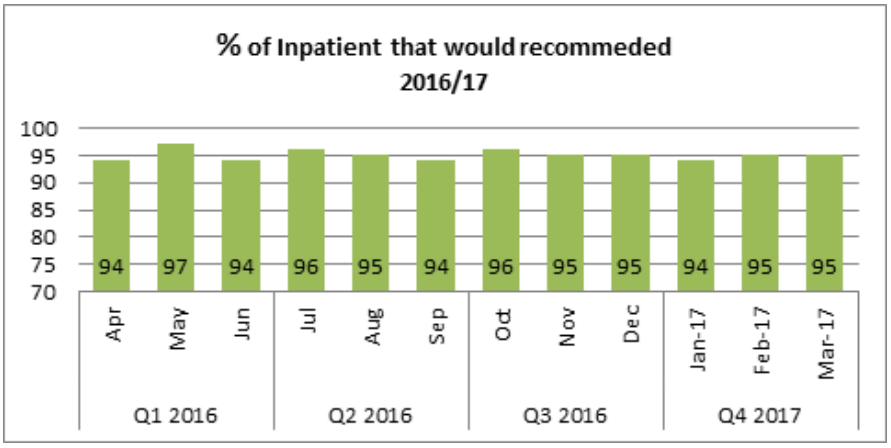


Table 2 Accident and Emergency Percentage Recommend Scores 2016/76

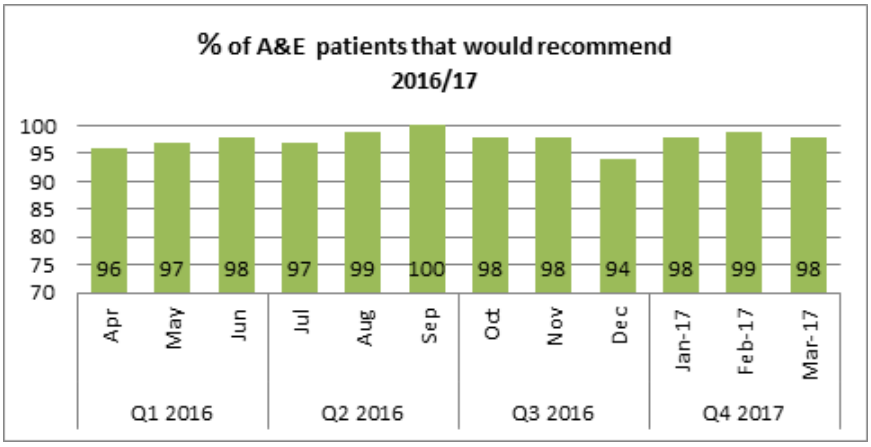


Table 3 Maternity Percentage Recommend Scores 2016/17

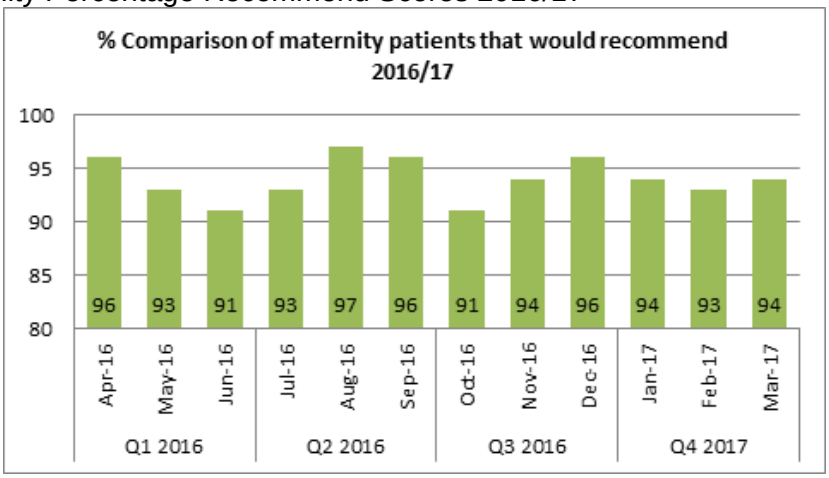
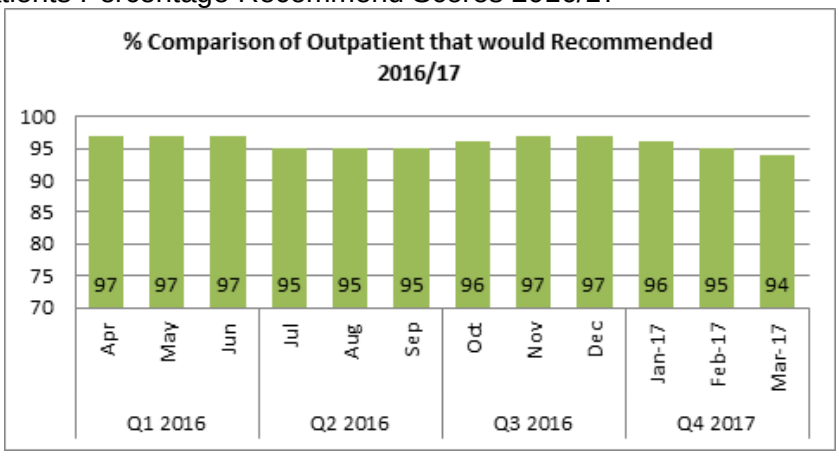
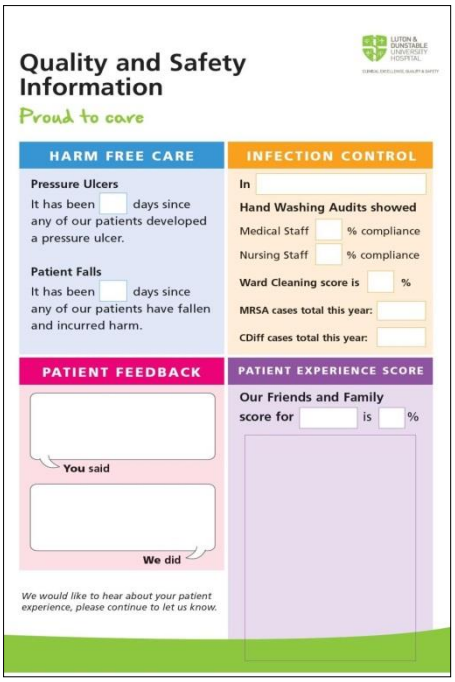


Table 4 Outpatients Percentage Recommend Scores 2016/17



The following are examples of action taken in response to feedback about individual wards:

- Reducing the risk of falls for patients by ensuring that they have a risk assessment completed within 6 hours of admission.
- Patients at risk of falls cohorted into one bay where possible to enable staff to monitor them more closely and easily.



Wards use the Quality and Safety Information Boards to report on the FFT recommend score and to display 'You Said/We Did' information for their patients to see. This information is updated monthly.

National Inpatient Survey 2015 Awaiting data therefore will be updated after the year end figures are published by the CQC

Results of the national in-patient survey 2015 - 2016 data not available yet

Category	2012	2013	2014	2015	2016	Trust year on year comparison	Comparison other NHS hospitals
The emergency / A&E department, answered by emergency patients only	8.4	8.4	8.2	8.6			The same
Waiting lists and planned admission, answered by those referred to hospital	9.0	9.1	8.9	8.8			The same
Waiting to get to a bed on a ward	7.0	6.5	7.1	7.3			The same
The hospital and ward	8.1	8.1	8.0	8.0			The same
Doctors	8.2	8.4	8.4	8.3			The same
Nurses	8.1	8.2	8.1	8.3			The same
Care and treatment	7.5	7.6	7.6	7.7			The same
Operations and procedures, answered by patients who had an operation or procedure	8.3	8.2	8.4	8.4			The same
Leaving hospital	7.0	7.1	6.8	6.8			The same
Overall views and experiences	5.5	5.5	5.5	5.3			The same

Note all scores out of 10

Hospital and Ward category asks questions about cleanliness, hospital food and sleeping areas. The category Doctors and Nurses includes questions on confidence and understanding staff and Care and Treatment covers privacy, information on treatment and decisions about care.

Patient Stories and Improvements following patient feedback.

Story One

Learning Disabilities

A patient who had severe learning disabilities and autism was admitted to ward 21. He had several needs relating to these diagnoses that made the hospital setting very difficult for him. Ward staff responded to these by making the following reasonable adjustments.

1) At a time when the patient was feeling particularly anxious, the ward sister found out that he likes washing machines (and other appliances!) and so showed him around the sluice room as a way to distract him from the things making him anxious.
2) Familiarity was extremely important, so the ward supported the patient's carers to bring in his own bedding from home.
3) He was given a side room, as noise, strangers and busy environments were extremely hard for him to manage, and he was able to leave the ward with a carer at regular intervals (e.g. to visit the canteen).

4) Ward staff responded in a very quick and considerate manner to his carer's needs; giving them regular breaks, enabling them to stay overnight with the patient, and keeping them up to date with his care.

Without these adjustments the family feel that he would have left the ward, and behaved in a way that would have become increasingly challenging for the ward staff to manage

Story Two

Distraction Toys

An 11 year old child was booked into the Paediatric Emergency Department with a mental health issue. The patient was triaged within fifteen minutes of arrival by a nurse. At triage it became apparent that this child and family were having a troubled time, the patient had expressed suicidal ideation and there was evidence of planning again. The family had been engaging with the community Mental Health Teams as the patient had been becoming more withdrawn, however a crisis response was not immediately available, this is why they attended the Emergency Department.

The nurse was able to offer the family a side room where they could sit without the distress of sitting in the busy waiting room. The nurse tried to engage by offering some distraction toys that the department owns. The child was not interested in watching DVD's and the other toys were more suitable for toddlers. The child said that he would rather play a board game; this is something the department doesn't have.

The child was referred to the child and adolescent mental health service (CAMH) and seen the following morning after an overnight stay as the referral was made out of hours.

The nurse from the Emergency Department was left feeling that more could have been done to put the child at ease and make his time in the Emergency Department more bearable. As a result the department now has a box of toys and games suitable for this age group and is intended for patients presenting with mental health problems. CAMH have also started a pilot trialling an extension to their hours of cover. The aim is to ensure children are seen more quickly and receive definitive management.

Improvement One

ITU Memorial Service

A non-religious service was held in the hospital chapel, having been organised by one of the the Healthcare Assistants from ITU. The main aim of the service was to allow relatives and friends of those who had died in ITU over the previous year, to come and remember their loved one whilst gaining support from staff who had cared for them during their stay. The staff involved in organising and holding this service do so in their own time and on a purely voluntary basis.

The most recent service was held in October and was attended by approximately 40 relatives. The order of service included poems read by staff, the reading out of the names of those who had died and a few words said by the Hospital Chaplain. The relatives were given an opportunity to light a candle for their loved one should they wish to do so and were invited to say a few words if they wished to.

Following the service, the relatives were shown to a room in the Comet centre where they were served with refreshments brought in by staff.

Some of the feedback we received following this service was that 'it was a beautiful service, you have done us proud', 'a wonderful caring organisation of a delicate service' and 'found it comforting and healing'

Improvement Two

"Please Call, Don't Fall"

As part of their Safeguarding Champions course, delegates are set a project to identify an area in their workplace that could be a safeguarding issue and to then look at ways of improving practice to reducing the risks.

Two nurses recognised that whilst staff aim to promote independence in activities of daily living, the variety of health conditions that affected their patients potentially increased the risk of falls particularly in bathrooms and toilets.

They have created an information poster to be placed in bathrooms and toilets to raise both patient and staff awareness of the risks. The poster explains how to keep safe and asks patients to call if they need help.

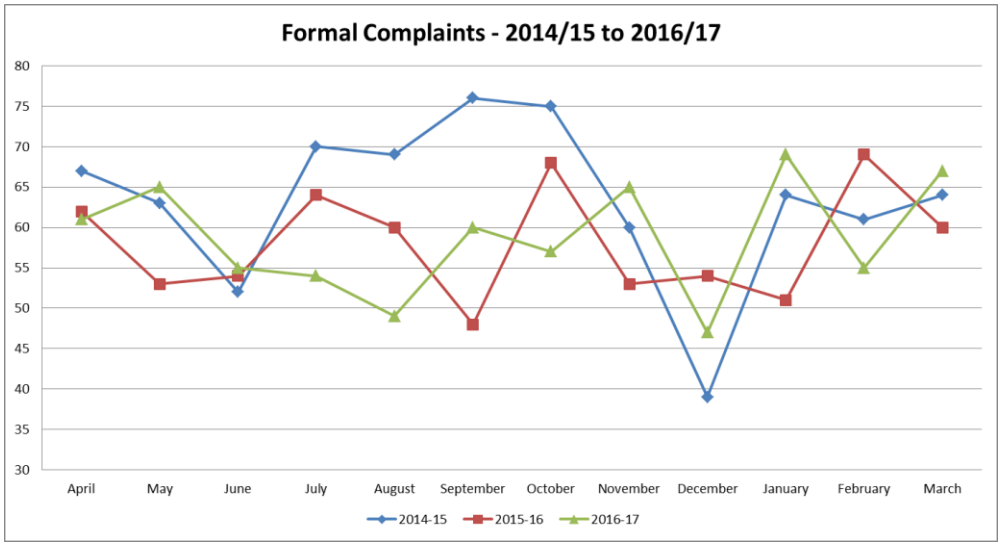
We plan to display the poster in all patient areas to promote a Trust wide patient safety message around falls prevention.

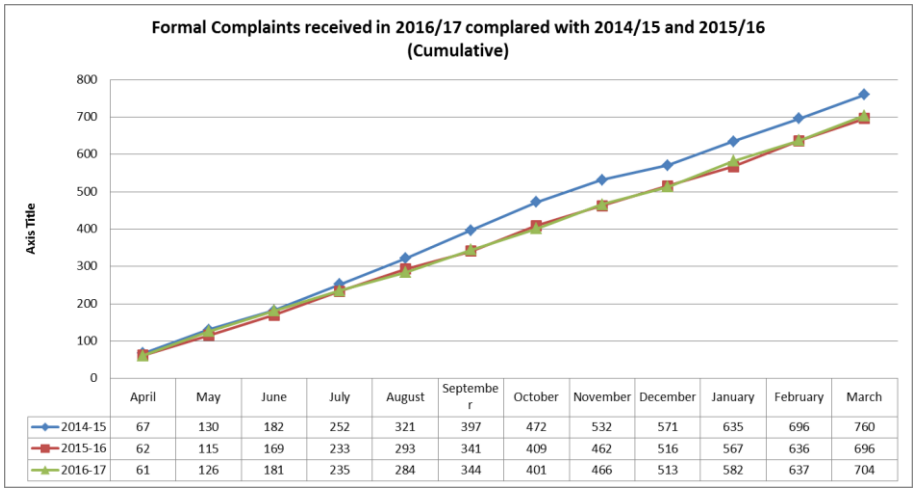
5.5 Complaints

During 2016/17 the Trust has concentrated on developing a process which allows the learning from complaints to be shared with staff and we have continued to welcome patient feedback. Following review of the Complaints and Concerns Policy in 2016 there has been a continuing focus to ensure that we efficiently answer complaints and concerns in a timely manner and continually use this information to improve our services.

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

During 2016/17 we received 704 formal complaints compared to 696 in 2015/16 and 760 in 2014/15. Whilst the number of complaints has remained static, with no significant increase or decrease, it is recognised that there is a heightened public awareness of the option to complain.





	April	May	June	July	August	September	October	November	December	January	February	March
2014-15	67	130	182	252	321	397	472	532	571	635	696	760
2015-16	62	115	169	233	293	341	409	462	516	567	636	696
2016-17	61	126	181	235	284	344	401	466	513	582	637	704

We continue to make improvements to our reporting and investigation of complaints by implementing the use of the recommended coding from NHS Digital. As we enter the new financial year, this will help us to better understand the nature of our complaints so that we can deal with them in a quality, as well as a timely, way.

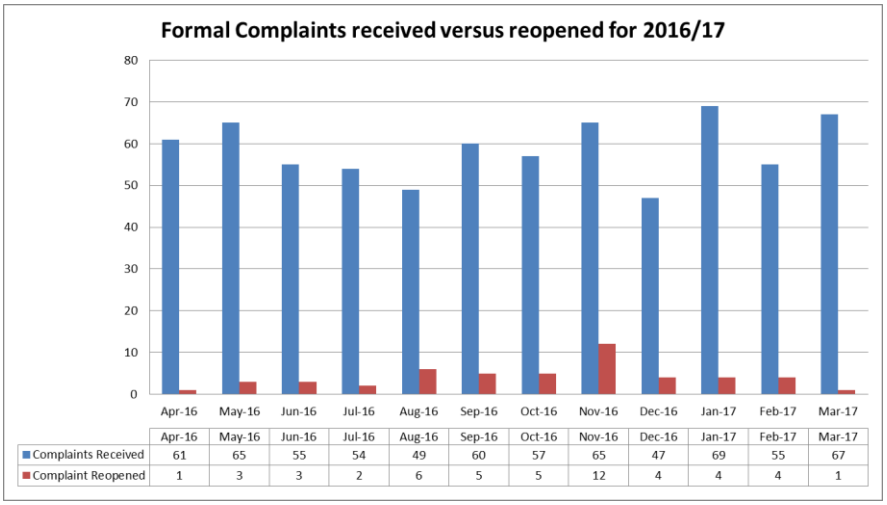
This will also enhance our internal and external reporting, highlighting specific areas where we can improve.

We have improved the way we acknowledge complaints. We work hard to acknowledge all complaints within 3 days and have achieved 100% success in 10 out of the 12 months. It is not always possible to formally acknowledge a complaint within 3 days if the complaint has been raised via the hospital's website and not all relevant details are available. The information required when submitting a complaint has now been highlighted on the hospital website to prevent unnecessary delay.

We aim to respond to complaints within 35 days but this has been difficult to achieve in some cases, often because of reasons outside of the investigators control. The Patient Affairs Team currently sends out a weekly report of breached responses to the divisions but to help us meet the target in 2017/18 we are developing a tracking system to monitor complaints through each stage of the complaints process. In 2017/18 the weekly report will include the status of all open complaints.

The monitoring and tracking of complaints handling is now part of the Divisional Performance Meeting monitoring agenda.

In 2016/17 we re-opened 50 complaints. The graph below shows the number of formal complaints re-opened in comparison to the number received. Our aim for 2017/18 is to reduce the number of re-opened complaints by ensuring 'first time right' responses.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Complaints Received	61	65	55	54	49	60	57	65	47	69	55	67
Complaint Reopened	1	3	3	2	6	5	5	12	4	4	4	1

Learning from Complaints
This year we have strengthened our complaints process to ensure that we are learning from complaints to improve the services we provide. Complaints where recommendations have been made have an action plan that is monitored by the divisions with assurance provided to the Complaints Board. Below are examples of some of the improvements made during 2016/17:

- There were concerns raised about clinics over-running and clinicians seemed distracted at times. As a result of these concerns, the number of patients seen in a clinic has been reduced to a more manageable number with an increase in the number of clinics. Longer clinic appointments are now available so that patients have time to discuss their concerns with the clinicians without feeling hurried.

- We received a complaint about poor patient experience at discharge following day case surgery where insufficient pain medication had been supplied. As a result of this complaint, the 'pain score' is now recorded for all patients admitted as a day case and they are not discharged unless the pain score is below 3/10.

- We have introduced a red flag system in the surgical division for clinic letters to be typed urgently where a patient needs imaging prior to a scheduled appointment or procedure. This has meant that patient experience is improved, delays prevented, and avoids waste of NHS resources.

Listening to Patient Concerns
We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. The top themes of complaints related to clinical treatment, delays, communication and attitude of staff.

In 2016/17 all complaints were thoroughly investigated by the General Manager for the appropriate division and a full and honest response was sent to the complainant.

The majority of complaints were resolved at local resolution level, with 8 complainants requesting the Parliamentary and Health Service Ombudsman (PHSO) review their complaints. Of these 8 cases the PHSO investigated 7. Five complaints were 'not upheld' and 2 complaints were 'partly upheld'.

In 2017/18 we also aim to:

- Promote informal and prompt resolution of concerns at a local level thereby reducing the number of formal complaints and improving patient experience
- Raise the profile of complaints within the Trust via newsletters and training
- Where investigators are having difficulty completing investigations due to circumstances outside their control they will be asked to work closely with the Patient Affairs Team to keep complainants updated and negotiate extensions where appropriate

Compliments
During the reporting period over **6,500 compliments** were received about our staff and our services.

Below are some extracts taken from the compliments we received:

'The reason that I am writing to you is to bring to your attention the wonderful treatment that I recently received when I attended for a breast screening assessment in January 2017.

I had a recall from a mammogram. This was obviously a very anxious time for me waiting for my second assessment.

I arrived early for my assessment and was seen very promptly. The nurse was delightful and so very reassuring. An assessment was carried out by the doctor who was absolutely wonderful, making me feel calm and relaxed. It was a real pleasure to meet such a professional and caring team of people.'

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

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

'I was admitted through A&E in January 2017 and wanted to say how excellent the care and treatment I received was. I could not have asked for more. I was seen immediately, and had lots of tests but every step was explained to me, the nursing staff hardly left me but if they did someone was always checking I was ok. I want to say thank you. In this difficult time for the NHS I could not have asked for more and wanted to pass on my thanks.'

5.6 Performance against Key National Priorities 2016/17

		2013/14	2014/15	2015/16	2016/17	Target 16/17
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	19	10	11	8	6
MRSA	To achieve contracted level of 0 cases per annum	3	3*	1	1	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	99.8%	100%	100%	99.9%*	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	91.5%	91%	88.4%	88.6%*	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.7%	95.5%	95.8%	96.4*	93%
Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	100%	98.9%	98.6%	100%*	94%
	Anti-cancer Drugs	100%	100%	99.8%	100%*	98%
Patient Waiting Times	Referral to treatment - percentage patients waiting so far within 18 weeks - incomplete pathways	96.5%	96.9%	96.3%	93.2%	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.4	98.6%	98.6%	98.8%	95%

		2013/14	2014/15	2015/16	2016/17	Target 16/17
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	N/A	N/A	N/A	0.7%	<1%

* Public Health England Healthcare Acquired Infection Surveillance Group identifies the number of MRSA bacteraemia "allocated" to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
** currently to February 2017 – March data to be added in May 2016

5.7 Performance against Core Indicators 2016/17

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

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time, divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality; however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. The L&D is a provider of level 3 Neo-natal care that cares for the most premature babies and it is acknowledged that SHMI does not adequately risk adjust for a level 3 NICU provided in a District General Hospital. Other benchmarking data is used to provide assurance on performance and data is also subject to on-going review. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' rather than the numerical codes which correspond to these bandings

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
Value and banding of the SHMI indicator	Published Apr 13 (Oct 11 –Sep 12)	As expected	As expected			2
	Published Jul 13 (Jan 12 - Dec 12)	As expected	As expected			2
	Published Oct 13 (Apr 12 –Mar 13)	As expected	As expected			2
	Published Jan 14 (Jul 12 – Jun 13)	As expected	As expected			2
	Published Oct 14 (Apr 13 –Mar 14)	As expected	As expected			2
	Published Jan 15 (Jul 13 – Jun 14)	As expected	As expected			2
	Published Mar 16 (Sep 14 –Sep 15)	As expected	As expected			2
	Published Mar 17 (Sep 15 –Sep 16)	As expected	As expected			2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level *(The palliative care indicator is a contextual indicator*	Published Apr 13 (Oct 11 –Sep 12)	12.4%	19.2%	0.2%	43.3%	N/A
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 –Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 – Jun 13)	12.6%	20.6%	0%	44.1%	N/A
	Published Oct 14 (Apr 13 –Mar 14)	13.7%	23.9%	0%	48.5%	N/A
	Published Jan 15 (Jul 13 – Jun 14)	14.7%	24.8%	0%	49%	N/A
	Published Mar 16 (Sep 14 –Sep 15)	13.8%	26.7%	0%	53.5%	N/A
	Published Mar 17 (Sep 15 –Sep 16)	26.2%	29.6%	0.4%	56.3%	N/A

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

- This is based upon clinical coding and the Trust is audited annually.

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

- Mortality rates remain as expected and other benchmarking, including HSMR remains one of the Trust quality priorities for 2016/17 and the Mortality Board maintains ongoing oversight of any indicators that flag as an outlier.

Indicator: Readmission rates

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

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 – 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2010/11	10.16	11.17	13.00	0.0%
	2011/12	10.64	11.26	13.50	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*

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

- This is based upon clinical coding and the Trust is audited annually.
- The Trust does not routinely gather data on 28 day readmission rates

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

- We will continue to work with our commissioners to prevent unnecessary readmissions to hospital through admission avoidance services available for patients to access. These include Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team, the Hospital at Home service, provider support in the Emergency Department and the integrated models of care

**The most recent available data on The Information Centre for Health and Social Care is 2011/12 uploaded in December 2013. The next information upload is in August 2016.*

Indicator: Patient Reported Outcome Measures (PROMs) scores

PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Groin hernia surgery	2010/11	0.110	0.085	0.156	-0.020
	2011/12	0.12	0.087	0.143	-0.002
	2012/13	0.09	0.085	0.157	0.014
	2013/14	0.079	0.085	0.139	0.008
	2014/15	0.088	0.081	0.125	0.009
	2015/16	**	0.088	0.13	0.08
	2016/17*	0.079	0.089	0.161	0.016
Varicose vein surgery	2010/11	**	0.091	0.155	-0.007
	2011/12	**	0.095	0.167	0.049
	2012/13	**	0.093	0.175	0.023
	2013/14	**	0.093	0.15	0.023
	2014/15	**	0.1	0.142	0.054
	2015/16	**	0.1	0.13	0.037
	2016/17*	**	0.099	0.152	0.016
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14	0.369	0.436	0.545	0.342
	2014/15	**	0.442	0.51	0.35
	2015/16	**	0.45	0.52	0.36
	2016/17*	**	0.449	0.522	0.329

Knee replacement surgery	2010/11	0.325	0.299	0.407	0.176
	2011/12	0.313	0.302	0.385	0.181
	2012/13	0.321	0.319	0.409	0.194
	2013/14	0.297	0.323	0.416	0.215
	2014/15	**	0.328	0.394	0.249
	2015/16	**	0.334	0.412	0.207
	2016/17*	0.29	0.337	0.430	0.260

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

- Results are monitored by the Clinical Audit and Effectiveness Group
- Results are monitored and reviewed within the surgical division

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

- Reviewing these results in both high level committees and within the surgical division.
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings.
- Patient level data is scrutinised and surgical team performance reviewed. The Trust completed a review in April 2015 that identified no concerns at the patient level.
- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

** Relates to April to September 2016 (most recent data published in February 2017 by HSCIC)*
*** Score not available due to low returns*

Indicator: Responsiveness to the personal needs of patients during the reporting period

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

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

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Responsiveness to the personal needs of patients.	2010/11	65.6	67.3	82.6	56.7
	2011/12	64	67.4	85	56.5
	2012/13	67.5	68.1	84.4	57.4
	2013/14	65.6	68.7	84.2	54.4
	2014/15	66	68.9	86.1	59.1
	2015/16	74.2	77.3	88	70.6
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*

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

- The source of the data is the National In-Patient Survey.

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

- Continued implementation of Electronic Prescribing system and that has improved timeliness of available medications for patients to take home
- On-going refurbishment programme to assess the high risk environmental areas that need attention particularly toilets and bathrooms
- On-going monitoring of patient feedback from the Patient Experience Call Centre and Friends and Family feedback

**The most recent available data on The Information Centre for Health and Social Care is 2015/16*

Indicator: Staff recommendation					
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.					
	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of staff who would recommend the Trust as a provider of care to family and friends when compared to other acute providers.	2010/11	57%	66%	95%	38%
	2011/12	57%	65%	96%	33%
	2012/13	61.5%	63%	94%	35%
	2013/14	67%	67%	89%	38%
	2014/15	67%	65%	89%	38%
	2015/16	72%	70%	*	*
	2016/17	77%	70%	95%	45%
The Luton and Dunstable University Hospital considers that this data is as described for the following reasons • The source of the data is the National Staff Survey.					
The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by: • The hospital runs with a clinically led, operating structure. • The Chairman and Non-Executive Directors have a programme of clinical visits and the experiences of each visit is reported to the Clinical Outcomes, Safety and Quality Committee. • Transforming Quality Leadership Group in place and supports areas across the Trust through a 'buddy' process. * Not available on the HSCIC website					

Indicator: Risk assessment for venous thromboembolism (VTE)					
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.					
	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of patients who were admitted to hospital and who were risk assessed for VTE.	2010/11 – Q4	90.3%	80.8%	100%	11.1%
	2011/12 - Q4	96.1%	92.5%	100%	69.8%
	2012/13 – Q4	95.3%	94.2%	100%	87.9%
	2013/14 – Q4	95.1%	96.1%	100%	74.6%
	2014/15 – Q4	95%	96%	100%	74%
	2015/16 – Q3	95.7%	95.5%	100%	94.1%
	2016/17 – Q3	95.74%	95.64%	100%	76.48%
The Luton and Dunstable University Hospital considers that this data is as described for the following reasons • There is a robust process for capturing the evidence of completion					
The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by: • The hospital has and will continue to ensure that all clinical staff are aware of the importance of timely VTE risk assessment of patients. This is undertaken at induction and through clinical bedside teaching. • There is daily clinical review and for any patient that have not been risk assessed, there is a follow up action to ensure that this is undertaken; this has resulted in achieving 95% and above throughout 2016/17. • We have implemented an electronic solution to the risk assessment process. • We undertake root cause analysis on all patients who develop a VTE.					

Indicator: *Clostridium difficile* infection rate					
The rate for 100,000 bed days of cases of *Clostridium difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period.					
	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Rate for 100,000 bed days of cases of *C. difficile* infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	5.1	15.1	62.2	0
	2015/16	5.4	14.9	66	0
	2016/17	3.5+	Not Avail*	Not Avail*	Not Avail*
The Luton and Dunstable University Hospital considers that this data is as described for the following reasons					

- The accuracy of the data is checked prior to submission. The data is also cross checked with laboratory data and verified before reporting to the Board.
- The Trust had 8 *C.difficile* for 2016/17 and this figure is one of the lowest numbers in the country.

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

- maintaining *C.difficile* high on the training agenda for all healthcare staff
- rigorously investigating all cases of *C.difficile* through the RCA mechanism and actioning all learning points identified
- assessing all patients suspected of *C.difficile* infection when alerted
- uncompromisingly isolating suspected cases of *C.difficile* when first identified
- attending the CCG Infection Control Network with its potential for shared learning
- monitoring high standards of environmental cleaning (including equipment) and exploring other mechanisms of reducing *C.difficile* contamination further

**Data not available on Health and Social Care Information Centre*
+ Local Data

Indicator: Patient safety incident rate

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.

	Reporting period	L&D Score	National Average	Lowest score (worst)	Highest score (best)
Total number and rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute trusts	2010/11	**	**	**	**
	2011/12	**	**	**	**
	2012/13	**	**	**	**
	2013/14	**	**	**	**
	2014/15	37.52	35.1	17	72
	2015/16	32.2	39.6	14.8	75.9
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Total number and rate of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2010/11	0.03	0.04	0.17	0
	2011/12	0.03	0.05	0.31	0
	2012/13	0.03	0.05	0.26	0
	2013/14	0.03	0.05	0.38	0
	2014/15	0.25	0.19	1.53	0.02
	2015/16	0.09	0.16	0.97	0
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*

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

- The hospital reports incident data and level of harm monthly to the National Reporting and Learning System
- 22 Serious Incidents were reported in 2016/17 compared with 32 in 2015/16, 46 in 2014/15 and 36 in 2013/14 (excluding pressure ulcers). One incident was downgraded in 2016/17 by the CCG on receipt of the investigation findings which identified that there were no acts or omissions in care that contributed to the outcome for the patient.
- The Trust reported 2 Never Events in 2016/17 under the following Department of Health criteria - a wrong implant/prosthesis, a wrong site surgery.
- The Trust is contractually required to notify its Commissioners of a Serious Incident within 2 working days of identification – in 2016/17 this target was met in 18 out of 22 cases (82%) compared to 21 out of 32 cases (66%) in 2015/16.
- The Trust is also contractually required to submit an investigation report for all Serious Incidents within 60 working days of the notification. During 2016/17 this target was met in 17 out of 19 cases (89%) compared to 20 out of 26 cases (77%) in 2015/16. Three incidents were still under investigation at the time of data collection but it is anticipated that these will all meet their deadlines for submission.
- The Trust continues to review its systems and processes to ensure it can meet the contractual requirements going forward.
- The Trust was 100% compliant with the Duty of Candour contracted requirements.

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

- The hospital has a low level of serious harm or death, however strives to continue to improve this through improved falls prevention, pressure ulcer avoidance mechanisms and improved learning from serious incidents.
- The hospital is a high reporting organisation and this demonstrates a culture of patient safety and openness. The hospital continues to ensure that patient safety is a quality priority and will continue to drive improvements.
- Learning from incidents is shared through Divisional Governance, Grand Rounds and Safety Briefings. Patient Safety Newsletters are issued to all staff each quarter and include a focus on learning from Serious Incidents. Examples of learning:
    - We have put in place closer monitoring of skin checks by Senior Nursing Staff

- We have introduced Paediatric High Dependency training days with skills stations
- We have introduced an intubation check list to introduced for Paediatric Emergency Intubation
- We have increased the level of support offered to new consultants in surgical specialties
- We have updated the WHO safer surgery checklist for cataract surgery to include a documented intraocular lens power
- We have introduced a multi-factorial falls risk assessment
- We have raised awareness of the early recognition and treatment of sepsis using agreed standards and protocols

*Data not available on Health and Social Care Information Centre
** NRLS amended their calculation from per 100 bed days to per 1000 bed days in 2013 so no comparable historical data available

5.9 Embedding Quality – Workforce factors

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

Recruitment and Resourcing

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

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

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

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

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

New starter questionnaires

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

Health Care Assistants (HCA's)

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

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

Agency Collaboration

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

Consultant Job Planning

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

Junior Doctor Contract

During 2016 the roll out of the new Junior Doctors Contract commenced and this will continue during 2017, with phased transition for all trainees in line with NHS Employer's timeline. The Trust appointed a Guardian of Safe Working and also established a Junior Doctors Implementation group that includes the Guardian of Safe Working, Director of Medical Education , Junior Doctors, General Managers, Finance and HR. The focus of the group is to ensure a smooth transition to the new contract by engaging with and listening to our Junior Doctors. The group also ensure that all actions are communicated to relevant staff

who may be directly impacted by new contract. The Medical Workforce team regularly attend the Regional Medical Personnel Specialist group meetings to ensure there is parity and shared practice with other local Trusts.

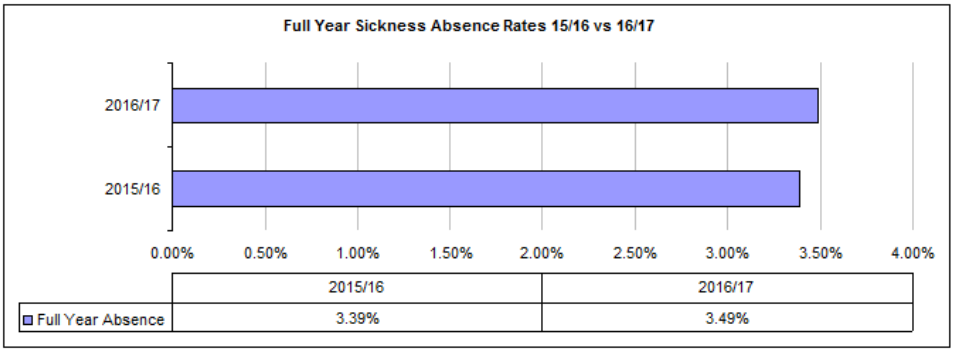
Managing Absence

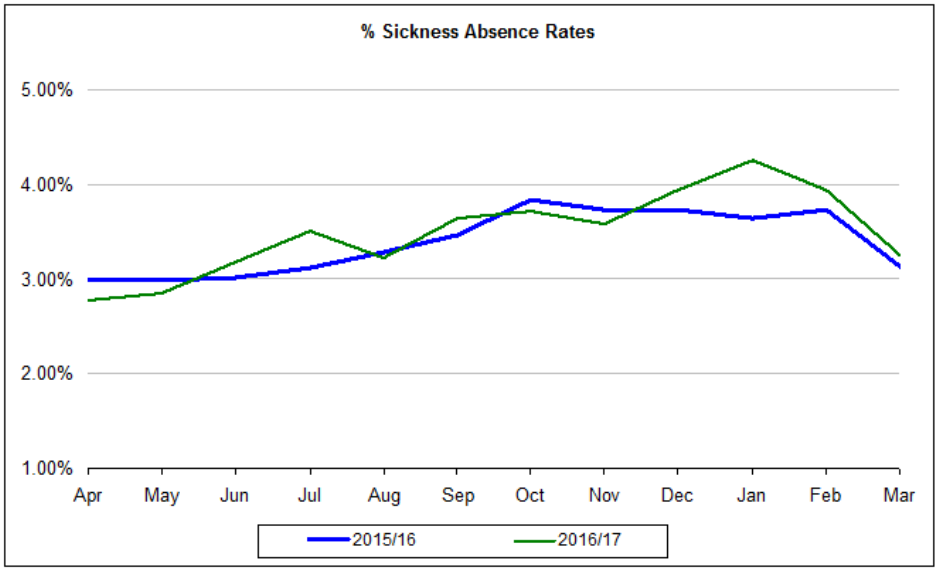
In October 2016, the Trust reduced the Bradford Score trigger point from 200 to 150 as a way of managing employee attendance more effectively through providing earlier formal support and continuing to deliver against the Trust's operational requirements.

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

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

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





Staff Engagement and Consultation

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

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

Partnership working is demonstrated in many varied ways for example:

Staff Involvement Group

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

Staff Recognition

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

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

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

Communicating and engaging with our staff

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

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

Examples of staff communications and engagement include:

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

Staff Involvement Group Newsletter

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

Engagement events 2016

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

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

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

Our Volunteers

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

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

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

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

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

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

During 2016/2017:

- Our Trust volunteers gave us a total of over 22500 hours, which is the equivalent to 11.5 full time band 2 staff.
- 87 new volunteers were recruited and there were a total of 85 Leavers. Of the other volunteers who left during this period, 4 returned as University of Bedfordshire Nursing and Midwifery students.
- 3 former volunteers have secured permanent or bank employment within the Trust.

National Volunteers Week is held during the first week of June each year .The Grove Theatre in Dunstable hosted the 'Cheering Volunteering Awards' which were organised by Central

Bedfordshire Council. David McDonald one of our own Main Reception volunteers was the proud recipient of an 'Outstanding Contribution' award for his professionalism and for the average 375 hours he gives us each year.
In November we worked with Nationwide Building Society who provided their support as part of their Employee Community Volunteering Programme. They transformed the garden area of our NICU parents bungalow and the balcony outside the Chemotherapy Unit. Their visit was a huge success and provided an excellent opportunity for positive publicity, they will be returning once again in May this year.
New roles this year include assisting Medical Education with the Junior Doctors mock OSCE exams by acting as patients and volunteers are now assisting with PLACE assessments. We have also extended volunteer cover to include weekend Pharmacy TTA deliveries.

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

Health and Wellbeing / Occupational Health

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

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

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

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

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

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

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

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

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

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

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

Health Checks for staff

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

Fruit and Vegetable Market Stall

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

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

Staff Health and Wellbeing questionnaire

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

- Occupational Health Department services
- Health and wellbeing emails

- Free on site eye tests
- Fruit and Veg Stall
- NHS Discounts

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

2016 NATIONAL STAFF SURVEY SUMMARY OF RESULTS AND ACTION PLAN

1. Introduction

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

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

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

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

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

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

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

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

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

2. Response Rates

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

* Acute Trusts

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

3. Staff Engagement

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

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

4. Key Findings

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

4.1 Top Ranking Scores

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

Top 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	54%	45%	36%	37%	Increase (better than)	Highest (best) 20%

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

- KF1 –-Staff recommendation of the Trust as a place to work or receive treatment
- KF2 - Staff satisfaction with the quality of work and care they are able to deliver
- KF3 - %agreeing that their role makes a difference to patients/service users
- KF4 - Staff motivation at work - highest (best) 20%
- KF5 - Recognition and value of staff by managers and the organisation - highest (best) 20%
- KF6 - %reporting good communication between senior management and staff
- KF8 - Staff satisfaction with the overall responsibility and involvement –highest (best) 20%
- KF10 - Support from immediate managers
- KF13 - Quality of non-mandatory training, learning or development
- KF14 - Staff satisfaction with resourcing and support
- KF24 - % reporting most recent experience of violence - highest (best) 20%

4.2 Bottom Ranking Scores

Bottom 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 16 % of staff working extra hours***	79%	72%	75%	72%	No significant change	Highest (worst) 20%
KF 20 % of staff experiencing discrimination at work in the last 12 months	15%	11%	12%	10%	No significant change	Highest (worst) 20%
KF 22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	15%	15%	14%	No significant change	Highest (worst) 20%

Bottom 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%	27%	30%	28%	No significant change	Highest (worst) 20%
KF 32 Effective use of patient/service user feedback	3.62	3.72	3.65	3.70	No significant change	Lowest (worst) 20%

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

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

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

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

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

Improvements	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 5 Recognition and value of staff by managers and the organisation	3.55	3.45	3.41	3.42	Increase (better than)	Highest (best) 20%
KF10 Support from immediate managers	3.79	3.65	3.65	3.69	Increase (better than)	Highest (best) 20%

Improvements	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF19 Organisation and management interest in and action on health and wellbeing	3.75	3.61	3.56	3.57	Increase (better than)	Highest (best) 20%
KF27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	54%	45%	36%	37%	Increase (better than)	Highest (best) 20%

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

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

5.10 Improving the quality of our environment

The Trust actively engages with patients through the Patient Led Assessment of the Care Environment (PLACE) initiative.

An annual inspection, led by a nominated patient representative, is undertaken as directed by the Department of Health. In addition to the annual inspection, monthly inspections are undertaken, again led by a patient representative and supported by Non-Executive Directors of the Trust. Information received from inspections is used to improve the patient environment and patient experience.

Improvements have been made to car parking with extra spaces now available for our patients and visitors.

In the year, a number of schemes of work have been undertaken to improve facilities for our patients, this includes:-

- Creating additional side rooms on wards
- Conversion of outpatient areas into new inpatient accommodation
- Refurbishment of existing chapel to create new multi faith place of worship
- Conversion of existing delivery suite room to include birthing pool

Looking forward into 2017/18, the Trust already has advanced plans to make further improvements to the hospital estate with:-

- Improvement to the existing Neo Natal accommodation
- Refurbishment of outpatient areas
- Expansion of endoscopy services
- Expansion of maxillofacial department

In the coming year, a number of schemes of work for the hospital estate are planned to take place. The works underpin our commitment to keep patients safe at all times; these works include the replacement of the automatic fire detection system, reinforcement works to power supplies and replacement of old heating systems.

5.11 Quality and Business Strategy

One of our key approaches to delivering high quality sustainable care is our Reengineering programme focussed on delivering care more efficiently and effectively. This is a formal programme to resolve the fact that overall systems and processes are not functioning to a maximum level of efficiency and that potential improvements represent a key opportunity to improve both quality and efficiency.

The overarching governance is through monthly dedicated Executive Board, and at Board Committee level through the Finance, Investment and Performance Committee. The Trust has a dedicated Executive Director to ensure delivery. Each scheme is described below and has its own project structure and quality impact assessment.

We have also continued to market its services to GP's and held a range of events to promote our services, where expert speakers have drawn consistently good attendances. These will continue, but will take place on the margin of our traditional catchment areas. We have worked hard to ensure we are the easiest place to refer to clinically, the quickest place to see patients, and can clearly evidence and promote the quality of our services. This will involve enhanced investment in marketing materials, but will require careful alignment with capacity released by re-engineering our processes. We have launched a strategically important maternity hub in Leighton Buzzard including the delivery of antenatal imaging conveniently located for local appointments. We have also been successful in securing a contract to deliver an innovative modern Sexual Health service for the area of Luton.

5.12 Review of Quality Performance - how the Trust identifies local improvement priorities

The hospital agreed the Corporate Objectives for 2014 – 2016, and these include the quality objectives. The Trust Governors were engaged with the development of these objectives.

The list of clinical indicators which were developed and added to in previous years remain included. People identified those indicators most important to them and also stated the elements of care that they would want the Trust to concentrate on improving.

Amendments to the quality priorities have been considered by staff in management executive based on performance and improvement needs.

Quality is discussed and monitored at quarterly monitoring meetings with our local Clinical Commissioning Groups. There remains a high level of agreement among the various groups of people that have contributed to determining priorities.

6. Statement of Directors' responsibilities in respect of the Quality Report

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to March 2017
  - papers relating to Quality reported to the board over the period April 2016 to May 2017
  - feedback from commissioners dated ???
  - feedback from governors dated 15/02/2017
  - feedback from local Healthwatch organisations received [not received at time of signing]
  - feedback from Overview and Scrutiny Committee (Luton OSC are not providing feedback and Bedfordshire OSC are reviewing the account on the 31/05/16)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/08/15, 23/10/15, 25/01/16 and 25/04/16
  - the 2016 national patient survey ??
  - the 2016 national staff survey 7/3/2017
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 18/5/16
  - CQC Intelligent Monitoring Report dated May 2015

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

- the performance information reported in the Quality Report is reliable and accurate; We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

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

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

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

24th May 2017
.....Date.....Chairman

24th May 2017
.....Date.....Chief Executive

Note: An Equality Analysis has been undertaken in relation to this Quality Account.

7. Comments from stakeholders:

NHS
Luton
Clinical Commissioning Group

Central Bedfordshire Council's Social Care, Health and Housing Overview and Scrutiny Committee

Comments from Luton Borough Council Health and Social Care Review Group

L&D Hospital NHS Foundation Trust Quality Accounts 2015-16

Comments were requested from Healthwatch Luton and Healthwatch Bedfordshire.

Comments requested – 28th April 2016
Comments chased – 24th May 2016 – no comments received as at 25th May 2016

Comments received from the Trust Stakeholders

Comment	Response

8. Independent Auditor's Assurance Report

9. Glossary of Terms

Term	Description
Anticoagulation	A substance that prevents/stops blood from clotting
Arrhythmia	Irregular Heartbeat
Aseptic Technique	Procedure performed under sterile conditions
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
CCG	Clinical Commissioning Group.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
Continence	Ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.
DME	Division of Medicine for the Elderly
Elective	Scheduled in advance (Planned)
EOL	End of Life
Epilepsy	Recurrent disorder characterised by seizures.
EPMA	Electronic Prescribing and Monitoring Administration system in place.
Grand Round	A lunch time weekly meeting with consultants and junior medical staff to communication key issues and learning.
HAI	Hospital Acquired Infection

Term	Description
Heart Failure	The inability of the heart to provide sufficient blood flow.
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
HSMR	Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate.
Laparoscopic	Key hole surgery
Learning Disability	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
LIG	Local Implementation Group
Meningococcal	Infection caused by the meningococcus bacterium
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
MUST	Malnutrition Universal Screening Tool is a nutritional assessment that is carried out on inpatients to ensure that they are maintaining their body weight
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Myringotomy	A surgical procedure of the eardrum which alleviates pressure caused by the build up of fluid
Neonatal	Newborn – includes the first six weeks after birth
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	Degenerative disorder of the central nervous system
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
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

Term	Description
	urinary tract infections, and Venous thromboembolism
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
SEPT	South Essex Partnership University NHS Foundation Trust
SHMI	Summary Hospital-level Mortality Indicator (**SHMI**) is an indicator which reports on mortality at trust level across the NHS in England using a standard
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply
Syncope	Medical term for fainting and transient loss of consciousness
Two week wait	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins

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

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

Local Clinical Audits

Local Clinical Audits April 2016 – March 2017 (Projects managed by the Clinical Quality Department)

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
AUDIT OF PREGABALIN & OXYCODONE USE IN PATIENTS REVIEWED BY PAIN SERVICE **N = 21**	**Anaesthetics**	**April 2016**	**Main Aims:** • Examine prescriptions/suggestions made by pain service related to pregabalin and oxycodone • Examine the presenting complaint and appropriateness of the prescription • Examine the reason for prescribing the drug • Examine if first line analgesic had been used prior to prescribing prgabalin or oxycodone **Findings:** • The predominant presenting complaint that resulted in prescription of either pregabalin/oxycodone was neuropathic/chronic pain condition (66%). 33% were acute pain or post-operative pain. This is appropriate and in line with primary care guidance • All patients had tried other opioid analgesics or anti neuropathic agents before switching to oxycodone or pregabalin • The doses prescribed or suggested by the pain service were in line with current guidance related to safe opioid prescribing **Key Recommendations/Actions:** • No risks identified
PRE-OPERATIVE FASTING IN ADULTS **N= 31**	**Anaesthetics**	**May 2016**	**Main Aims:** • Assess compliance with national guidance on pre-operative fasting in adults • Identify areas of good compliance • Identify areas of poor practice with a view to making improvements The proposed standards from the Royal College of Anaesthetist, for best practice, that were taken into consideration were: • 100% of healthy elective adult patients should be permitted to drink water or other clear fluids until 2 hours before the induction of anaesthesia. Patients should be

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			encouraged to drink clear fluids up until 2 hours before elective surgery **Findings:** • Ninety four percent of patients stated the time of last fluid intake was more than 2 hours prior to surgery • Fifty five percent of patients felt they were thirsty/dehydrated before their operation • Fifty eight percent of patients were unaware they could drink until 2 hours before surgery • Eighty four percent of patients were an ASA grade of I & II, the remaining 16% had a ASA grade of III or above **Key Recommendations/Actions:** • To raise patients' awareness by improving communication with them. • To inform patients promptly when a delay happens to keep themselves rehydrated. • To find a sample letter sent to patients containing fasting instructions and adjust accordingly, if necessary. Action: Communication with waiting list manager, Fyne Brenda to see pre-assesment letter sent to patients and amend it if needed.
RECORD KEEPING AUDIT 2015 – GYNAECOLOGY **N = 20**	**O&G**	**May 2016**	**Main Aims:** To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings **Findings:** • 47% of standards fully compliant • 14% of standards with high compliance • 16% of standards with moderate compliance • 23% of standards with low compliance **Key Recommendations/Actions:** • The use of patient specific EVOLVE in patient sheets. • Staff need to be aware that whoever makes the first written entry is responsible for completing these details. • Use of stamps • The importance of clear handwriting to be fed back to staff

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
VENOUS THROMBOEMBOLISM RE-AUDIT OF NICE CG 92 GENERAL SURGERY **N = 121**	**General Surgery**	**May 2016**	**Main Aims:** Overall purpose to re-measure compliance with the standards identified in NICE CG 92. Specifically to: • Identify improvements following the audit completed in 2013 • Identify whether L&D are adhering to NICE guidance • Identify areas where compliance with the recommendations made by NICE need to be improved • Identify areas of good practice **Findings:** High compliance with 3 standards; suboptimal compliance (<74%) compliance with 3 standards. Areas of por compliance include: assessing patients on admission to identify those who are at high risk of VTE; assessment of risk of bleeding and VTE within 24 hours of admission and whenever clinical situation changes; encouraging patients to mobilise as soon as possible **Key Recommendations/Actions:** Thought likely that these results reflect a problem with data capture (poor record keeping) rather than an omission in clinical care. It was agreed that changes could be made to the surgical admissions proforma to make it easier to record assessments and advice to mobilise. Dr Taylor will liaise with Miss Brown regarding changes to the proforma
AUDIT OF THE USE OF PCA POST-OPERATIVELY FOR LAPAROSCOPIC HYSTERECTOMIES **N = 21**	**Anaesthetics**	**June 2016**	**Main Aims:** • To review the current practice of anaesthetic management of patients undergoing laparoscopic hysterectomy in our trust. • To identify the key elements essential in establishing a successful ER program after laparoscopic Hysterectomies in our trust. • To suggest practical recommendations on the peri-operative anaesthetic policies for an ERAS pathway in gynaecological surgeries. **Findings:** • The majority (72%) of the patients included in this audit were classified as ASA grade 2 and only 28% were written as ASA grade 1. • 85% of the patients had a consultant grade anaesthetist delivering the peri-

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			operative anaesthetic care. • We found that the average length of stay for these patients undergoing laparoscopic hysterectomies were 2.7 days. However, the maximum number of days any patient stayed in the hospital after laparoscopic hysterectomies was found to be 7 days. We didn't probe into the reasons for this delayed discharge but post-operative ileus, PONV and inadequate pain relief could have been a few possible causes. • Looking at the intra-operative analgesia given in these patient we found that almost all of the patients received paracetamol (91%), fentanyl (81%) and intermittent morphine(81%).There was a relatively small percentage of patients receiving NSAIDS (33%).We did notice a small but striking number of patients receiving short acting opioids infusion(29%) intraoperatively. Only one patient was reported to have received combined spinal anaesthesia (CSE). • The results from the post-operative analgesia prescribing demonstrated that a large majority of the patients had regular Paracetamol prescribed (91%).We found that more than half of the patients(62%) had a PCA morphine written up for post-operative pain relief and the remaining 38% patients had intermittent morphine prescribed. One patient had a PCA oxycodone setup for pain relief. Again there were a relatively small number of patients who were prescribed NSAIDS (48%) post-operatively. • We recorded the pain scores in all these patients in the immediate post-operative period and at different time intervals (6hrs, 12hrs, 24hrs, 3 days and at discharge). • We found that in the immediate postop period 52% patients had a pain score of zero.19% of the patients were having moderate pain and in 23% patients pain was recorded as severe pain. • Based on post-operative analgesia prescribing we broadly grouped the patients into one who received a PCA (patient controlled analgesia e.g morphine and oxycodone) and the other without a PCA. We then compared the pain scores in these two groups at different time intervals. We found that the pain scores at various time intervals in both the groups were more or less the same, hence suggesting that the group with PCA analgesia were not getting any added benefits in terms of pain relief. Thus helping us draw a conclusion that PCA for laparoscopic hysterectomies in not essential. **Key Recommendations/Actions:**

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			• STANDARDISED ANAESTHETIC PROTOCOL (SAP) for Enhanced Recovery in laparoscopic hysterectomies • Liaise with the Enhanced recovery team of our trust to help in implementation of the Enhanced recovery protocol (anaesthetic component) for gynaecological surgeries. • Disseminate the information • Auditing Compliance post-ERAS protocol for gynaecology surgery
OPHTHALMOLOGY INTERNAL HEALTH RECORD KEEPING AUDIT 2015/2016 **N = 30**	**Ophthalmology**	**June 2016**	**Main Aims:** • To measure compliance with standards set out by NHSLA, CQC and local guidelines. **Findings:** • Standard Fully Compliant (100%) = 90% • High Compliance (91 – 99%) = 3% • Moderate Compliance (75 – 90%) = 2% • Low Compliance (<75%) = 5% **Key Recommendations/Actions:** • Poor compliance with documentation on Consent Form (patient dating form and printing names): Ensure this is fully completed by the patients • Poor compliance with documentation of initial patient history: To be fully completed by health care professional • Availability of prescription chart or ePMA: This is a must for all patients
RE-AUDIT OF 'SAFE PAEDIATRIC INTUBATION IN A&E AND PAEDIATRIC WARDS (PAEDIATRIC EMERGENCY INTUBATIONS)' **N = 20**	**Anaesthetics**	**July 2016**	**Main Aims:** • To have an initial assessment of the resources available for remote site paediatric emergency airway management • To identify the key components essential in establishing a standardised airway resource (equipment and monitors) for out of theatre paediatric intubations in our Trust • Endorse a multi-disciplinary approach to improve resources, bring about changes in practice to ensure safe airway management and maintain the standards set out by the AAGBI and RCoA. **Findings:** • In forty five percent of the paediatric emergency intubations the paediatric registrar

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			was not present. **(LOW COMPLIANCE)** • In thirty five percent of the paediatric emergency intubations an ODP (operating department practitioner) was not present. **(LOW COMPLIANCE)** • In all 20 cases there was a Bag-valve-mask apparatus available (100%). **(FULLY COMPLIANT)** • In 19 cases there were laryngoscope, bougie and endotracheal tubes available (95%) **(HIGH COMPLIANCE).** • In all 20 cases there was an end-tidal CO2 monitor available (100%) **(FULLY COMPLIANT).** • In all 20 cases a pulse oximeter, non-invasive blood pressure monitor and ECG monitor were available (100%) **(FULLY COMPLIANT).** • Eighty five percent of the paediatric emergency intubations were supervised by a consultant Anaesthetist, seventy percent were attended by a paediatric consultant and a hundred percent emergency intubations were attended by a Neonatal Consultant **(LOW TO MODERATE COMPLIANCE).** **Key Recommendations/Actions:** • A dedicated '**Paediatric Airway Trolley'** to be positioned in these areas. This Paediatric airway trolley should be the gold standard of resource provision for increasing the safety of emergency paediatric airway management. • Regular maintenance of the Airway Trolley in the form of keeping a checklist. • ODP to be included in the '**Paediatric Emergency Airway'** call alerts/fast bleeps. • Paediatric Resus bag to be moved from theatres (A-D) to paediatric ward.
AUDIT OF THE ADMINISTRATION OF INTRAVITREAL INJECTIONS IN OPHTHALMOLOGY **N = 15**	**Ophthalmology**	**July 2016**	**Main Aims:** The overall purpose of the audit is to measure compliance with the revised protocol of administration of intravitreal injections. Specifically to: • Identify whether the Ophthalmology Department are adhering to the revised protocol • Identify areas where compliance with the protocol need to be improved • Identify areas of good practice **Findings:** 100% compliance with all standards identified

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			Key Recommendations/Actions: No risks identified. 100% compliance achieved with all standards.
ESSENCE OF CARE RESPECT & DIGNITY TRUSTWIDE AUDIT 2015 **Patient Survey N = 183** **Data Collector N = 55**	**Corporate**	**August 2016**	**Main Aims:** The survey aims to provide information about patients' experiences of respect and dignity during their stay or visit. It also aims to identify compliance with the benchmark and local guidance, and then highlight any problems as well as areas of good practice with a view to making improvements **Findings:** • 99%of patients felt they had enough privacy when being examined and treated always, and 3% felt this was the case sometimes. • 99% of patients felt curtains were well fitting and long enough to provide adequate privacy. • 83% of patients stated staff always knock/ask before entering their bed area/room. A further 15% stated staff sometimes knock/ask before entering. • 92% of patients felt they always had enough privacy when using the commode or toilet. Ninety three percent of patients felt they always had enough privacy when washing by their bed. • 88% of patients always felt their personal space/bed area was respected and protected. • Only 75% of patients stated that staff always introduced themselves on initial contact, and 76% stated that staff discussed what name they would like to be called by. • 89% of patients felt they were always given enough privacy when discussing their condition or treatment. A further 8% felt this was the case sometimes • 22% of patients felt that information about them was shared inappropriately, i.e. in a way that could be overheard or overseen. • Most patients were either always (88%) or sometimes (12%) happy with the way in which staff communicated with them. • 97% of patients felt they have been supported by staff to maintain confidence and a positive self esteem. • 95% of patients felt they have been listened to and have been supported to express

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			their wants and needs. • All patients felt their modesty was maintained when moving between wards/departments. • 98% of patients felt they have been treated with dignity and respect throughout their time in hospital, and 99% of patients were overall satisfied with their experience with regards to respect and dignity. • 61% of wards/areas were divided into male/female sides/ends. • 86% of areas stated their patients were in single sex bays • 59% of areas stated their toilets/washrooms were single sex • Most toilets/bathrooms were lockable. • 87% of areas had a nurse call bell in place in toilets/washrooms which patients could access in case of an emergency. • 85% of areas felt their toilets/washrooms were well maintained and cleaned regularly. • For 6% of areas confidential information about patients is on display. • Only 63% of areas had a room for patients and relatives where discussions could be carried out in private. • 47% of areas do not have privacy signs on bed curtains. • 31% of areas stated they do not have sufficient supplies of night clothes on their ward • In 63% of areas all staff were aware of respect and dignity guidelines and in 37% some staff were aware of the guidelines. **Key Recommendations/Actions:** • Reinvigorate the 'hello my name is' campaign • Include in daily safety briefing for 2 weeks (preferred name to be documented in handover and on the patients board above the bed/chair) • All nurses to have a whiteboard marker in their pocket to facilitate them writing their name on the patient status board – to be checked each morning by the nurse in charge • Implement as part of new paperwork launch • Distribute hospital gown guidance poster around the hospital (see breast screening

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			guidance) – investigate potential of including this in the 'Nursing News' • Review hospital dressing gown availability • Liaise with communications team to ensure this is included in the new build signage plans • Quote for costs to install signage across the hospital (bulk order) • Trial new blue curtains with privacy embroidery
PSORIASIS: ASSESMENT AND MANAGEMENT NICE CLINICAL GUIDELINE 153 **N = 30**	**Dermatology**	**July 2016**	**Main Aims:** • The overall purpose of this audit is to measure compliance with the standards identified in NICE Clinical Guideline 153. Specifically to: - Identify areas of good practice - Identify areas of practice which require improvement **Findings:** • Not 100% in recording of DLQI, PASI AND PEST. • Not all patients with suspected psoriatic arthritis were referred to Rheumatology. • Narrowband UVB offered appropriately except in 1 patient. • Systemic treatment offered appropriately in all patients, except in 5 patients where no info available as they have been on systemics pre-2009. • 5 patients in total managed appropriately on topicals only **Key Recommendations/Actions:** • To record DLQI, PASI and PEST at first visit, pre and post start of new treatments and then at least once a year. To get PEST form on evolve. • Any patients with PEST 3 or more can be referred directly to Rheumatologists • Undertake audit for phototherapy and relapse
RE-AUDIT OF SAFER MEASUREMENT AND ADMINISTRATION OF ORAL LIQUID MEDICINES **N = 26**	**Corporate**	**September 2016**	**Main Aims:** • Assess practice in all clinical areas against the standards for oral liquid medicine administration to enable improvements in practice where needed. The aim is to ensure we provide safe care to our patients **Findings:** • 100% compliance with all standards. **Key Recommendations/Actions:** • No risks identified

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
OMFS INTERNAL HEALTH RECORD KEEPING AUDIT 2015/2016 **N = 20**	**OMFS**	**November 2016**	**Main Aims:** • To measure compliance with standards set out by NHSLA, CQC and local guidelines. **Findings:** • Standard Fully Compliant (100%) = 57% • High Compliance (91 – 99%) = 7% • Moderate Compliance (75 – 90%) = 18% • Low Compliance (<75%) = 18% **Key Recommendations/Actions:** • Ensure all entries made within patient notes are named, signed, dated, timed and legible. Findings of audit shared/presented to department to improve awareness • Ensure all relevant information is included within electronic discharge letters. If no clinical information is required or a particular box on he discharge letter, it should be specified that it is not applicable to the patient as it cannot be assumed so. Findings o audit shared/presented to department to improve awareness • Ensure all communication with patients/carers is documented within medical records
PATIENT IDENTIFICATION AUDIT 2016 **N:** **INPATIENT = 261** **OUTPATIENT = 80**	**Corporate**	**December 2016**	**Main Aims:** • Measure compliance with the Trust Policy on Patient Identification. Specifically to identify whether staff are adhering to the policy; identify areas where compliance with the policy need to be improved; identify areas of good practice **Findings:** • Inpatients: The most significant finding that poses a risk to the safety of our most vulnerable patients is that patients with diminished capacity appear not to have the ward identifier written onto their name bands routinely. Patients who are most likely to wander off the wards must be kept safe by enabling their early return to the safest place for their care to continue. • Outpatients: In the past year, one never event and one near miss event occurred whereby patients responded to a call for a different patient. An elderly lady received an injection into her eye intended for a different patient and a child had blood taken by a phlebotomist who had called a different patient. It is vital that action is taken to

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			ensure that patients are appropriately identified in the outpatient setting. **Key Recommendations/Actions:** 33% of patients with diminished mental capacity or may pose a risk to themselves by wandering off the ward, had had the ward identifier manually added to their wrist band. 100% of these patients should have the ward identifier written on. Risk is that if the patient does wander off the ward, it will be more difficult to relocate them. In accordance with 2.2.5 of the patient ID policy, all patients with reduced mental capacity or may pose a risk by wandering off the ward/dept., pts. must have the ward / dept. written onto the name band. 1. Present audit finding and remind nursing teams through Matron's meeting 2. Send out a mini presentation with case study to all ward managers to share with their teams each handover for two weeks. 3. Article in Nursing News 4. Put a laminated mini SOP near the ID band printer by way of visual reminder 5. Present finding and actions at Sisters meetings (January) 6. Matrons to review name bands of patients with DoLS in place as these are the higher risk patients 7. Mini audit by end of February 2017. 8. Review the ID policy to make the action a 'must do' (rather than a 'may do') Not all patients were checked for verbal identify in OPD (reception and upon being called into a consulting room) in accordance with the policy. There is a risk that patients will respond to someone else's name being called and this will not be picked up until it is too late (e.g. patient may have procedure or consultation which was intended for another patient). Actions include: 1. Review the patient ID policy to ensure that OPD checks for ID are in line with best practice and meet confidentiality requirements. 2. Incorporate ID checking procedure into customer care training for OPD admin staff. 3. Prepare mini presentation using case studies and action points 4. Incorporate patient ID checks into LOCSSIPS (as part of NatSSIPs programme) 5. Cascade information for consultants via Clinical Directors 6. Cascade information via Nisha Nathwani for Junior Doctors 7. Use team meetings to discuss and raise awareness 8. Local audits broken down by speciality in OPD to review practice

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			9. Exit interviews with patients to explore their experience of identity checks. Not all staff have read the updated patient ID policy (61% had read it). Actions include: 1. To produce a summary of the key, most important elements in the Nursing News. 2. To produce a summary of the key most important elements relevant to groups other than nursing, for the patient safety news 3. Cascade key messages via CDs, MD for med education, Matrons, Sisters and admin management teams
WARD AUDIT 2016 - ARE DRINKS THICKENED TO THE CORRECT CONSISTENCY? **N = 35**	**Therapies**	**February 2017**	**Main Aims:** • Establish to what extent drinks are being thickened to the recommended consistency across the elderly and stroke wards • To establish, if possible, reasons for drinks being the wrong consistency • To create some learning points/ actions for improving adherence to recommended thickening of drinks **Findings:** • Out of the 35 cases audited, in 4 cases (11 %) no drink was available to the Patient. There were 17 cases (49%) where the drink provided was an incorrect consistency. Only in 14 cases (40 %) out of the audited sample the drink provided was the right consistency. • 47 % (8/17) of the incorrect consistency drinks were served in Blue cup (250 ml) followed by red cup 29% (5/17), white plastic cup 18% (3/17) and white paper cup 6% (1/17). • In summary, the main findings demonstrate that action is required to ensure that patients receive their drinks with the correct consistency and to improve availability of these fluids in order to keep patients safe. Though within the 4 cases where there was no drink available, it may have been that a patient had finished a drink, which was then replaced after the data was collected. • 47% of the drinks prepared to the incorrect consistency were in the blue 250ml cup, followed by the red 200ml cup. There is a wide range of cups available to patients on the ward, and this therefore changes the amount of thickener needed to achieve the correct consistency drink, dependent on the volume of the cup used. • Volumes are also not indicated on any of the cups available (though Speech and Language Therapy bed signage does explain how to thicken drinks within the white plastic 150ml cup). The variety of cups, and lack of labelling may have led to

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			confusion for staff or patients when thickening drinks. • Out of 17 drinks which were thickened to the incorrect consistency 11 were prepared by Unknown person representing 65 % (11/17), followed by 4 drinks prepared incorrectly by a Nurse 23% (4/17) and 2 drinks were prepared to the incorrect consistency by a Health Care assistant. (2/17) 12%. Please refer to the above tables for detailed analysis and breakdown. • While additional training may be beneficial to ensuring drinks are correctly thickened by staff, a trust policy/clinical guideline may also aid staff adherence to modified consistencies. • It was also of note that on all occasions there was no further written instructions (apart from the bed signage given by Speech and Language Therapy) available to the patient or staff which described how to make a thickened drink to the advised consistency. Speech and Language Therapists could have left leaflets with further information on thickened consistencies to aid staff and patients in adhering to our recommendations. • Additionally the audit so far gives statistical data, without indicating solutions to the problems highlighted, and therefore a follow up questionnaire will be sent to each ward to indicate what staff feel would be helpful in improving drinks being appropriately thickened. **Key Recommendations/Actions:** • The audit findings will be presented at Nutrition Steering Committee meeting 2017 and relevant Audit and Clinical Governance meetings • Annual training to continue to be provided to nursing/HCA staff by a Resource trainer • Discuss with the wards how they would like information to be displayed (Resource manual, posters on trolleys, posters in kitchen?) • Speech and Language Therapists to leave leaflets for each patient who requires thickened consistencies, which explain how to make a thickened drink.
MENTAL CAPACITY ACT AUDIT 2016 **N:**	**Corporate**	**February 2017**	**Mains Aims:** • To receive feedback from Medical/Nursing staff to identify the current level of knowledge and awareness of procedures relating to mental capacity, and to identify gaps in education and training needs

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
Documentation Review = 41 **Staff Survey = 37**			• To measure compliance with completion of Mental Capacity Act documentation **Findings:** **<u>Documentation Review</u>** 38/41 of clinical records reviewed evidenced the need for a Mental Capacity Assessment to be completed. Of the 38 cases where the need for a Mental Capacity Assessment was identified, only 28 were completed. Of these 28 completed Mental Capacity Assessments, only 9 were completed fully with all domains filled and required information documented. The key areas identified within this part of the Audit were: • Missing signatures. • No evidence that a Best interest decision was made as the section had no documentation or was incomplete. • No evidence to support staff attempted various means of communication during the assessment period. A best interest decision was deemed necessary in 31/38 of the cases reviewed which evidenced that in 6 cases a decision was made without a capacity assessment being completed. A common theme was that the consent form 4 was completed in place of a Mental Capacity form. Around 50% of the cases where a need was identified for family/advocacy to be involved showed no evidence of this occurring. Only 15/24 reviews of a prior best interest decision took place. Examples of required reviews included a decision to treat cancer, reconsideration of the best means to obtain an MRI and several Deprivation of Liberty Safeguards. In 72% of cases reviewed, there was no evidence of communication methods being

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			adapted to meet the needs of the patient (e.g. simple language, pictures, interpreters). There was, on occasion, evidence of advice given from specialist teams on how this could be achieved. Throughout this part of the audit there was a common theme that staff often worked on the assumption that a patient did not have capacity without formally assessing and fully evidencing how they came to that decision. **Staff Survey** Overall, the majority of staff understood the term mental capacity, however some thought that this was related to a patient's mental health, diagnosis or ability to care for him/herself (basic tasks). Some staff referred to a patient being able to make a "right" or "sensible" decision. The majority of staff understood knew when a Mental Capacity Assessment should be completed, however several also stated that this should be done for every patient on admission or at each shift change rather than it being a time and decision specific task. Many staff members answered that they would document capacity assessments and best interest decisions in medical notes, rather than on MCA paperwork. The majority of staff understood when a Best Interest decision would be required, however the theme of assuming that a person didn't have capacity based on a diagnosis, with no evidence of assessing this, was present again. The majority of staff clearly evidenced how to access advice/support in relation to Mental Capacity. Only 2/37 staff members were unsure of where to find advice and guidance on this subject. Only 9 out of 41 staff members asked said that they would be confident to complete a capacity assessment, although a small number stated that they would with support / following training.

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			When asked, who is responsible for completing a Mental Capacity Assessment, most staff answered that they felt it was the responsibility of the medical/specialist teams. Approximately 50% of people asked how they would assess someone's Mental Capacity gave a correct answer. 17/37 staff either did not know the answer or documented an answer evidencing a lack of understanding in what to do if they were informed a POA or Advanced decision existed. Out of the remaining staff questioned there was evidence to show they would either check the paperwork for authenticity or seek help from their peers/specialist teams. **Key Recommendations/Actions:** • The audit identified 2 key themes: a lack of knowledge and understanding of Mental Capacity Act processes amongst staff; a lack of confidence in assessing someone's mental capacity formally. **Action**: To introduce new Level 3 Adult Safeguarding Training Programme which will provide detailed learning on Mental Capacity Act and the completion of Mental Capacity Assessment forms. This will be aimed at particular clinical staff grades to ensure compliance with the MCA 2005 • A need for awareness of the MCA 2005 was identified in some key areas where mental capacity assessments are not commonly required and therefore not common practice. Staff felt they required further training to increase their confidence and knowledge ensuring they can identify/complete an assessment when required. **Action:** To complete a Mental Capacity Training Day – Perinatal Study Day • Increase knowledge and awareness of the MCA 2005 and the legal implications. **Action:** Joint training day or clinical staff alongside the Trusts Legal Team on the Mental Capacity Act 2005 • For staff to have easy access to templates/examples that can assist them in the completion of a MC assessment. **Action:** Upload good examples of MC Assessments to the Trust's intranet to be used as guidance by staff members undertaking these assessments • Feedback of findings. **Action:** To present the findings of the audit at the Medical Grand Round, NMB and Ward Sister's Meeting

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
RE-AUDIT OF AETIOLOGICAL INVESTIGATION OF CHILDREN WITH PERMANENT HEARING IMPAIRMENT **N = 28**	**ENT**	**February 2017**	**Main Aims:** • Assess efficiency of Joint Paediatric Audiology Clinic • Establish current practice of aetiological investigations for PCHI at L&D Hospital in line with the guidelines produced by British Association of Audio vestibular Physicians and British Association of Paediatricians Audiology • Identify improvements following the baseline audit • Identify areas requiring further improvement **Findings:** • Only 18% of newly diagnosed children with permanent hearing loss were seen within 4 weeks of referral. This is a significant decline compared to the previous audit in 2014 where 65% were seen within 4 weeks of referral. • Inappropriate referral rate has dropped to only 4%. • The number of patients offered appropriate aetiological investigations has risen from 61% to 86%. • MRI / CT scans of inner ear were performed in 64% of patients whereas only 20% of patients underwent this important investigation in 2014 audit cycle. No requests for MRI / CT scan were rejected by the Radiology Department. **Key Recommendations/Action:** • Number of newly diagnosed children seen within 4 weeks of referral dropped from 65% to 18T. **Action: ENT Managers to ensure that newly diagnosed children with hearing loss are seen in Joint Paediatric Audiology Clinic within 4 weeks**
GENERAL SURGERY/UROLOGY RECORD KEEPING AUDIT 2016/17 **N = 20**	**General Surgery**	**March 2017**	**Main Aims:** To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings **Findings:** • 54% of standards fully compliant • 13% of standards with high compliance • 27% of standards with moderate compliance • 6% of standards with low compliance **Key Recommendations/Actions:**

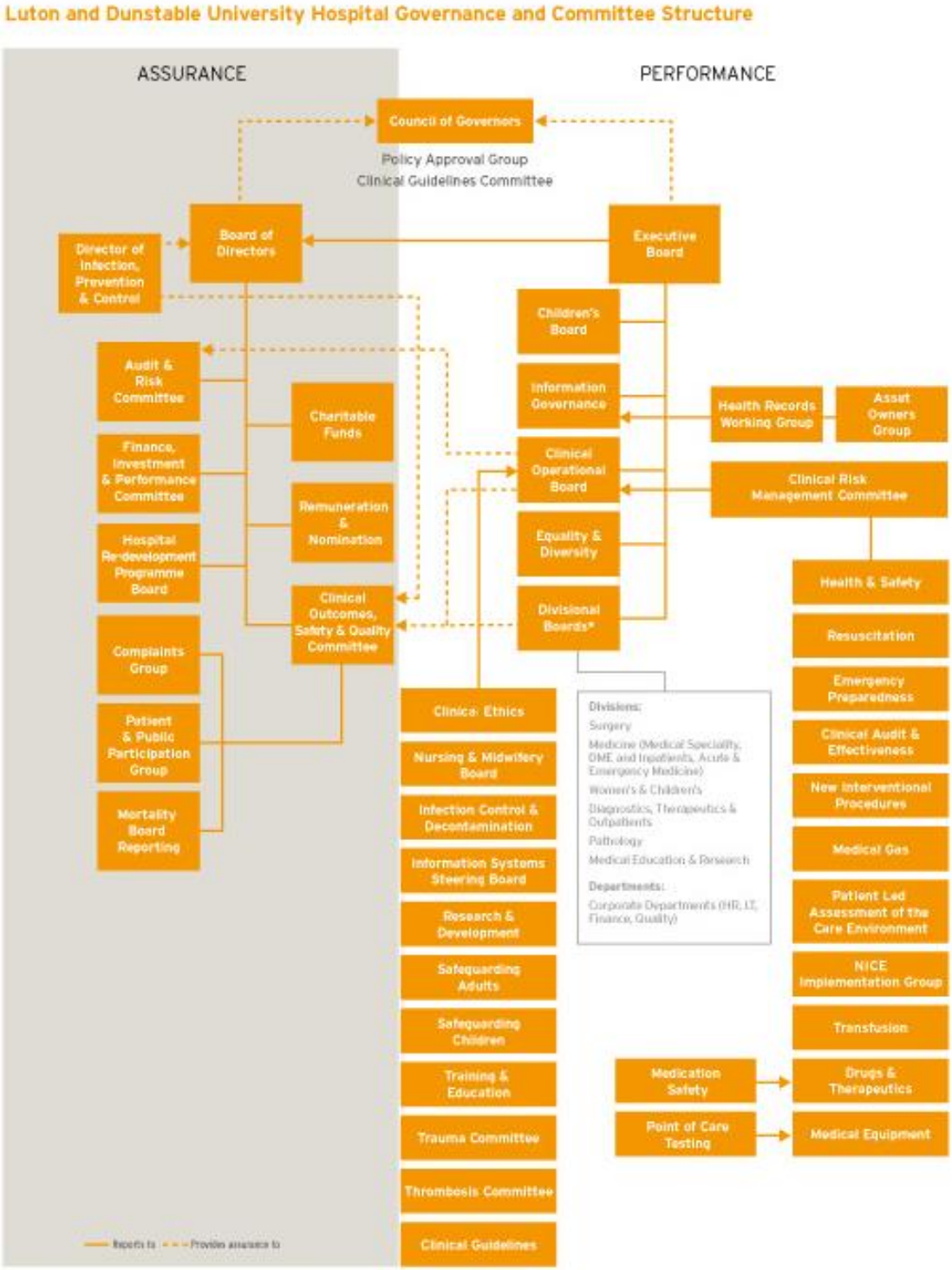
Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			• Greater accuracy required in recording of information on electronic discharge summaries • Need for timed entries in the record. **Action: To be shared with all staff at Clinical Governance Meeting**
LEARNING DISABILITIES AUDIT **N:** **Staff Survey = 127** **Patient Survey = 33** **Notes Review = 30**	**Corporate**	**March 2017**	**Main Aims:** Obtain baseline information on specific arrangements currently in place at this Trust for patients who have a learning disability **Findings:** **Organisational Snapshot Audit:** • Eighteen audit standards were identified. The position statement as at 01.09.16 identified the Trust is fully compliant with 50% of stadanrds, partially compliant with 44% of standards. The Trust is not compliant with 1 standard **Staff Survey:** • Forty seven percent of staff felt there was a patient care pathway in place for patients with a Learning Disability admitted as an emergency, 51% of staff were unsure and the remaining 2% of staff felt there was no pathway in place. • Ninety percent of staff stated they had cared for a patient with a learning disability. • Thirty five percent of staff stated they had attended a local training session on caring for the needs of patients with a learning disability. The main forms of training were through Induction and the Trust's Learning Disability Workshop. • Sixty percent of staff felt the Trust has recognised processes in place to help staff be aware that a patient has a Learning Disability. Eight percent of staff disagreed with this statement whilst 32% of staff were unsure. • Sixty five percent of staff felt they have access to information/resources in the hospital to help them identify the specific needs of patients with a Learning Disability. Eight percent of staff disagreed with this statement and the remaining 27% of staff were unsure. • Eighty nine percent of staff felt patients with a Learning Disability have access to the same investigations and treatments as anyone else, whilst acknowledging and accommodating that they may need to be delivered differently to achieve the same outcome. Five percent of staff disagreed with this statement whilst 6% of staff were unsure

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			• Fifty nine percent of staff stated they would consider using the Learning Disability Liaison Nurse to help care for a patient with a learning disability. • Twenty eight percent of staff stated they have been required to make a referral to the Learning Disability Liaison Nurse. • Forty six percent of staff stated there were information/materials specifically available in their ward/department to help patients/carers with a Learning Disability during their visit/stay. • Sixty one percent of staff felt Mental Capacity Act advice is easily available 24 hours a day • Sixty one percent of staff stated they had received Mental Capacity Act Training • Twenty three percent of staff felt they were very confident in applying the principles of mental capacity laws. Fifty seven percent felt somewhat confident and the remaining 20% were not confident at all with applying principles of mental capacity laws • Thirty three percent of staff felt they would feel more anxious caring for a patient with a learning disability than with other patients. • Seventy percent of respondents felt they have the necessary skills to care for patients with learning disabilities. • Sixty four percent of staff felt confident evaluating the baseline health needs for patients with a learning disability. • Sixty eight percent of staff felt able to respond appropriately to patients with a learning disability who are distressed. • Sixty three percent of respondents felt there are processes in place within their ward/department that enables care to be adjusted to meet the needs of patients with a learning disability. **Patient Survey:** • All patients stated they had been told why they needed to come to the hospital. • All patients felt they have always been able to ask questions about their stay. • Ninety four percent of patients felt they are listened to by the hospital staff. • All patients felt they were safe in the ward they were staying in. • Ninety six percent of patients stated they felt involved in decisions about their care,

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			whilst 4% of patients felt they were not involved in decisions. • Fifty seven percent of patients stated they were not given any leaflets/additional written information whilst in the hospital. • Forty four percent of patients stated hospital staff read their 'All About Me' • Ninety three percent of patients stated they had seen a learning disability nurse during their visit/stay • The majority of patients (90%) felt happy whilst in hospital, 3% felt unhappy and 7% of patients were unsure **Notes Review:** • High compliance with 2 standards; poor compliance with 7 standards **Key Recommendations/Actions:** • There was little evidence available to confirm that the Trust recognises people who have learning disabilities as a high risk group for deaths from respiratory problems. **Action**: Trust must ensure compliance with National Learning Disability Mortality Review (as of 01/04/17). Advice to Respiratory Leads around learning disability being a high risk group for respiratory related deaths • Many staff did not seem to have an awareness of the available resources, care pathways etc. in place for patients who have a learning disability. **Action:** Update Learning Disability Resource Folder and disseminate across hospital • Less than half of the staff who returned the survey had received any training around caring for patients who have a learning disability. **Action:** Begin to consider options to increase LD Awareness training uptake • Less than a third of staff who returned the survey were confident in applying the principles of the Mental Capacity Act. **Action:** As per actions detailed within Trust Mental Capacity Act Audit (2017) • There was little evidence to show that the All About Me document is being used by hospital staff. **Action:** Document is in the process of being updated using feedback from hospital staff Consider ways to promote this document (discuss with Communications) • Very few patients who returned the survey received written information in a way that was accessible to them. **Action:** This will continue to be followed up / discussed as part of Accessible Information Standard. Discuss with Patient Experience Leads

Title/Topic	Specialty	Completed	Aims, Findings, Key Recommendations/Actions
			• Less than half of the notes reviewed contained evidence that family members or carers where communicated with. Very few patients / carers felt that support made was available to carers. **Action:** Continue with the development of a welcome pack for those who have learning disabilities and their carers, and to include details of the Carers Lounge in this, with support from LD Liaison Nurses. Review the 'Guidelines for Support or Carers of Patients who have a Learning Disability with support from LD Liaison Nurses

Committees of the Board of Directors



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

Appendix F

East London NHS
NHS Foundation Trust

DRAFT
May 2017

Contents

Achievements

Executive Summary

Part 1 – Statement on Quality

1.1 Statement on Quality from Dr Navina Evans, Chief Executive

1.2 Statement on Quality from Dr Kevin Cleary, Medical Director

Part 2 – Priorities for Improvement

2.1 ELFT Quality Strategy

2.2 Quality Indicators & Priorities

2.3 Review of Services

2.4 Participation in Clinical Audits

2.5 Research

2.6 Goals Agreed with Commissioners - CQUINs

2.7 What Others Say about the Trust – CQC inspection report

2.8 Data Quality

2.8.1 Information governance Toolkit attainment levels

2.8.2 Clinical Coding Error Rate

Part 3 - Quality Performance 2016/17

3.1 Review of Performance 2016/17

3.1.1. Quality indicators for 2016/17

3.1.2. Positive Stories from across the Trust

3.2 Patient Feedback

3.2.1 Reported Experience Measures (PREM)

3.2.2 Complaints and PALS Report

3.3 Staff Feedback

3.3.1 Staff Survey

3.3.2 Staff Friends and Family Test

3.4 An Explanation of Which Stakeholders Have Been Involved

3.5 Joint Statement from NHS Tower Hamlets, NHS Newham and NHS City and Hackney Clinical Commissioning Groups (CCGs)

3.6 Statement from Tower Hamlets Healthwatch

3.7 Statement from Tower Hamlets OSC

3.8 An Explanation of any changes made to Quality Accounts Report

3.9 Feedback

3.10 2016/17 Statement of Directors' Responsibilities

Glossary

Contact with the Trust

If you require any further information about the 2015 Quality Accounts please contact: ELFT Communications Team on 0207 655 4000 or email webadmin@elft.nhs.uk

Awards & Achievements 2016/17

The Trust is proud of the achievements made over the last year, here are some of the most significant:

HSJ Awards 2016
Provider Trust of the Year – winner
Clinical Research Impact – Shortlisted

HSJ Value in Healthcare Awards 2016
Training and Development – Highly Commended
Mental Health – Shortlisted
Community Health Redesign – Shortlisted

BMJ Awards 2016
Education Team of the Year – Winner
Nursing Times Awards 2016
The Prince of Wales Award for Integrated Approaches to Care – Shortlisted

Positive Practice Awards 2016
The London Pathways Partnership (LPP) – Winner
(Health, the Emergency Services and Criminal Justice category)
Early Intervention – Shortlisted

Royal College of Psychiatrist' Awards 2016
Team of the Year for Child and Adolescents – Newham Child and
Family Consultation Service – Winner
Psychiatric Trainer of the Year – Dr Ian Hall, Consultant Psychiatrist – Winner
Team of the Year – Tower Hamlets Adult Mental Health Inpatient Team – Shortlisted

HSJ Awards 2016
Provider Trust of the Year – Winner
Clinical Research Impact – Shortlisted

NHS Employers 2017
Annual Flu Fighter Award – Shortlisted
(Most improved flu fighter campaign)

Patient Safety Awards 2017
Mental Health Category
Mental Health Street Triage project - Shortlisted

Health Service Journal (HSJ) 2017
Value in Healthcare award
Mental Health Street Triage project – Shortlisted
Medical Unexplained Symptom project – Shortlisted

UK Rail Industry Award 2017
Back on Track project (Corporate Social Responsibility category)
Awarded to KeolisAmey Docklands in partnership with ELFT

Executive Summary

The Quality Accounts Report is an important tool for strengthening accountability for quality within our organisation. In this report you will see how the Trust has worked hard to ensure that resources and energy are focused on improving the quality of the services we provide and ensuring they are sustained, putting our service users and staff at the heart of all we do.

We have made a commitment to quality of care being our foremost priority. This is embodied in our mission to provide the highest quality mental health and community care in England by 2020. This document demonstrates both our ongoing commitment, and the progress we are making towards this challenging goal.

The report is in three parts. Part 1 contains the statements from the Chief executive and the Medical Director. Part 2 sets out progress against our quality priorities for 2016/17 and looks ahead to 2017/18 and sets out the Trust's 'Priorities for Improvement'.

Part 3 of the report provides a review of quality performance in 2016/17. Where possible we present the data together with comparative information so that you can see how well the Trust is doing against previous levels of performance and alongside our NHS colleagues.

Part 1 – Statement on Quality

1.1 Statement on Quality from Dr Navina Evans, Chief Executive

2016-17 will go down in memory as an exceptional year in the history of the Trust. Attaining a CQC 'Outstanding' rating has made us so proud and is recognition of the consistent attention to detail of staff to provide healthcare that is thoughtful and effective, and truly supports people in their recovery.

The work of the Trust in improving the quality of the care we provide was further recognised by a number of awards we have received in the last 12 months most notably, the HSJ's Provider Trust of the Year.

Providing good quality services is only possible if you have a supported and motivated workforce, so we were pleased that our Staff Survey scores were again in the top five for the fourth year running. Thank you to all staff who took the time to share their views. This is a vital tool for us to understand staff experiences at work and to help us improve.

The overall results are very positive and feedback from suggests that we have improved on a significant number of key areas. The results also raised some areas where we need to continue to improve. Our staff engagement is high at 3.95 out of 5.0, this is well above the national average which is 3.80 for similar Trusts.

Our QI programme launched four years ago. With most services and teams involved in a QI project, QI has become a mainstream part of the work of the Trust. As projects are led by staff and areas of potential change are identified by teams, the impact and benefits to patients are immediate and sustained as it involves everyone.

As well as our quality improvement programme, we have succeeded in meeting key local and national standards and Commissioning for Quality and Innovation (CQUIN) standards. I want to thank staff for their tremendous efforts this year which has seen the Trust hit green on all our key performance indicators.

In 2017/18, we will be building on the progress made in integrating services in Bedfordshire and Luton into the organisation. We have enhanced clinical leadership and introduced new systems and processes to support clinical practice and provide staff with the tools they need to provide high standard care.

Going forward, we will be working more closely with partner organisations both at a local level within our local boroughs and regions, and on a broader scale within two Sustainability and Transformation Plan areas in London and Bedfordshire. This represents another opportunity to share our learning with others, learn from partners and look at quality measures to ensure we make the best use of our joint resources to the satisfaction of patients and their families. In particular, with the addition of our new community health service workforce in Tower Hamlets, we will be looking at new ways of working in a community setting and new models of care.

The last 12 months have been a remarkable period for the Trust. We need to work together now to ensure that we stay focused and continue to deliver sustained high quality care to every patient who needs our input, their families and our communities.

1.2 Statement on Quality from Dr Kevin Cleary, Medical Director and Director for Quality and Performance

2016/17 has proved to be another exciting year for us as an organisation. The continued work to transform services in Luton and Bedfordshire, to meet the needs of the local population, has entered year two, with tangible success. Our work around quality improvement continues apace, and we continue to work closely with our partners the IHI; and look to share, and seek out, ideas and innovation nationally and internationally.

We have received an outstanding rating from the Care Quality Commission (one of only two providers of Mental Health services to receive such a rating) and an HSJ Provider of the Year award are this is testament to the tremendous efforts of our staff - do we really need to do anything differently? There is no doubt that we have made some good progress with our quality improvement programme and we have learnt much but there is so much more that we could do. To really do our best we need to be flexible and responsive to our stakeholders and understand the local and national context. We need to get the right balance between quality assurance, improvement and control. Our framework for quality assurance needs to improve and change as we change as an organisation.

Again, as last year, finances have been a constant feature of the discourse about healthcare in England. How can we focus on quality when we have other demands? Well, quality is our organising principle. It is not an add-on, it is what we do every day of the week. If we focus on what is important to our patients, service users and staff then we can provide the highest quality care. We inevitably have targets that we need to meet, for waiting times, physical healthcare for patients with severe mental illness and access times for patients with first episode psychosis to name a few. These are all aspects of quality which are important in their own right. The most important thing for us is that we integrate this work into overall approach to quality and not view these as this year's targets. We need our improvements to be sustainable.

Part 2 – Priorities for Improvement

2.1 ELFT Quality Strategy

East London NHS Foundation Trust has committed to providing the highest quality mental health and community care in England by 2020. This is a demanding goal which requires a focused commitment from us as an organisation on all the components of quality.

Why are we doing this? Our patients, service users and carers deserve the very best care that we can provide for them. High quality care is not an accidental by-product of good intentions. We can only deliver the best care if we nurture our staff and ensure that they are developed and are working in an environment that fosters positive attitudes and a desire to strive to improve.

Our Quality Strategy is the plan we have for providing the highest quality mental health and community care in England for patients by 2020. The strategy reflects our core values.

To deliver the strategy we need to:

- Ensure that every day, for every patient, our staff have quality underpinning every decision.
- Listen to our patients, carers and service users.
- Provide the safest care we can and learn lessons when things go wrong.
- Support our staff to deliver our high standards.
- Attract and retain the best staff and then develop them further.
- Work with our commissioners in a positive relationship, making sure that quality is the number one aim.
- Foster a culture of quality improvement that is an integral part of who we are.
- Maintain our financial viability.

Quality assurance

While we have placed great emphasis on supporting the organisation to develop an improvement focus and culture over the last two years, our success in achieving high levels of care for our service users depends on bringing together our efforts in research, assurance and quality improvement to meet our strategic goals.

Strengthening our programme of quality assurance is particularly important to make sure we continue to meet key local and national standards. This includes ongoing internal inspection, clinical and service-user led audit, using patient experience feedback to drive local improvement, building different ways to support learning from experience and sharing of knowledge, and assuring effective implementation of NICE clinical guidelines.

Quality Control

We now have established systems of quality control, with our quality and safety dashboard tracking key measures, and reported regularly to the Trust Board.

2.2 Quality Priorities 2017/18

Quality Improvement context

East London NHS Foundation Trust has a **mission** to:

‘Provide the highest quality mental health and community care in England’

We have two broad aims to help move us towards achieving our goal:

1) Reduce harm by 30% each year, by tackling the ‘big safety issues’:

- Reduce physical violence
- Reduce falls
- Reduce restraints
- Reduce medication errors
- Reduce harm from pressure ulcers

2) Right care, right place, right time

- Improve patient and carer experience
- Reduce delays and inefficiencies
- Improve reliability of evidence-based care
- Improve access to care at the right location

ELFT has made great progress with its work on QI and has developed a national reputation for its work on QI in mental health and community services. This has had a large impact on the developing culture of the organisation and we need to hold the gains that we have made and to use the lessons learnt to develop the programme further and integrate it into operations so that it becomes work as usual.

Current Quality Improvement Priorities

Teams have freedom to work on issues of quality that matter most to the staff in the team, the service users and carers that they serve, and the local priority areas for improvement. This facet of the programme is unusual for large-scale improvement programmes, but is critical to engaging staff and making QI feel relevant and meaningful.

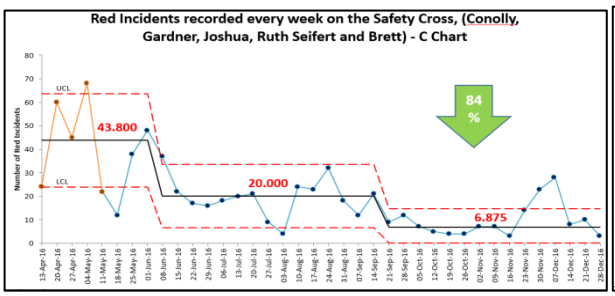
The current four Trust-wide priority areas of QI work have been determined by this dual process of identifying common themes emerging from the frontline projects and identifying issues of strategic importance for the Trust.

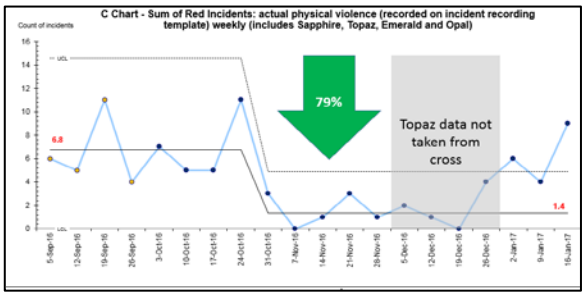
The priority areas are approved by the Board on an annual basis.

Progress against this year's key priorities (2016/17)

1. Scaling up and spreading the violence reduction work across other directorates

The violence reduction collaboratives continue to operate in City and Hackney and Newham. City and Hackney are observing an 84% reduction in violence across 5 wards whilst Newham have observed an initial reduction of 79%.

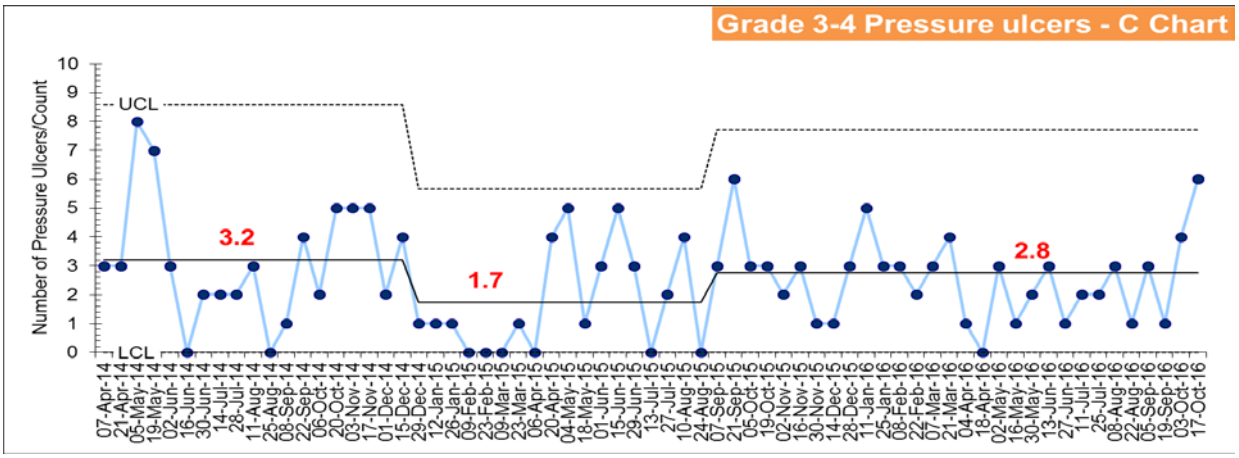


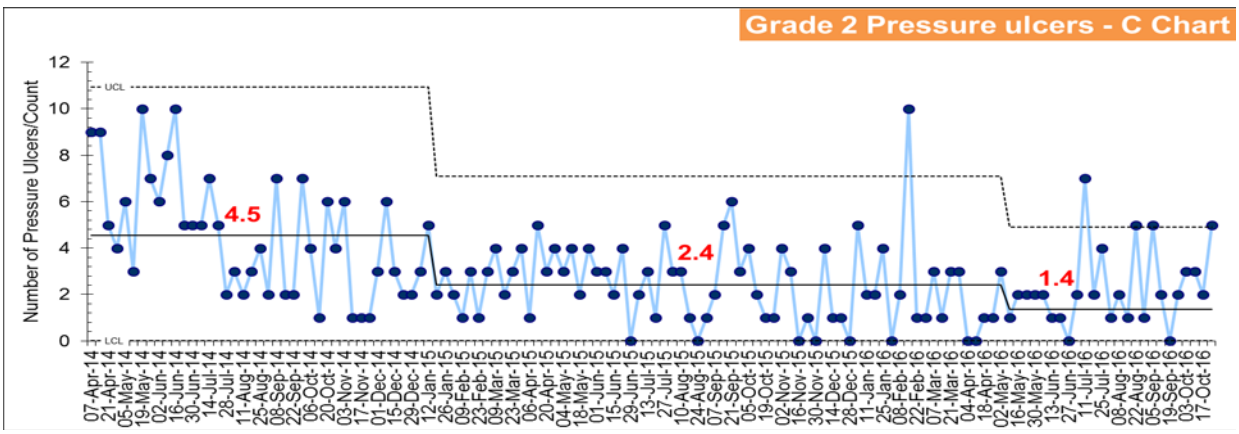


A forensics violence reduction collaborative is now operating in Forensics. A formal dashboard is now live and meetings have commenced.

2. Re-energising the pressure ulcer work with more direct care staff involvement

Overall we continue to observe a 12% reduction in the number of grade 3-4 pressure ulcers since the QI project began in 2014. However, we are now observing increased variation in the number of reported grade 2 pressure ulcers since June 2016. The EPCT management team are currently investigating potential causes for this.





In addition to making clinical RAG rating meetings reliable, current work in the EPCT is focused on 3 areas. The first of these is retention of staff, which is seen to be a critical driver in pressure ulcer prevention and is now a QI project in its own right. The second of these areas is bringing Waterlow assessment completion rates back under control. Reliability of this process is now improving and currently stands at 92%. The third area is proactively working with patients with a high risk of recurrent pressures. Clinical practice leads will be taking change ideas forward once RAG rating meetings are reliably re-established.

3. **Continuing the access learning system, which has only been in operation since April 2015**

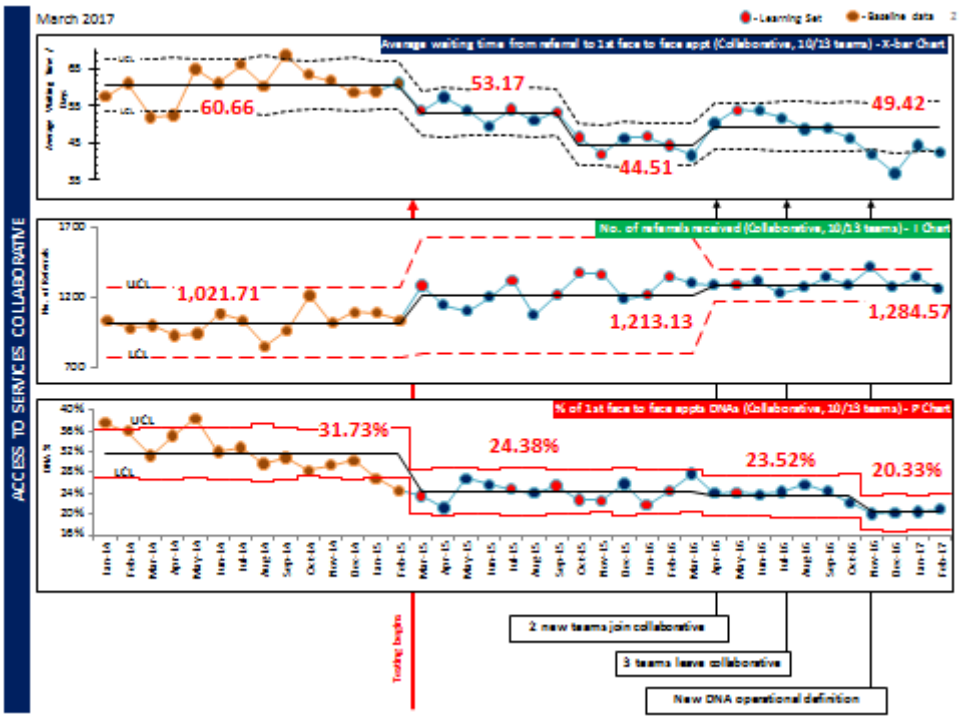
The improving access to services learning system was formed in March 2015. The aim of the learning system has been to bring together quality improvement projects from across the Trust working on:

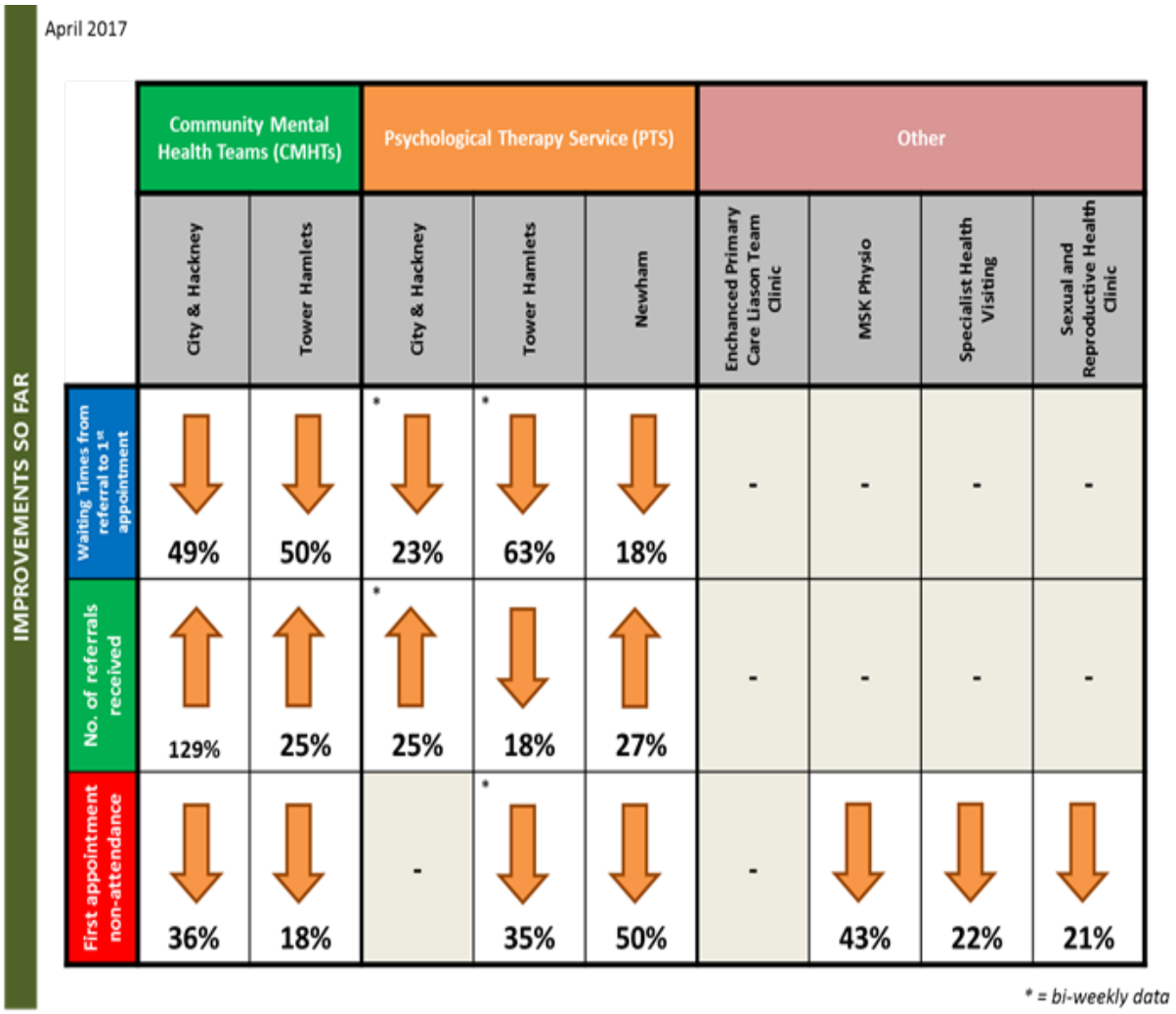
- Reducing Wait Times - Average days from referral accepted to first face-to-face contact
- Reducing DNA Rates - DNAs before first face-to-face contact / total number of appointments booked (excluding cancellations)
- Increasing New Referrals - Total number of referrals received from external referrers (non-ELFT)

Over the past two years, the teams have tested out a variety of different change ideas with the aim to develop a change bundle that can be shared across the wider Trust.

The teams that are part of the learning system have already achieved some fantastic results. To date across ten of the thirteen teams within the learning system we have seen a 19% reduction in average waiting times despite there being a 26% increase in the number of new referrals. In addition the teams have achieved a 40% reduction in first face to face DNAs.

The data below sets out progress in adult community mental health teams, and forms part of the dashboard for monitoring the progress of the project.





4. Reducing cardiovascular risk for people with severe mental illness through supporting physical health work across the Trust on health promotion interventions

The QI team is currently supporting three QI projects within the forensic service that are focusing on reducing cardiovascular risk for their service users. Ludgate, Clissold and Woodbury wards, at Wolfson House Low Secure Forensic Services, are all focusing on increasing physical activity and reducing weight and we are currently thinking about how we build a collaborative around these times to that we can share and maximise learning.

Looking ahead - Strategic Priorities for 2017/18

As part of our transition to a more systematic way of aligning improvement work to strategic priorities, we will be moving towards a small number of strategic Trust-level priorities which will be delivered through rigorously designed and run improvement projects with a greater level of support from the central QI team. Most team-level improvement work will now align with directorate-level priorities, with support coming from local improvement coaches and sponsors.

The five strategic priority areas for the coming year, following consultation with our stakeholders, are proposed to be:

1. Reducing inpatient violence
2. Improving access to community services
3. Improving joy in work

4. Recovery-focused community mental health services
5. Improving value for money

Collaborative learning systems and project boards chaired by an executive director will be set up for each of these areas to provide line of sight with local testing and learning.

Progress will be monitored via our Quality and Safety Dashboard of key metrics, and a regular Quality Report to the Trust Board.

Local directorates are being supported to develop a quality planning cycle which will help identify local quality priority areas, based on the views of service users, carers and staff as well as all available data and intelligence.

2.3 Review of Services

East London NHS Foundation Trust (formerly East London and The City University Mental Health NHS Trust) was originally formed in April 2000. In April 2007, the Trust was awarded University status in recognition of the extensive research and education undertaken in the Trust. On 1 November 2007, the Trust was authorised to operate as an NHS Foundation Trust under the National Health Service Act 2006.

In February 2011, the Trust integrated with community health services in Newham making us now a Trust that provides mental health and community health services. This was followed in June 2012 by joining with Richmond Borough Mind to provide The Richmond Wellbeing Service (Improving Access to Psychological Therapies service).

In April 2015, the Trust became the mental health provider for Bedfordshire and Luton. In May 2015, we took over the provision of specialist alcohol and drug services in Redbridge (R3) and on 1 September 2015, ELFT became the provider of Bedfordshire specialist addiction service (P2R) providing services to Bedford Borough and Central Bedfordshire

ELFT provides a wide range of community and inpatient services to children, young people, adults of working age, older adults and forensic services to the City of London, Hackney, Newham, Tower Hamlets, Bedfordshire and Luton. We provide psychological therapy services to the London Borough of Richmond, as well as Children and Young People's Speech and Language Therapy in Barnet.

In addition, the Trust provides forensic services to the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, and some specialist mental health services to North London, Hertfordshire and Essex.

The specialist Forensic Personality Disorder service serves North London and the specialist Chronic Fatigue Syndrome/ME adult outpatient service serves North London and the South of England.

The Trust's specialist Mother and Baby Psychiatric Unit receives referrals from London and the South East of England.

The Trust provides local services to an East London population of 820,000 and to a Bedfordshire and Luton population of 630,000. We provide forensic services to a population of 1.5 million in North East London. East London is one of the most culturally diverse parts of the country but is also one of the most deprived areas. Bedfordshire is a predominantly rural area with some of the most affluent communities in the country living alongside some of the most low income and deprived groups. Both areas therefore pose significant challenges for the provision of mental and community health services. The Trust operates from over 100 community and inpatient sites, employs almost 5,500 permanent staff and has an annual income of £349m.

During 2016-2017 the East London NHS Foundation Trust provided and/or sub-contracted 165 relevant health services. ELFT has reviewed all the data available to them on the quality of care in 165 of these relevant health services. The income generated by the relevant health services reviewed

in 2016-17 represents 100% of the total income generated from the provision of relevant health services by the East London NHS Foundation Trust for 2016-17.

East London – at the vanguard of integrated care

During 2016/17, the Trust has continued to work with partners to develop more integrated health and care services that place service users and carers at the centre and promotes life as well as health outcomes. across all of the boroughs in which we provide services, we are working with service users and carers, GP's, hospitals, other community and mental health providers, and councils and the voluntary sector to identify how best to organise services around people and communities: joining up primary and secondary care, health and social care, mental and physical health care. We are also working across two Sustainability and Transformation Plan areas, North East London and Bedfordshire Luton and Milton Keynes, both of which have designing and delivering integrated accountable care services as priorities. Whilst each borough is designing services around the specific needs of their populations, there are a number of similar features in the design of new integrated services across boroughs, and as we provide services in a number of boroughs we are working to both ensure we share learning and that mental health is kept at the heart of the thinking.

In Tower Hamlets, moving into its third year as a multi-specialty community provider vanguard, we have worked with the GP Care Group, Barts Health NHS Trust and the Council to deliver the best performance on emergency admissions to acute hospital of all of the vanguards, keeping more people at home more effectively. Our integrated care mental health nurses working as part of locality based multi-disciplinary teams, consultant and occupational therapists working in care homes have provided support to service users with complex mental and physical health needs and to the district and care home nurses supporting them. Our psychiatric liaison services have provided a comprehensive mental health and drug and alcohol service to the Royal London Hospital, delivering a statistically significant reduction in the length of time people with mental health problems stay in hospital over the course of this year.

In Hackney and the City, we have worked with the GP Confederation, the Homerton Hospital and the Council to deliver mental health nursing into the One Hackney and City programme, providing coordinated whole person care to people at risk of admission to hospital, and through dementia, talking therapies and CAMHS alliances. We are continuing to work with Hackney partners through the devolution pilot to develop new ways of delivering support through locality based multi-disciplinary teams with streamlined access.

In Newham we continue to work with GPs, Barts Health NHS Trust and the Council to deliver high quality community and mental health services for people with complex needs, through improved MDT working with practices and rapid response for people in need of more urgent support in their own home.

Across all of the boroughs in which we work, in response to the context of the STP's, we are beginning to consider how we can develop the contractual infrastructure and financial flows that appropriately incentivise integrated care delivery.

Bedfordshire and Luton – continued service development to meet local needs

Improvements to Inpatient Services

In year 2, we have continued to enhance our in-patient services, now providing single-sex accommodation to all acute in-patient services. A stabilised leadership structure is in place and improved staffing is reducing use of bank and agency staff. Bedfordshire in-patients will no longer be provided in Weller Wing, Bedford, a building identified by the CQC as inappropriate.

By the end of March 2017, we will have closed Townsend Court, a unit for older people with dementia and this will be reopened as an adult acute in-patient service for women. For Bedfordshire and Luton, older people's in-patient services will now be provided at Poplars (functional illness) in Houghton Regis, or Fountains Court (organic/functional illness) in Bedford.

We are consulting on the rehabilitation service based in London Road, Luton, with a proposal to move from a bed based model of Rehabilitation to an enhanced non bed based community support model.

Community Mental Health Services

Transformation of our Community Mental Health Services is well underway. Within Luton the teams have increased to four CMHTs, incorporating the Assertive Outreach Team and Primary Care Link workers bridging the interface between Primary and Secondary care services are established and are being received positively. Similar work has commenced in Bedfordshire. Teams are engaged in developing new ways of working to improve the outcomes for people accessing the service and operational policies and procedures are being reviewed to support the governance of the new services.

Liaison Psychiatry Service Expansion

The Liaison Psychiatry Service at Luton and Dunstable Hospital has been expanded to provide 24-hour care to patients. A 24 hour liaison psychiatry service came into being on 1 November 2015 providing specialist care for patients aged 16 or older. The service now provides a maximum 2 hour waiting time for Urgent referrals and the outcome of the bid to extend the service to achieve Core 24 principles, 1 hour max waiting time is expected shortly.

Integrated care

In Luton we have begun working with Cambridgeshire Community Services NHS Trust and GPs to consider how mental health can be integrated into the primary care home model they are piloting as part of the National Association of Primary Care pilot.

In Bedfordshire, we are working with GPs, the Council and South Essex Partnership University NHS Foundation Trust to pilot a more integrated multi-disciplinary approach in Iwel Valley as a starting point for further work across Bedford county and borough.

Other service developments

A review of the proposed model for Specialist Learning Disability service has been completed and the service now operates through a single point of access, as one specialist team for people in Luton and Bedfordshire.

As part of a pilot we have been providing a Street Triage service with Bedfordshire Police and the Ambulance service. This is currently being reviewed, the hours of operation may be extended as a result of the review and due to the positive feedback so far, it is expected that the model will continue to be delivered next year.

Bedfordshire Academy

The Recovery College was launched in May 2016 and continues to grow, providing a range of workshops/learning opportunities across Bedfordshire and Luton. Links with Bedfordshire University have been established, improving nurse learning experiences and good recruitment opportunities for nurses in our local services.

Break the Stigma Campaign

The Break the Stigma Campaign has made great progress in year 2, reaching into Schools and Colleges as well as working within communities and wider services, as well as receiving extensive media coverage.

2.4 Participation in Clinical Audits

The national clinical audits and national confidential enquiries that East London NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of **three** national clinical audits (POMH 7e & 11c and AEIP), and **one** national confidential enquiry (NCISH) were reviewed by the provider in 2016/17. The Trust develops specific action plans for each audit report which are managed and coordinated through either the Quality or Medicines Committees.

During that period the Trust participated in **100%** (four out of four) of national clinical audits and **100%** of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that East London NHS Foundation Trust participated in during 2016/17 are as follows:

Description of National Audit	Submitted to
National Confidential Inquiry (NCISH) into Suicide and Homicide by People with Mental Illness	Centre for Suicide Prevention Psychiatry Research Group School of Community-Based Medicine University of Manchester 2nd Floor, Jean McFarlane Building Oxford Road Manchester M13 9PL
Early Intervention in Psychosis Audit (AEIP)	Royal College of Psychiatrists 21 Prescot Street London E1 8BB
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	NCEPOD Ground Floor Abbey House 74-76 St John Street London EC1M 4DZ
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists 21 Prescot Street London E1 8BB

TOPIC	TRUST PARTICIPATION		NATIONAL PARTICIPATION	
	Teams	Submissions	Teams	Submissions
POMH 1d & 3d: Prescribing high does and combined antipsychotic *Data collection still underway (March), report due July 2017	38	484	TBC teams still in data cleansing	TBC submissions still in data cleansing
POMH 7e Monitoring of patients prescribed lithium	8	21	829	5182
POMH 11c Prescribing antipsychotic medication for people with dementia	11	185	508	10199
POMH 16a Rapid Tranquillisation *Report due June 2017	7	36	300	2000

The reports of **seventeen** local clinical audits were reviewed by the provider in 2016/17 and East London NHS Foundation Trust intends to implement the recommendations to improve the quality of healthcare provided. The Trust develops specific action plans for each audit which are managed through the Quality Committee.

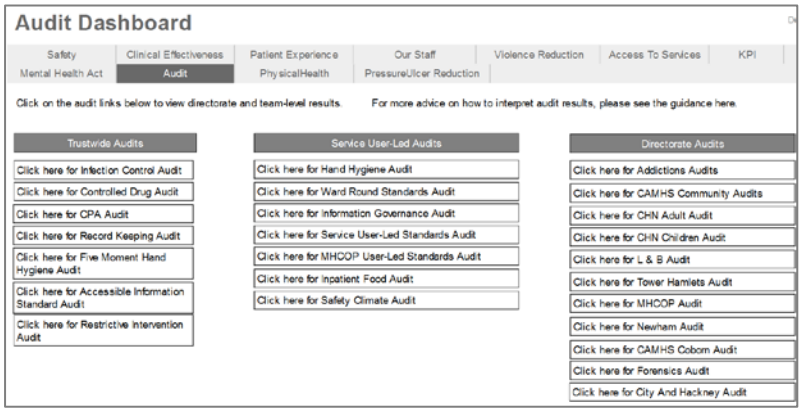
Audit Priority	Lead Committee	Directorate
CPA and Risk Assessment Audit	Quality Committee / CPA Group	All mental health
Record Keeping Audit	Quality Committee / Health Records Development Group	All
Medication Audits – Controlled Drugs, Prescribing, Administration and Rapid Tranquilisation	Quality Committee / Medicines Committee	All
Infection Control Audit	Quality Committee / Infection Control Committee	All
Hand Hygiene Audits – Five Moments, and Service User-observed	Quality Committee / Service Delivery Board	All inpatient units
Accessible Information Standard	Quality Committee	All
Restrictive Interventions Audit	Quality Committee	All inpatient units
Mental Health Act (including Consent to Treatment)	Quality Committee / Mental Health Act Committee	All
10 x Individual Directorate Audits (NICE/Safety Critical Standards)	Quality Committee / Directorate DMTs	All
Community Treatment Orders	Quality Committee / Mental Health Act Committee	All community teams

Auditing for Improvement

This year the Quality Outcomes and Experience Team have carried out a major reshaping of the Trust's audit process to create a system that enables maximum focus on improvement by equipping them with quick access to clear data, and a robust system for planning and tracking actions.

Early in the year, the Trust moved to reporting audits entirely by means of time series analysis to enable services to track their progress over time on each standard. In addition, this quarter saw Luton and Bedfordshire become fully aligned to the ELFT audit programme with the launch of their directorate audit and participation in Infection Control and Service User-observed Hand Hygiene audits.

Following this, in Q2, the Trust developed and rolled out a new system for tracking change ideas emerging out of audit findings with the goal of ensuring that the Trust's Clinical Audit programme is built for continuous improvement. Each directorate appointed an audit lead and was given local ownership over an "Audit Action Tracker". Directorates are now responsible for populating and following up actions emerging out of audit findings, and uptake of this process is reported to Trust Quality Committee every quarter.



Complementing this, significant work took place to bring audit reporting online into the new "Quality and Performance Dashboards", alongside other data such as patient experience feedback. These represent a significant step forward for transparent audit data at ELFT, providing quicker access to results, displaying all audit standards in time-series charts and offering team-level data for the first time.

In addition to the automation of data, the Quality Outcomes and Experience Team has developed a network of audit leads covering the whole Trust to promote and embed consistent clinical audit practice across the Trust. The main benefit of this effort has been to drive up the number of change actions arising out of audit results and to improve awareness of areas of low compliance. All directorates have participated in change planning based on audit findings this year. This is evidence of increased engagement with clinical audit as a result of the innovations made this year.

To close the loop between smart data and a comprehensive network of audit leads, the Trust has also just introduced "Audit Summary Reports" to provide dedicated feedback to each directorate to inform their discussions about audit. These Summary Reports condense a

Case Study: How ELFT CAMHS use audit to improve services

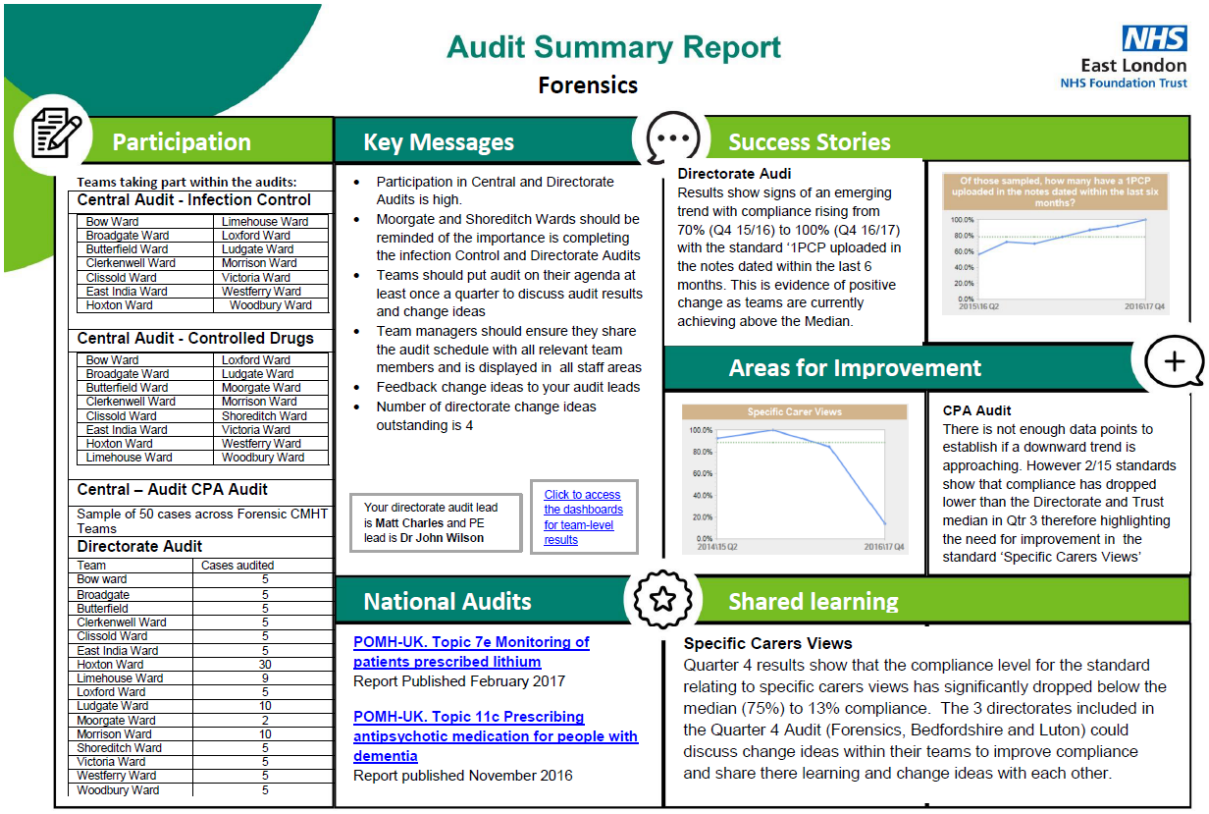
CAMHS' proactive audit process involves interrogating their data regularly and testing change plans to drive down non-compliance. A team of audit leads meets regularly to plan their response to audit data, linking closely with the central audit team for support around data display, interpretation and action tracking. CAMHS collects audit data via informatics on a monthly basis which allows for more data points and the ability to see changes more quickly.

During the year, CAMHS teams made a number of changes to their processes to improve compliance with standards. They began laminating treatment standards for clinicians, standards were included in induction packs, and caselists were distributed among clinicians with gaps highlighted. Around this time compliance with risk assessment completion began to jump up markedly leading initially to a trend, then a shift in a positive direction.

The drive towards greater compliance with core record keeping standards also revealed some thornier underlying problems which were contributing to lower results. It was felt that these issues would benefit from the more concerted focus of a QI project. For example, the directorate plans QI projects around reducing inactive caseloads and reducing the number of patients with no next appointment.

CAMHS directorates that have now reached a position of strong compliance are continuing to devise change plans to sustain this level. Despite compliance approaching 90%, City & Hackney services introduced a reminder checklist in the new patient folder at the assessment clinic. By maintaining momentum on core standards, CAMHS have sustained the gains they made earlier in the year.

large array of data into the key highlights, helping clinicians quickly see: where to celebrate success, where to focus improvement action and when to share learning.



Audit Summary Report

Forensics

NHS East London NHS Foundation Trust

Participation

Teams taking part within the audits:

Central Audit - Infection Control

Bow Ward	Limehouse Ward
Broadgate Ward	Loxford Ward
Butterfield Ward	Ludgate Ward
Clerkenwell Ward	Morrison Ward
Clissold Ward	Victoria Ward
East India Ward	Westferry Ward
Hoxton Ward	Woodbury Ward

Central Audit - Controlled Drugs

Bow Ward	Loxford Ward
Broadgate Ward	Ludgate Ward
Butterfield Ward	Moorgate Ward
Clerkenwell Ward	Morrison Ward
Clissold Ward	Shoreditch Ward
East India Ward	Victoria Ward
Hoxton Ward	Westferry Ward
Limehouse Ward	Woodbury Ward

Central – Audit CPA Audit

Sample of 50 cases across Forensic CMHT Teams

Directorate Audit

Team	Cases audited
Bow ward	5
Broadgate	5
Butterfield	5
Clerkenwell Ward	5
Clissold Ward	5
East India Ward	5
Hoxton Ward	30
Limehouse Ward	9
Loxford Ward	5
Ludgate Ward	10
Moorgate Ward	2
Morrison Ward	10
Shoreditch Ward	5
Victoria Ward	5
Westferry Ward	5
Woodbury Ward	5

Key Messages

- Participation in Central and Directorate Audits is high.
- Moorgate and Shoreditch Wards should be reminded of the importance is completing the infection Control and Directorate Audits
- Teams should put audit on their agenda at least once a quarter to discuss audit results and change ideas
- Team managers should ensure they share the audit schedule with all relevant team members and is displayed in all staff areas
- Feedback change ideas to your audit leads
- Number of directorate change ideas outstanding is 4

Your directorate audit lead is **Matt Charles** and PE lead is **Dr John Wilson**

Click to access the dashboards for team-level results

Success Stories

Directorate Audi

Results show signs of an emerging trend with compliance rising from 70% (Q4 15/16) to 100% (Q4 16/17) with the standard '1PCP uploaded in the notes dated within the last 6 months. This is evidence of positive change as teams are currently achieving above the Median.

Areas for Improvement

CPA Audit

There is not enough data points to establish if a downward trend is approaching. However 2/15 standards show that compliance has dropped lower than the Directorate and Trust median in Qtr 3 therefore highlighting the need for improvement in the standard 'Specific Carers Views'

National Audits

POMH-UK. Topic 7e Monitoring of patients prescribed lithium
Report Published February 2017

POMH-UK. Topic 11c Prescribing antipsychotic medication for people with dementia
Report published November 2016

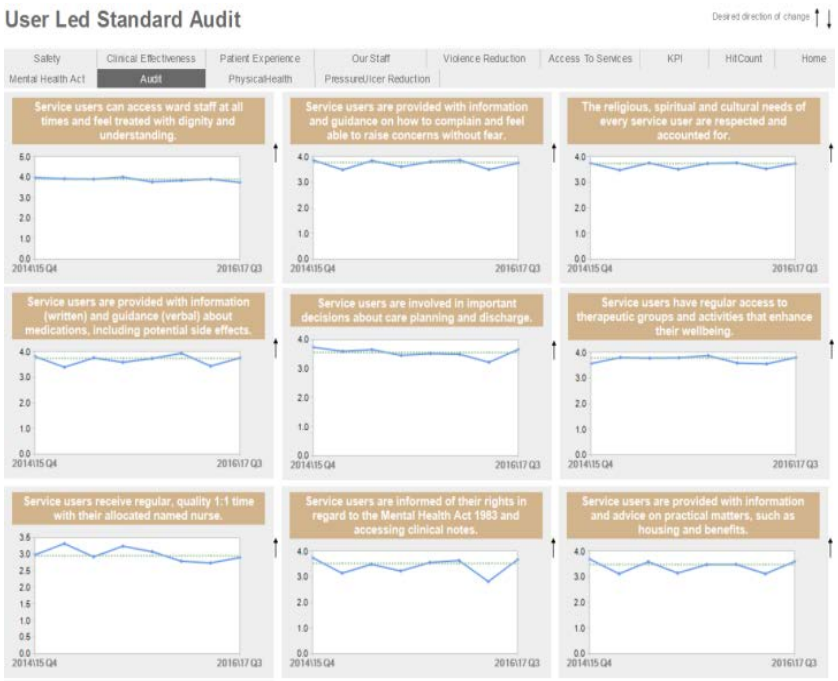
Shared learning

Specific Carers Views

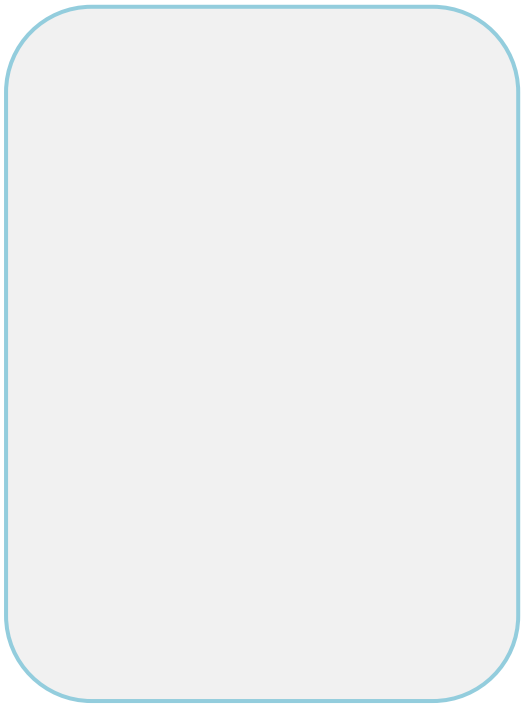
Quarter 4 results show that the compliance level for the standard relating to specific carers views has significantly dropped below the median (75%) to 13% compliance. The 3 directorates included in the Quarter 4 Audit (Forensics, Bedfordshire and Luton) could discuss change ideas within their teams to improve compliance and share there learning and change ideas with each other.

Service Users and Audit

The Trust continues to pioneer service user leadership of clinical audits with its Service User-Led Standards Audit (SULSA) programme. This year a consultation exercise took place across a wide range of Service User groups, carers forums, focus groups to review and revise the Service User-led Audit Standards. New standards were drawn up under the headings of a new "Knowledge and Information" Audit and a "Respect and Understanding" Audit. In quarter 4 these were piloted in City & Hackney, Newham and Tower Hamlets inpatient wards and they will be extended to Luton and Bedfordshire in Q1 2017/18.



New Service User-Led Standards:



Respect and Understanding

1. How often do you get to have a meaningful conversation with a staff member?
2. Do you feel respected by staff on the ward?
3. Do you feel respected by the other service users?
4. Are your family/carers respected by staff?
5. Do you feel encouraged personally?
6. Do you feel encouraged to engage with your health & wellbeing?
7. Do you find it easy to understand staff?

As well as complementing the clinical audit programme with additional insight about standards on our wards, the SULSA programme also acts as a work readiness programme for the auditors themselves. Auditors are recruited, trained and supervised throughout their time working for the Trust and they report a number of benefits in their own recovery and development as well as making a contribution to improving quality at the Trust. For example, during 2016/17, Bedfordshire and Luton services successfully collaborated with the Recovery College to roll out the Service User-Led Standards Audit and training programme. A number of Service User auditors have since been recruited and audits are now taking place regularly within the adult inpatient wards.

External Accreditations

The Trust has gained national accreditation for the quality of services provided in many wards and teams.

Accreditation scheme	Location	Services Accredited
AIMS ACCREDITATION FOR ASSESSMENT AND TRIAGE MENTAL HEALTH WARDS CCQI	City & Hackney	Gardner Ward Ruth Seifert Ward
	Newham	Emerald Ward (Excellent) Ruby Ward (Excellent) Sapphire Ward (Excellent) Topaz Ward
	Tower Hamlets	Brick Lane Ward Roman Ward (Excellent)

CAMHS QUALITY NETWORK FOR INPATIENT CAMHS CCQI	East London	Coborn Centre for Child and Adolescent Mental Health
QNLD QUALITY NETWORK FOR INPATIENT LEARNING DISABILITY SERVICES CCQI	Bedfordshire	The Coppice (Excellent)
PERINATAL QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES CCQI	East London	East London NHS Foundation Trust Perinatal Services
QUALITY NETWORK FOR OLDER ADULTS MENTAL HEALTH SERVICES CCQI	East London	Columbia Ward (Excellent)
AIMS PICU ACCREDITATION FOR PSYCHIATRIC INTENSIVE CARE UNITS CCQI	Newham	Crystal PICU
FORENSIC QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES CCQI	East London	John Howard Centre Wolfson House
ACOMHS ACCREDITATION FOR COMMUNITY MENTAL HEALTH SERVICES CCQI	City & Hackney	South Hackney Recovery Team
CAMHS QUALITY NETWORK FOR COMMUNITY CAMHS CCQI	City & Hackney	City & Hackney Child and Family Consultation Service
	Newham	Newham CAMHS Community Team
	Tower Hamlets	Tower Hamlets CAMHS Community Team
HTAS HOME TREATMENT ACCREDITATION SCHEME CCQI	City & Hackney	City & Hackney Home Treatment Team
	Tower Hamlets	Tower Hamlets Home Treatment Team
ECTAS ECT ACCREDITATION SERVICE CCQI	East London	Tower Hamlets Centre for Mental Health

MSNAP MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME CCQI	City & Hackney	City & Hackney Memory Service
	Newham	Newham Diagnostic Memory Clinic
	Tower Hamlets	Tower Hamlets Diagnostic Memory Clinic
	Luton & Bedfordshire	Luton Memory Assessment Clinic Bedford Memory Assessment Service Mid-Bedfordshire Memory Assessment Service South Bedfordshire Memory Clinic
PLAN PSYCHIATRIC LIAISON ACCREDITATION NETWORK CCQI	Newham	Newham Liaison Psychiatry Team
	Tower Hamlets	Tower Hamlets Department of Psychological Medicine (RAID Team)

Following a period of service development and stabilisation Luton and Bedfordshire in-patient wards will be applying for AIMS accreditation during 2017/18.

2.5 Research and Innovation

Fostering a research culture

In 2016 the Service User and Carer Research group developed the first service user led research project and successfully applied for a grant from Queen Mary University, Centre for Public Engagement. The project, called PRIDE, is led by Paul Binfield (People Participation Lead), Domenico Giacco (Researcher from the Unit for Social & Community Psychiatry) and Frank Röhricht (AMD Research & Innovation); it will investigate the impact of people participation work on service user recovery and the project is a unique step forward as the research topic was chosen by service users and the award is utilised to provide training on research methodology to service users, so that they can participate as research assistants.

The HORIZON research scanning advisory group is now well established and new senior clinicians joined the team in 2016.

In August 2016 the group presented change ideas for large scale projects with potentially high impact to the group of clinical and service directors in a "Dragon's Den" format; the ideas were chosen according to ELFTs QI priorities and included three main project pitches as follows:

- Patient Controlled Admission (aiming at reduced bed occupancy, improved self-management/empowerment, and reducing violent incidents)
- Transitional interventions pre/post discharge from inpatient care (aiming to foster recovery during crisis and to reduce readmission rates)
- Structured Medicines Optimisation (main aims: Optimise physical health and reduce harm through reducing number of prescribed medications, Improve treatment adherence, improve cost-effectiveness)
-

These ideas have since been taken forward by directorates for local QI projects. The group is currently working on new ideas for the next round of pitches to directors, concentrating on the themes "Access and Demand management" and "Cost effectiveness".

Following the introduction of the new CPA process and template a group of clinicians is getting involved with a large scale service evaluation that ELFT is about to undertake in partnership with Professor Alan Simpson's team from City University.

Implementation of locally derived research findings into clinical practice

Following the successful implementation of DIALOG as the trust-wide PROM (Patient Reported Outcomes Measure), "DIALOG-plus" (providing all care coordinators with solution-focused therapy skills) has been tested in local QI projects. At the same time a multidisciplinary working group developed a new CPA template and corresponding clinical processes that utilise the evidence based approach of DIALOG+ for service user engagement and care planning as the main building block.

Seven teams across ELFT piloted the new approach and both service users and health professionals rated the new approach highly, acknowledging that it fosters recovery care and puts the service user at the centre of the care planning process.

Innovations and Service Development

The Arts & Wellbeing Group is now collaborating with a team from Charite University Hospital in Berlin (Psychiatrist and Architect) with a view to initiate innovative service redesign projects for inpatient and community team environments. In May 2017 a joined workshop will be facilitated with the team from Berlin and the staff on Joshua ward in City & Hackney with a view to launch a pilot project.

This is followed by a one-day conference on “Architecture & Mental Health” on Friday 19th May, organised in partnership with the Royal College of Psychiatrists Arts special interest group.

A new working group has started to gather ideas for new models of primary care pathways, aiming to test innovations that integrate mental health care into generic medical primary health care. New ideas will be piloted both in Community Health Newham and the Newham Transitional Practices managed by ELFT.

There are now two projects under way to explore telehealth technologies as opportunities for innovative health care interventions and support systems. A QI project in Tower Hamlets and a research project in Newham are testing innovations in information sharing and gathering as well as recovery care support systems using technology such as the Florence text messaging service.

ELFT continues to explore opportunities to pilot innovations to improve the supervision experience for all staff members, aiming to systematically relate and structure the supervision to capture staff concern and to relate to staff needs in respect of maximising the quality of work environments.

Aligning research and QI strategy, ELFT is now exploring ways to maximise synergies between the two approaches to care quality improvement and service development. See: https://qi.elft.nhs.uk/bringing-research-and-qi-together/

Other

ELFT recently reviewed its processes and policies for different types of data collection. Guidance for clinicians has been developed, outlining the different practical and ethical implications between data collection in the context of audit, service evaluation and research. The guidance and the new Service Evaluation / Development Protocol Template can be accessed through ELFTs website: https://www.elft.nhs.uk/Research/Conducting-Research

A research project developed and implemented by the Unit for Social and Community Psychiatry (WHO Collaborating Centre for Mental Health Services) was shortlisted for the 2016 HSJ Research Impact award: Using Dialog+ to Improve Patient Outcomes in Community Mental Health Services.

The Trust has been shortlisted for the HSJ Value in Healthcare Award, in the category for ‘Improving the value of primary care services’, in recognition of a research project for a primary care treatment package that aims to meet the unmet health needs of patients with medially unexplained symptoms.

Participation in clinical research

The number of patients receiving relevant health services provided by East London NHS Foundation Trust in 2016-17 that were recruited during that period to participate in research approved by a research ethics committee is in excess of 900.

Throughout the 2016/17 year, the Trust has been involved in 96 studies; of which 62 were funded studies included on the NIHR Portfolio, 11 were unfunded explorations such as pilot studies, plus 23 student theses.

During 2016, researchers associated with the trust have published over 75 articles in peer reviewed journals.

Further information regarding the research undertaken across the Trust, including a list of on-going and previous research is available: https://www.elft.nhs.uk/Research

2.6 Goals Agreed with Commissioners for 2016/17

Use of the CQUIN Payment Framework

A proportion of East London NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals, known as CQUINs (Commissioning for Quality and Innovation). These CQUINs were agreed between the Trust and our local Clinical Commissioning Groups (CCGs): Tower Hamlets, City and Hackney, Newham, Luton and Bedfordshire, for delivery of Adult and Older Adult Mental Health Services, Children's Services and Community Health Services in Newham and IAPT in Newham. We also agreed CQUINs for our provision of specialist services, which includes forensic services, mother and baby services and inpatient CAMHS (Tier 4).

The table below summarises the Trust's position on delivery of 2016/17 CQUIN targets. Further details of the agreed goals for 2016/17 are available on request from the Trust Secretary.

Goal #	Goal	Description of Goal	Performance
National CCG Goals			
1a	**Introduction of health and wellbeing initiatives (Option B)**	Implementation of Health and Wellbeing initiatives (as agreed in their signed off plan) and actively promoted these services to staff to encourage uptake of initiatives.	**Achieved***
1b	**Healthy food for NHS staff, visitors and patients**	Providers will be expected to achieve a step-change in the health of the food offered on their premises in 2016/17, including: a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS)[1]. The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets; b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS); c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts; and d. Ensuring that healthy options are available at any point including for those staff working night shifts.	**Achieved**
1c	**Improving the uptake of flu vaccinations for frontline clinical staff**	75% of frontline health care workers have taken up flu vaccinations	**Achieved***
2a	**Cardio metabolic assessment and treatment for patients with psychoses**	a. To demonstrate full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in inpatients with psychoses and	**Achieved***

[1] The Nutrient Profiling Model can be used to differentiate these foods while encouraging the promotion of healthier alternatives. https://www.gov.uk/government/publications/the-nutrient-profiling-model

		community patients in Early Intervention psychosis teams.	
2b	**Communication with General Practitioners**	b. 90% of patients should have either an updated CPA i.e. a care programme approach care plan or a comprehensive discharge summary shared with the GP. A local audit of communications should be completed.	**Achieved***
Goals for East London CCGs (Tower Hamlets, City and Hackney and Newham)			
3a	**Training Mental health staff in smoking cessation**	a. Provider to implement a comprehensive programme of training in smoking cessation for staff so that at least a third of professional staff have been trained in a recognised brief intervention protocol.	**Achieved***
3b	**Recording of patients smoking status**	b. Nicotine smoking status of service users recorded in at least 75% of electronic patient records.	**Achieved**
3c	**Care planning for smoking cessation**	15% of service users who identify themselves as smokers and have accepted an offer of an intervention	**Achieved**
4a	**Complete package of lifestyle care for all initiations of antipsychotics to improve physical health**	Provider to improve the identification of lifestyle care needs of patients and work with existing other providers, for example, in facilitating external providers use of ELFT services.	**Achieved**
5a	**Improve the levels of staff trained to use the Lester Tool**	Improve the levels of staff trained to use the Lester Tool	**Achieved***
6a	**Implement smoke free wards across the trust**	Implement smoke free wards across the trust – Two Year CQUIN	**Achieved**
7a	**Reducing staff smoking**	Assist a reduction of the percentage of staff that smoke	**Achieved***
8a	**Development of Home Treatment Teams – Newham**	Delivery against a programme of metrics agreed in Quarter 1 to support the development of HTT access and core standards.	**Achieved***
9a	**Being organised as part of the THIPP – Tower Hamlets**	Achieving THIPP delivery standards.	**Achieved***
10	**Access and Waiting Time to Early Intervention in Psychosis (City & Hackney)**	Expanding EIS to establish a relevant group programme for those aged over 35.	**Achieved***
Goals for Community Health Services Newham			
N2	**Quality improvement across Adult community services – Falls prevention and Preventing Harm from Falls for people on the EPCT caseload**	100% of cohort patients who have a multi factorial risk assessment completed 50% of harm prevented from falls in house bound patients (defined by admission in Q3 and Q4 to hospital due to a fall) against the baseline	**Achieved***
N3	**Integrated Care – Improving quality of End of Life Care**	• % of patients identified by ELFT as at End of life with a care plan on EMIS • ELFT staff to undertake mortality audit within each cluster with primary care	**Achieved***

		colleagues (minimum 20 patients per cluster) • Each of the 6 nursing homes to have a named EoL lead who attends nursing home monthly MDTs to discuss care for EoL patients home • ELFT EoL co ordinators to support palliative care MDTs in primary care by discussing patients known to the service (may be combined with H&SC MDTs) • ELFT to develop ongoing action plan for EoL care for 2017/18 with CCG	
N4a	**Increasing the uptake and quality of Health Checks provided for people with a Learning Disability in Newham**	• Current take up numbers (Compare previous 2015-16 CEG Quarter) • Update current programmes delivered (Divided into Individual & Groups) • Visibility: Sample of Practices	**Achieved***
N4b	**Increased number of health action plans developed for people with a learning disability who have had an annual health check**	Increase in numbers of those with a Health Action based on on a baseline assessment from 2015/16.	**Achieved***
N5	**Quality improvement across Adult community services – Extended Primary Care Teams- Dressings Clinic Service**	Delivery of dressing clinical service redesign programme, including service specification, training plan, stakeholder engagement.	**Achieved***
Goals for Newham IAPT Service			
	Development of Non GP referral routes and marketing	Development of a marketing and communication programme and delivery of that programme.	**Achieved***
Goals for Luton CCG			
L3	**Adult Community - Therapy Provision in the CRHT (Crisis Resolution Home Team)**	Development and roll out of psychosocial intervention training programme for crisis resolution and home treatment staff.	**Achieved***
L4	**Establishment of Peer Support Network in Luton**	Recruitment, training and commencement of work for 5 peer support workers and identification of future peer support workers.	**Achieved***
L5	**Primary Care Link Consultant Input**	22 practices visited by a MH consultant each quarter and 15 practices to have been visited by a primary care link worker and progress on numbers of meetings with GPs, service review involving stakeholders, patient feedback and GP survey results.	**Achieved***
Goals for Bedfordshire CCG			
3	**Primary Care Mental Health Workers – piloting a step down model from CMHTs to Primary Care**	Delivery of step down clinics in primary care for an identified group of service users	**Achieved***
4	**Improving the quality of referrals to the Memory Assessment Services (MAS) and increasing the ability of primary care to screen people diagnosed with a Mild Cognitive**	Baseline audit and re-audit of quality of referrals to the Memory Assessment Service. Develop referral standards, deliver training. Re-audit the proportion of service users assessed by MAS who have a diagnosis outcome of MCI.	**Achieved***

	Impairment (MCI) for dementia 12 Part Achieved (Mth 9)months after the or Part Achieved (Mth 9)iginal diagnosis		
5	**Support for children who are demonstrating age inappropriate Sexualised behaviour**	Develop a baseline of numbers of children in CAMHS for child sexualized behavior. Identify any gaps in the management of their behavior and recommend treatment options. Provide report on suitable pathway and treatment options and what training should be offered to external organisations.	**Achieved***
Goals for NHS England Specialised Services			
MH2 (2 yr CQUIN)	**Recovery Colleges for Medium and Low Secure Patients**	Proportion of target patient group enrolled and participating in courses.	**Achieved***
MH3 (2yr CQUIN)	**Reducing Restrictive Practices within Adult Low and Medium Secure Services**	Implementation and evaluation of changes in practice to reduce restrictive practices.	**Achieved***
MH4	**Improving CAMHS Care Pathway Journeys by Enhancing the Experience of Family/Carer**	Action plan and progress report to monitor improvements in family/carer experience.	**Achieved***
MH7	**Perinatal Involvement and Support for Partners/Significant Others**	Services will have developed systems to record and evidence: 1) The emotional, practical and informational support offered to all partners and significant others with the mothers consent. 2) The types of interventions offered from the following: Group I – All partners & significant others should be: • Seen within 1 week of admission by a senior clinician to discuss the mother's condition • Offered the opportunity to attend ward reviews and significant meetings • Informed that requests for additional discussions are welcomed • Informed of the joint activities that are available • Directed to the range of written and electronic information available. Group II – Partners/significant others should be offered at least one of the following documented in care plan • Partner support sessions • Family sessions • Couple sessions Group III – at least one of the following: • Parent-infant activities e.g. massage, rhyme time, music sessions etc • Practical parenting advice/support with nursery nurse, health visitor etc Group IV – Offered access to at least one of the following:	**Achieved***

		• Written/video narratives of experience and recovery of perinatal patients • Meeting recovered patients (e.g. service/family days, charities)	
Local Scheme	**Repatriation of London Adult Secure and CAMHS Patients**	A dedicated plan for all patients to be developed, that demonstrates all patients who can be repatriated back and those that will require a more considered option for local management. Rollout of business case with additional capacity, in line with the plans shared clinically for each of the patients on the list that have been clinically agreed.	**Achieved***
OBS	**Providers required to complete an OBS compliance Audit and a robust Exit Plan for the mobilization of the new CHIService hubs.**	Submission of an audit of OBS Compliance and Exit Plan.	**Achieved**

* data available to end of month 9 for these indicators, they are on track to be achieved at the time of writing and the year-end position will be available by June 2016.

2.7 What Others Say about the Trust

Care Quality Commission inspection

East London NHS Foundation Trust (ELFT) is required to register with the Care Quality Commission and its current registration status is 'Outstanding'.

ELFT has no conditions on registration and the Care Quality Commission has not taken enforcement action against ELFT during 2016/17.

The Trust received the following ratings following inspection:

Key Question	Safe	Effective	Caring	Responsive	Well-Led
Trust Rating	Good	Good	Outstanding	Outstanding	Outstanding

The CQC inspection report is naturally positive. Crucially, the introduction concludes:

> *"Although we have rated the trust outstanding overall, our inspection has identified a number of areas in core services rated good or outstanding where further improvement can be made. We expect the trust to continue its journey of continuous improvement and we will work with the trust to agree an action plan based on the findings of our inspection."*

The report identifies 5 'must do' actions that the Trust is required to undertake to ensure that it continues to comply with the regulations set out in the Health and Social Care Act (2008):

1. The trust must ensure that risk assessments for the use of electronic devices relate to individual patient care plans and reflect the views of the patient and that all risk assessments for each patient are easily accessible to the staff that need to use them.

2. The trust must make changes to the alarm systems on the learning disability ward to support the needs of patients especially those with an autism spectrum disorder. This should include considering how the use of flashing and noisy alarms could be reduced.

3. The trust must ensure that as most patients using the service had challenging behaviours that they have care plans reflecting a positive behaviour support approach.

4. The trust must ensure that waiting times for patients referred to memory clinics to attend a first appointment and to receive a diagnosis continue to be improved especially across the Bedfordshire services.

5. The trust must ensure all patient records are maintained appropriately. This is to ensure that patients have the necessary assessments, that assessments have been reviewed at appropriate timescales, that records of physical health observations are available and care plans in place. This is to ensure that district nurses in particular, deliver the appropriate care or recognise when the patients' needs are changing and if it is necessary to involve another care professional such as a tissue viability nurse.

The Trust has formulated a detailed action plan that sets out how it will address these issues. Progress is regularly tracked and reported on. These must do actions have naturally been prioritised, but all the issues identified by the inspection have been reviewed and the themes identified to help inform planning and prioritisation, namely:

1. Record keeping and the electronic patient record system

2. Use and recording of physical restraint

3. Evidencing the provision of information of legal rights to detained patients

4. Recording of consent, capacity and best interest decisions

5. Maintenance of equipment and medical devices

The report identifies further actions that the Trust should undertake to improve the services it provides. Our action plan sets out its response to all those actions required or suggested by the Care Quality Commission.

Special Reviews

East London NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

In response to the Southern Health report into the investigation of patient deaths, the Trust obtained comparison data from Mazars that benchmarked the Trust against similar organisations nationally, providing assurance as to its reporting and investigation processes.

2.8 Data Quality

The Trust's Information Governance (IG) framework, including Data Quality (or "Information Quality Assurance") policy and responsibilities/management arrangements are embedded in the Trust's Information Governance and Information Management and Technology Security Policies.

Information Quality Assurance:

- The Trust established and maintains policies and procedures for information quality assurance and the effective management of records

- The Trust undertakes or commissions annual assessments and audits of its information quality and records management arrangements
- Data standards are set through clear and consistent definition of data items, in accordance with national standards
- The Trust promotes information quality and effective records management through policies, procedures, user manuals and training.

The Trust's Commissioners, Trust Board and Information Governance Steering Group receive regular reports on data quality/completion rates against agreed targets. The IG Steering Group receives and reviews performance on data quality benchmarked across London and nationally – including the use of the national data quality dashboard.

To support action and improvement plans, Directorate Management Teams receive a range of cumulative and snapshot data quality reports from the Trust's Information Management team – these show missing or invalid data at ward, team and down to individual patient level. Data validity and accreditation checks are undertaken annually in line with the IG Toolkit national requirements and an annual audit of clinical coding is undertaken in line with the IG Toolkit national requirements.

East London NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data taken from local RiO data as of 31st December 2016 which are shown below:

	Inpatient Mental Health	Community Mental Health	Community CAMHS	CHN	Addiction Services
Patient's valid NHS number (including Bedfordshire Luton)	98.5%	100%	100.0%	99.3%	100%
Patient's valid General Medical Practice Code (including Bedfordshire Luton)	92.7%	98.0%	99.0%	86.7%	99.1%

2.8.1 Information Governance Toolkit attainment levels

The Trust achieved a Satisfactory compliance rate of 74% for Version 14 of the Information Governance Toolkit

2.8.2 Clinical coding error rate

East London NHS Foundation Trust was recently audited for Clinical Coding by Maxwell Stanley Consulting. The audit evaluated the standard of coding using the NHS Health and Social Care Information Centre (HSCIC) Clinical Coding Audit Methodology Version 8.0 and was undertaken by accredited clinical coders who are registered NHS approved Clinical Coding Auditors.

The sample taken for the audit at the East London NHS Foundation Trust amounted to 50 finished consultant episodes (FCEs) and covered the Adult Mental Illness, Old Age Psychiatry and Child and Adolescent specialties following National Clinical Coding Standards. The Audit Results summary is as follows:

IG Audit	Primary diagnosis correct %	Secondary diagnosis correct %	Primary procedure correct %	Secondary procedures correct %	Unsafe to Audit %
2012/13	94.00%	83.65%	N/A	N/A	0

2013/14	98.00%	96.24%	N/A	N/A	0
2014/15	96.00%	89.58%	N/A	N/A	0
2015/16	94.00%	89.50%	N/A	N/A	0
2016/17	100.00%	93.75%	N/A	N/A	0

The results of the audit demonstrate an excellent standard of diagnostic coding accuracy in the classification of both primary and secondary diagnosis coding, with both areas exceeding Information Governance requirements for Level 3.

PART 3 – Review of Quality Performance 2016/17

3.1 Review of performance for 2016/17

Our quality strategy underpins everything we do and enables us to set targets and monitor their impact. In addition to the national clinical targets, we have developed a range of quality indicators covering patient safety, clinical effectiveness and patient experience.

We have continued to encourage a culture within all our services where staff feel recognised and supported but also where poor performance is challenged and managed appropriately.

This quality report will detail the key achievements and a summary of progress across indicators. Each indicator is described in respect of improvements achieved during the year, and the identification of further improvements required during 2016/17.

3.1.1 Quality Indicators for 2016/17

NHS Improvement Assurance

East London NHS Foundation Trust has a range of NHS Improvement (NHSI) targets on which we report throughout the year. The targets outlined below are tested by external auditors to provide assurance that the data provided are reliable. Two are statutory, one is locally defined.

The figures below show the trust has exceeded all national targets. As set-out in section 2.8 the Trust considers that this data is as described for the following reasons; the Trust has data quality arrangements in place which ensure the Trust's Commissioners, Trust Board and Information Governance Steering Group receive regular reports on data quality/completion rates against agreed targets. The IG Steering group receive and review performance on data quality benchmarked across London and nationally – including the use of the national data quality dashboard.

NHSI Target	1. CPA inpatient discharges followed up within 7 days (face to face and telephone)	2. Patients occupying beds with delayed transfer of care - Adult and Older Adult	3. Admissions to inpatient services had access to crisis resolution home treatment team
Target 2016/17	95%	7.5%	95%
Q1	96.0%	1.9%	97.2%
Q2	96.7%	1.2%	100%
Q3	95.9%	1.1%	100%
Q4	97.3%	0.9%	99.7%

*Data available via: http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/

** Delayed transfer of care is calculated as (N days delayed / N occupied bed days) – national comparison data is not available

The Trust has successfully reached all NHS Improvement targets for 2016/17. The data presented above is in line with national averages, for example, national CPA inpatient discharges followed up within 7 days data are all above the 95% target for Quarters 1 to 4 respectively.

It should be noted, to calculate the figure for 7 Day follow-up, the Trust excludes Older Adult, Forensic and Rehabilitation services due to the clinical nature of the patient population and the structure of the services.

The table above also shows an improvement in all areas from 2015/16, where DTOC has improved from 2.8% and gatekeeping has improved to 100%

The average occupancy rate for Mental Health beds in England open overnight was 89.7% in Quarter 3 2016/17 compared with 88.6% in Quarter 3 2015/16. East London occupancy was 85.5% for Quarter 3 2016/17 and 89.1% for Quarter 3 2015/16. Target Occupancy is 85%, showing the Trust is moving towards safer occupancy levels.

The table below details each of the Trust's NHSI/Monitor Indicators for the last two reporting periods.

Monitor Target	Target 2016/17	Actual 2015/16 (Q4)	Actual 2016/17 (Q4)	Actual 2016/17 (Q4)
Mental Health Patients occupying beds with delayed transfer of care - Adult & Older Adult (Only CAMHS excluded)	7.5%	3.5%	0.9%	improved
Admissions made via Crisis Resolution Teams (end of period)	95.0%	99.7%	99.7%	improved
Number of adult CPA patients meeting with care-coordinator in past 12 months	95.0%	93.3%	97.3%	improved
Access to healthcare for people with a learning disability – report compliance to CQC	Self-Assessment Completion	19	19	same
Completeness of Mental Health Service Data Set (MHSDS) – PART ONE	97.0%	99.5%	100%	improved
Completeness of Mental Health Service Data Set (MHSDS)– PART TWO	50.0%	83.1%	87.0%	Decreased – still compliant
Referral to treatment time within 18 weeks (non-admitted patients)		100.0%		No longer reported
Reduction in Clostridium Difficile - reported instances	0	1	0	
Meeting commitment to serve new psychosis cases by early intervention teams measure. People experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	84.9%	92%	improved

Improving Access to Psychological Therapies - Patients referred with 6 weeks measure	75%	76.0%	96.4%	improved
Improving Access to Psychological Therapies - Patients referred with 18 weeks measure	95%	92.0%	99.7%	improved
NHSI Targets - Community Information Data Set (CIDS - Data Completeness)				
Community Referral to treatment information	50%	100.0%	100%	No change
Referral information	50%	72.1%	73.6%	improved
Activity information	50%	88.0%	89.1%	improved

NB: Maximum time of 18 weeks from point of referral to treatment in aggregate is not included as ELFT does not have elective inpatients

Care Programme Approach (CPA)

The CPA is the framework through which care and treatment is delivered for a large proportion of the Trust's service users. The table below containing Quarter 4 data shows that for the vast majority of services users on CPA are seen every month by their care coordinator but the number of care plan in date are below target at 91.4%, a slight improvement on 2015/16.

However, the proportion of service users on CPA is below the level we would hope to achieve. Increasing contact time is one of the Trust's priorities for the year ahead. The Trust is also implementing new ways of working using a more recovery focused approach and has started to roll out DIALOG+ / eCPA in March 2017. This will include closer collaborative working with service users and carers, and include a formal review of CPA patients every twelve months.

Indicator	Target	Actual Performance Q4
CPA patients – care plans in date (documents 12 months old)	95%	91.4%
CPA patients – care plans in date (documents 6 months old)	N/A	78.7%
% CPA patients seen per month – face to face only	85%	83.8%

Trust figures for CPA are now increasing for both 6 month and 12 month reviews as Luton & Bedfordshire services have focussed on getting reviews in place as they embed the use of RiO and are now monitoring reviews regularly. Luton and Bedfordshire continue to monitor CPA cases seen in month where teams are not meeting the 85% target.

Patient Safety

The Patient Safety is one element of the Trust's Quality and Safety Dashboard, the means by which it monitors each of the elements of service quality.

The number of 'patient safety incidents' indicator is reliant on staff reporting incidents and there is a degree of clinical judgement regarding the classification of harm associated with any incident. The Trust undertakes regular reviews of these data. As such the figures presented here may vary from those currently held by the NRLS.

The total number of patient safety incidents, including the percentage of such incidents that resulted in severe harm or death	2016/17	2015/16	2014/15
• Total incidents reported	9260	8981	8774
• Incidents identified as 'patient safety incidents' (as per NPSA definition)	5893	4043	4119
• Of which resulted in severe harm or death	153 (2.6%)	143 (3.5%)	82 (1.9%)

The Trust continues to work to increase the reporting of incidents, but reduce the patient experience of harm. The Trust are supporting this by seeking to develop whole system measures of quality, which would allow us to better understand whether we are improving the quality and safety of our services over time.

Improving Safety: Training Compliance

The following information should demonstrate how good performance in training compliance in health and safety areas leads to fewer staff contributing to improved safety and quality.

Safeguarding Children Level 1

Total	Number of staff	Number of staff attended	% compliance
2014/15	3,324	3,198	96.4%
2015/16	988	956	96.8%
2016/17	999	878	87.89%

'Safeguarding Adults' training compliance

Total	Number of staff	Number of staff attended	% compliance
2014/15	3,449	2,523	73.2%
2015/16	4,521	3,953	87.4%
2016/17	4,559	4,125	90.48%

'Health and Safety' training compliance

Total	Number of staff	Number of staff attended	% compliance
2014/15	3,464	2,685	77.5%
2015/16	4,530	4,182	92.3%
2016/17	4,565	4,254	93.19%

'Manual Handling' training compliance

Total	Number of staff	Number of staff attended	% compliance
2014/15	2,711	2,202	81.2%
2015/16	3,677	3,401	92.5%
2016/17	3,806	3,506	92.12

'Fire Safety (including fire marshal)' training compliance

Total	Number of staff	Number of staff attended	% compliance
2014/15	2,393	1,640	68.5%
2015/16	1,301	913	70.2%
2016/17	4,691	3,618	77.13%

Medicines Safety

Incident data

	Prescribing error	Dispensing error	Administration error	Medication availability	Other	Total
2015/16	65	128	225	29	35	482
2016/17	145	54	487	17	13	716

Training Compliance

All non-mental health nursing staff and pharmacy staff are to receive medicines safety training. This increases awareness of how to minimise risks around the prescribing, dispensing and administration of medicines.

	% compliance
Total	84.94%

Medicines Reconciliation

The Trust's target is that over 95% of patients' medicines are to be reconciled by pharmacy staff within 72 hours. This is a directive from the NPSA, NICE and has previously been a CQUIN target for the Trust. Reconciliation of medicines on admission ensures that medicines are prescribed accurately in the early stages of admission. It involves checking that that the medicines prescribed on admission are the same as those that were being taken before admission and involves contacting the patient's GP.

Directorate	**2015/16 Complete (%)**	**2016/17 Complete (%)**
City and Hackney	96.7%	93% (1077/1155)
MHCOP	99.0%	95% (242/256)
Newham	98.6 %	96% (1401/1460)
Tower Hamlets	98.1%	96% (1061/1103)
Forensics	100%	76% (47/62)
Trust Total	**98.5%**	**95% (3828/4036)**

Duty of Candour

Regulation 20: Duty of Candour came into operation in November 2014 to promote honesty, openness and transparency throughout the NHS. Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust.

Its purpose is to create a culture of openness and transparency between healthcare providers and patients about their care and treatment, including when it goes wrong. The process entails recognising when an incident has occurred which has caused the patient harm, notifying the patient and stating the known facts as to what has happened, keeping them informed as an investigation progresses, and most importantly, giving the patient a meaningful apology. For non-compliance there are fixed penalties of up to £4,000 that can be imposed by the Care Quality Commission and fines of up to £50,000 that can be imposed by magistrates.

The Trust is undertaking a Quality Improvement Project on Compliance with the Duty of Candour, the aim of which is to be fully compliant with the statutory Duty of Candour for 80% of cases to which it applies by 30 June 2016.

The Trust utilises the Datix Risk Management system for the reporting of incidents. Any member of the Trust has the ability to report an incident and will detail as much information as possible when they do so. The Governance Team monitors incidents where a Duty of Candour requirement exists, which includes a review of the severity of the incident against set criteria which is updated daily by the Governance Team.

In response to the internal audit report additional assurance has been built in to the duty of candour process. All incidents are screened by the Chief Medical Officer for potential duty of candour thresholds, additional fields have been added to Datix, the Trust's incident reporting system to ensure decisions are captured and there has generally been awareness raising throughout the Trust, both globally and at directorate level.

3.1.2 Positive stories from across the Trust

Quality Improvement – Violence Reduction April 2016 – March 2017

Building on work started in Tower Hamlets in 2012, we have continued to focus on reducing violence on our inpatient wards, using a Quality Improvement approach. This year the original test site in Tower Hamlets, the Tower Hamlets Violence Reduction Collaborative, continued to focus on holding the gains achieved in 2015, of 40% across the unit and 60% across the acute wards.

New Quality Improvement learning collaboratives were launched in City and Hackney adult inpatient unit in early 2016 and Newham adult inpatient unit, using the change ideas that were effective in Tower Hamlets. Major change has already been seen on a number of wards, as outlined below. Forensics has also launched its own violence reduction collaborative, drawing on learning from adult inpatient wards, but recognising the differences of the Forensic inpatient environment.

Results from this work include:

Tower Hamlets 6 inpatient wards have reduced violence across all 6 wards by 40% and restraints per 1000 occupied bed days across all 6 wards by 60%. There has been a 57% reduction in violence per 1000 occupied bed days across the acute wards only. There has been a 77% reduction in restraints per 1000 occupied bed days across the acute wards. As the first test ward on this project, Globe Ward in Tower Hamlets has achieved greater reductions, and has now sustained an 88% reduction over the past 4 years. Roman Ward, has achieved a 72% reduction in violent incidents, dropping from 42 in 2014 to 14 in 2015.

Violence has reduced by 42% across the acute wards in City and Hackney and there are early signs of reduction on Bevan PICU. Gardner Ward and Joshua Ward in City and Hackney have sustained reductions of around 66% since May and September 2016 respectively

Topaz Ward and Emerald Wards in Newham have seen early signs of reduction in the region of 60%.

Comments by staff, service users and patient liaison workers across the 3 units about the impact of this work include:

- *"4 months ago I was really scared to come to work, but it's getting better"*
- *"I think there is a shift. Before we started this, no one talked about it. Now we are bringing it up, which says 'it is not ok' "*
- *"We're no longer fire-fighting all the time… "*
- *"I'm just really pleased that it's permeating out and patients are feeling able to broach the subject"*
- *"The team feels more confident and are having better discussions around issues that may arise. The team are talking about risk and making decisions - something that would never have happened 18 months ago"*

- *'I find them (huddles) an essential part of the shift; a space for us all to communicate and highlight risks to keep us safe'*
- *"There's a better therapeutic environment and patient satisfaction. You can feel the lowered levels of stress for staff and patients. There's a much closer working relationship and respect between disciplines now and I think this has been a driving force"*
- *"Well, what can I say, the team are fantastic! Thank you for helping all the patients here. You save lives and give us a second and third chance"*

If you would like to learn more about this, work please find papers and blogs published in the past year:

Rethinking Expectations: Reducing Violence in Mental Health Using QI
By Andy Cruickshank, Associate Director of Nursing for QI and Improvement Advisor, ELFT | Friday, August 12, 2016
http://www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=291

"Violence was the elephant in the room" – Empowering Staff to Face Hard Truths and Lead Change
By Jen Taylor-Watt, QI Lead and Improvement Advisor, ELFT | Thursday, February 16, 2017
http://www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=364

Reducing physical violence and developing a safety culture across wards in East London
By Jen Taylor-Watt, Andy Cruickshank, James Innes, Brian Brome, Amar Shah | British Journal of Mental Health Nursing January/February 2017 Vol 6 No 1
https://qi.elft.nhs.uk/wp-content/uploads/2017/02/Violence-reduction-at-ELFT.pdf

Positive feedback from the CQC - Service User Involvement at ELFT

Our CQC inspection report highlights the great work going on across the Trust to involve service users, and their carers, in their care and in the development and improvement of services. It is evident that this was a key contributor to the outstanding rating we received. We are particularly proud that by putting the service user and carer values at the heart of day-to-day working, our People Participation Team has been able to support:

- Training, supporting and facilitating service users and carers to sit on staff interview panels
- Training staff in a range of topics like care planning, compassion, recovery and engagement
- Helped develop a new CPA process which has a greater focus on Recovery
- Our Back On Track project (with Docklands Light Railway) won a UK National Rail Award
- Training all Job Centre Staff in our East London boroughs in Mental Health Awareness
- Continuing to improve the input from service users/carers in our quality improvement programme
- Expanded the team to include a CAMHS People Participation Lead
- New interview process for consultant psychiatrists (formal and informal panels)
- First ever People Participation awards to celebrate the contributions of service users and carers
- Started an academic research project to measure the potential impact of people participation on recovery
- Have been working tirelessly to improve the impacts of stigma in our services, ourselves and our communities

Building on these in 2017/18, the People Participation Team will continue to support people to get involved. This will include on-going outreach and supporting new people to get involved; to continue to increase the number of people involved; to increase the range of activity, training and opportunities; to challenge poor service delivery and work towards continuous improvement.

Service Transformation - Luton and Bedfordshire CAMHS

Huge strides have been made during 2016/17 in developing CAMHS services across Luton and Bedfordshire to better meet the needs of the local population.

Leadership

The clinical leadership and management structure is now embedded across all teams to ensure the service is clinically led and managerially supported.

Access to services

The new model has now become embedded within everyday practice following the implementation of the single point of entry and the daily triage of all new referrals. The service has developed a Clinician of the Day (COD) rota which all clinical staff contribute towards. In addition to screening all referrals for risk the COD acts as a single point of contact for all new or urgent business coming into CAMHS, such as new referrals, urgent enquiries about future/possible referrals and urgent queries about cases where the allocated clinician is not available. They also gather addition information from referrers and/or families when it is unclear whether the referral is appropriate for CAMHS. This model and the development of new services has improved access and reduced waiting times for people referred to our services.

Crisis Services

The local transformation plans continue to progress with momentum and we are pleased to confirm that we have now appointed 5.00 of the 6.00 wte funded posts for the countywide CAMHS Crisis service covering Luton and Bedfordshire.

The service is staffed with Registered Mental Health Nurses who are skilled to provide rapid face to face mental health crisis assessment to any young person in mental health crisis at the local acute NHS Trusts (L&D and/or Bedford hospital) between 09.00 – 21.00 weekdays and 10.00 – 14.00 hours at weekends. It is hoped to increase the weekends to 16.00 hrs once all the staff are in place.

Once assessment has been completed the outcome will determine appropriate signposting to relevant services on the presenting clinical needs and risk; which may include in-patient admission, therapeutic interventions from any of the local CMAHS teams for further treatment options or other mental health services if appropriate.

The staff are also able to offer telephone advise to potential referrers on the management of cases presenting with potential risks which may trigger a possible referral into the services – such cases have been diverted from local A&E departments, and offered an assessment in the CAMHS clinic or home environment. This has helped to reduce numbers of young people being admitted onto paediatric wards

Community Eating Disorder Services

The countywide Community Eating Disorder service (CEDS) are currently working in line with the National Eating Disorder targets for assessment of 5 days for urgent cases and 28 days for routine cases. The COD will assess daily and if the presenting problem is eating disorder will forward the referrals to the Eating Disorder team to ensure any unnecessary delays are eliminated.

Staffing into the team is almost complete and it is hoped that the Consultant Psychiatrist and Dietician will be appointed in Q4.

The team have had various team away days to plan priorities for the service and agree a training plan. In keeping with NICE guidance, the team have recently completed training for Dialectic Behavioural Therapy (DBT) in Family Therapy for the management of Anorexia Nervosa at the Maudsley NHS Trust.

Early Help/School Programme

The targeted CAMHS workers are both now embedded in each of the Early Help teams within BBC and CBC and are providing integrated support to children, young people and their families.
The key objective is to offer advice, support, consultation and training as well as directing case work, with the intention of early intervention and prevention. Intervention at an early stage aims to prevent escalation, therefore reducing the need for statutory or further interventions later in life. This can involve intervening both at an early age and an early stage of a presenting difficulty.
The Early Help CAMHS staff have negotiated strong links with both the Local Authorities, in order to bridge the gap between health and social care, and work closely with a range of statutory services, voluntary organisations, and schools.

In addition to direct clinical work which is predominantly undertaken at home or in the school, the Early Help CAMHs workers will provide consultation and training to local authority staff within the Early Help Teams. Consultation will consist of case discussion and exploration of current difficulties as presented by the worker. The training is led by a needs analysis based upon feedback from workers with regards to broadening an understanding of child and adolescent mental health. The training will also aim to equip staff with strategies and interventions where necessary in order to respond to early presentations of mental health difficulties that emerge within the Early Help arena.

Health promotion - Flu fighter campaign.

In 2017 East London NHS Foundation Trust (ELFT) became one of the most improved trusts in the country increasing its uptake among staff of the flu vaccine from 21 per cent the year before to 67 per cent.

More than 3,000 staff were protected (up from 1,000 the previous year!) following an ambitious campaign engaging staff across more than 100 sites ranging from Bedford and Luton to east London.
A survey carried out the previous year showed the extent of the challenge. Staff were cynical about the merits of the flu jab and were sceptical of its relevance, especially in mental health.

The decision was taken to have a bespoke campaign tested with staff that tackled the myths around the vaccine and ensured it was as easy as possible for staff to get the jab.

The previous year's survey of ELFT staff showed the top three reasons for refusal were:

- The vaccine doesn't fully protect
- Flu isn't a serious illness
- Events should take their course

It was decided that the myth busting campaign, which ran for four weeks prior to the vaccinations starting, would relay four key messages:

- All patients are at risk
- Flu is a serious illness
- You're better protected with the flu jab
- You can't catch flu from the vaccine

Each week, over four weeks, a different theme was used for the myth-buster campaign with posters and flyers sent to all sites, a specially dedicated intranet page featuring frequently asked questions, and a letter was sent to the home of all staff from the chief executive asking for their support. A new story appeared on the staff intranet almost every day including an interview with the chief pharmacist to emphasise that the 'science behind the jab does work' and that the main cause of staff illness were colds and flu and the impact that had on colleagues struggling to provide cover.

Vaccinations began with an intensive two week campaign with clinics at more than 50 sites. This was supplemented with 121 specially identified peer vaccinators available on request in every team.

The entire campaign ran from September 2016 to March 2017. ELFT ensured the Trust's success was celebrated and those we'd rely on for next year's campaign, especially the peer vaccinators,

were thanked. An extensive survey has already been launched with staff to find out what worked well and what didn't so we can start already preparing for next winter.

In the meantime, ELFT's patients are better protected, myths have been busted changing the culture of the organisation to make it easier in future years to encourage staff to be vaccinated and the Trust looks set to realise £660,000 of CQUIN incentive money to invest in frontline services.

3.2 Patient Feedback

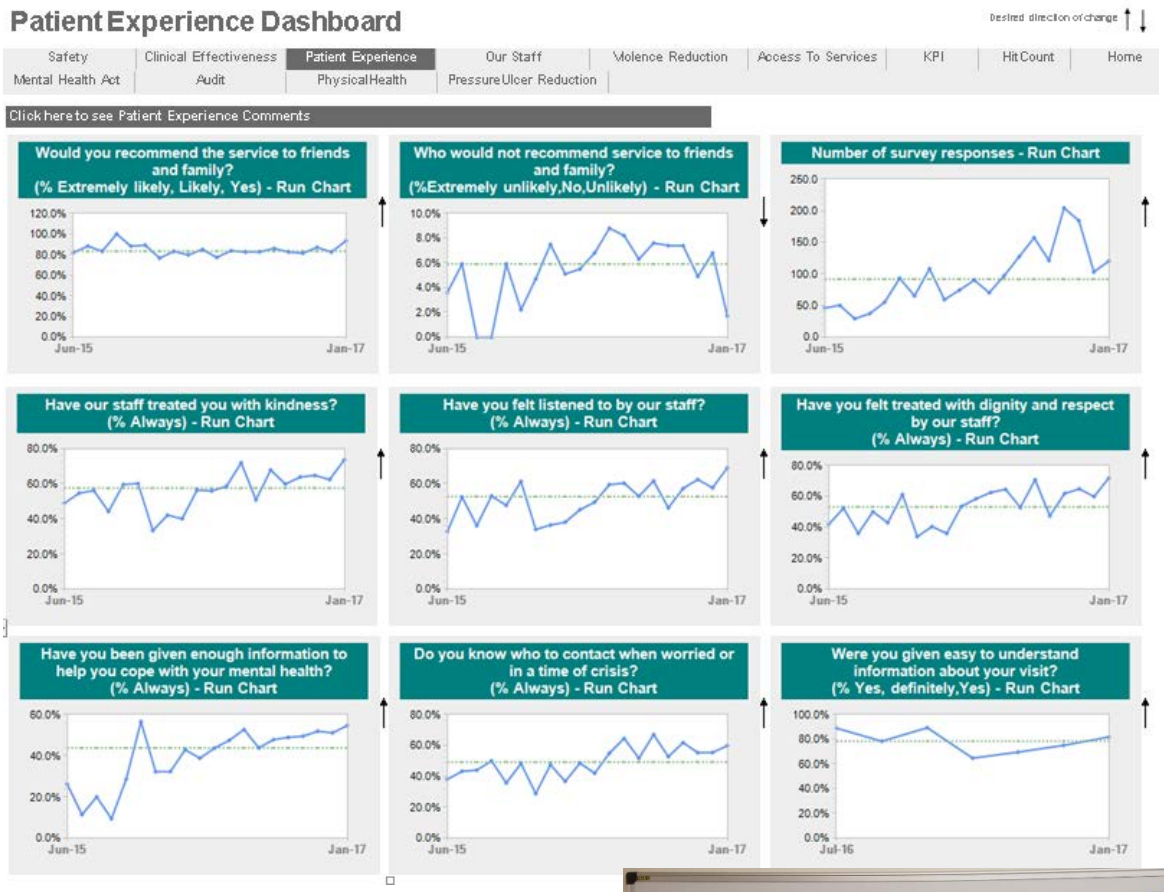
3.2.1 Patient reported experience measures (PREMs)

Central to the Trust's Quality Strategy is the belief that all people who use the services provided by the Trust should have the opportunity to leave feedback regarding their experience. The Trust employs a range of approaches to collect this information, using a variety of methods and measures. The primary measure is the Friends and Family Test (FFT) which is collected alongside appropriate Patient Reported Experience Measures (PREM) from all inpatient and community services across East London, Bedfordshire and Luton. All FFT data is then submitted to and published on the NHS England website. The Trust continues to exceed the average 'mental health recommend' response across the country during 2016/17.

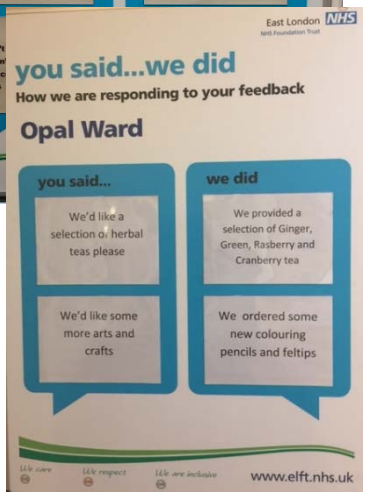
All data is collected using electronic devices such as 'tablets' or kiosks, however, it is also possible for service users and carers to complete feedback questions via the Trust website. All questions are available in easy-read versions to ensure that all people are able to provide feedback. During 2016/17, 85% of teams across the trust collect patient feedback electronically, with 100% of teams inputting the data electronically.

The FFT and PREM data is available to view by both clinical and operational staff via the development of real-time patient experience dashboards in the Trust. Illustrated below is an example Directorate dashboard. The dashboards are an innovative idea used by staff to monitor feedback and identify changes to improve the quality of the service and can be broken down to Trust, Directorate and Team-level data. The dashboards also display all qualitative feedback (comments) received and reports are printed and displayed in communal areas within each service. In addition, Directorates are also provided with supporting 'summary reports' which condense large amounts of data into the key highlights including where to: celebrate success, focus improvement action and share learning.

An example of the real-time Patient Experience Dashboard FFT & PREM by direcotrate



In addition, it is vital services are acting on feedback and during 2016/17 the Trust implemented the 'You Said We Did' board campaign across the Trust to provide an opportunity for services to demonstrate actions arising from service user comments and showcase the changes made in response to this. Furthermore, 'Patient Experience Action Trackers' were formally introduced within services to monitor and document any changes identified from feedback received.



Also, a series of supporting videos were created to provide an accessible 'step-by-step' guide to collecting, reviewing and taking actions based on their patient experience feedback, which has led to the Trust being successfully shortlisted for two Patient Experience Network National Award categories including 'Measuring, Reporting and Acting' and 'FFT and Patient Insight for Improvement'.

Alongside this, a review of all comments was under taken throughout the year and a large number commented on what was good about their visit. A number of themes emerged from the data with the majority of service users stating that they had a positive experience of care, a sample are highlighted below:

"Everything is fantastic"

"Nothing is too much trouble; I have always been offered time and advice in equal measures when needed. The amount of care dignity and kindness shown to my father in law by all staff has surpassed my expectations in every way. I go home and know he is truly being cared for and for me that us priceless...THANK YOU ALL"

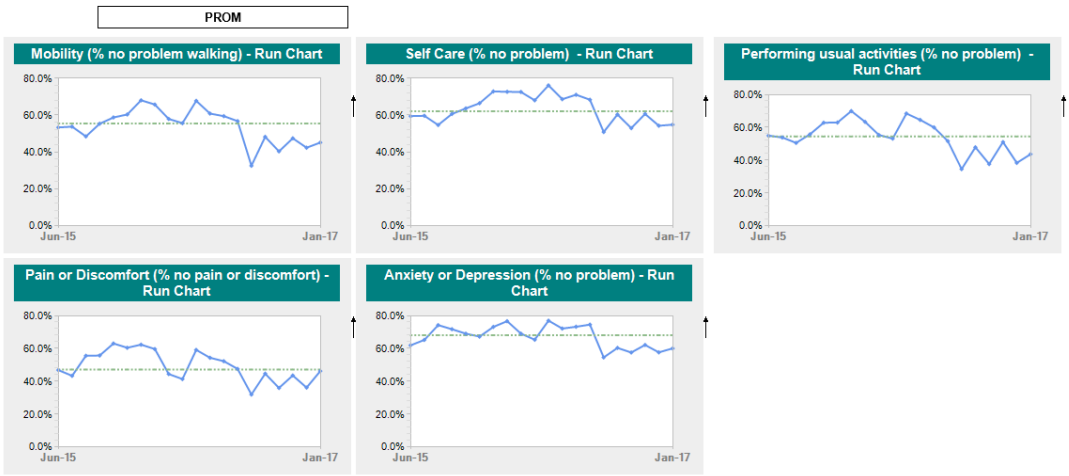
"The level of care here is amazing and everyone is the same, I've not come across anyone here who has not shown a genuine kindness"

Further to the automation of data, a network of patient experience leads have been identified within each Directorate to promote and embed consistent patient experience practice across the Trust. The main benefit of this effort has been to drive up the number of change actions arising out of patient experience feedback and to further embed changes across the services.

Community Health Newham (CHN) – Patient Reported Outcome and Experience Measures (PROM and PREM)

In addition to patient experience data, services across Community Health Newham (CHN) collect patient reported outcome measure (PROMs) data which includes collation of the national EQ-5D tool. All services collect the data via tablet devices, touchscreens and via the trust website. Results from PROMs are circulated to teams and monitored by the CHN Quality Assurance Group. In addition, a number of CHN services have added bespoke questions to the PROM tool, in order to tailor the information obtained. The PROM questions are also displayed on the Trusts real-time patient experience dashboard.

An example of the Community Health Newham PREM & PROM summary dashboard



CQC – Survey of people's experiences of community mental health services (2016)

The Trust also participates in the CQC National Community Mental Health Patient Survey. Although the response rate for this is relatively low, the feedback is often very positive. At the start of 2016, questionnaires were posted to 850 people who received community mental health services. Responses were received from 180 service users. The Trust's scores are compared against scores from other trusts nationally. This takes into account the number of respondents from each trust as well

as the scores for all other trusts, and makes it possible to identify which scores we can confidently say are 'better' or 'worse' than the majority of other trusts.

CQC summary table of ELFT data compared to all other trust and data from the previous year

Patient survey	Patient responses	Compared with other trusts	Change since (2015/16)
Health and social care workers	**7.8**/10	About the same	+ 0.2
Organising Care	**8.6**/10	About the same	- 0.1
Planning Care	**7.1**/10	About the same	- 0.1
Reviewing Care	**7.4**/10	About the same	- 0.3
Changes in who people see	**7.4**/10	Better	+ 0.3
Crisis Care	**6.5**/10	About the same	- 0.4
Treatments	**7.5**/10	About the same	-
Support and wellbeing	**5.3**/10	About the same	- 0.4
Overall views of care and services	**7.2**/10	About the same	- 0.2

[2] *Detailed data are available on the CQC website:* http://www.cqc.org.uk/provider/RWK/survey/6

ELFT service user ratings are similar to last year across most domains. The areas where ratings have reduced, ELFT scores are still 'about the same' as most other mental health trust scores. The Trust ratings are 'about the same' as national averages in eight of the nine domains and 'better' in one. The overall rating (6.9) is slightly up since last year's score.

3.2.2 Complaints & Patient Advice and Liaison Service's Annual Report 2016/17

East London NHS Foundation Trust is a learning organisation that is committed to listening to the views of its services users, their carers and families and continually improving the quality of care and services we provide.

Concerns and complaints were dealt with by both the Patient Advice & Liaison Service (PALS) and Complaints functions. We want the process to be fair, flexible and conciliatory and PALS staff work with patients who wish to have a speedy and informal resolution to their concerns. Between 1 April 2016 and 31 March 2017, PALS received 786 contacts. This is currently a slight proportionate increase on last year (730 contacts for the entire year). The service assisted on 445 occasions when individuals had concerns and sought resolution compared to 385 for the entire 2015/16 year. This is a proportionate increase on the number of contacts.

Individuals who contacted PALS for assistance in resolving concerns, most commonly raised issues relating to Communication (11%) Clinical management of mental health (7%) and access: Appointment issues (Late/DNA/Cancellation) (6%). In 56% of cases, PALS were able to resolve the issue to the satisfaction of the individual. Of the remaining cases, 47% of issues were either passed to the local teams to undertake further work with the service users, or the Trust considered there was nothing further that could be done to resolve the issues. In 5% of cases, concerns could not be resolved informally and were escalated for formal investigation under the Trust's complaints procedure. In 9% of cases where concerns were raised remained unresolved or resolved from the Trust point of view only.

During the same period, the Trust received 402 complaints. This is a proportionate increase compared to the whole previous year 2015/16, when 298 formal and 7 informal complaints were received. Four complaints were referred to the ombudsman, one was withdrawn, one remains under ongoing investigation, one was partially upheld, and one of those was upheld.

The Trust aimed to acknowledge 90% of complaints within 3 working days and 82% of complaints received were acknowledged within this timeframe. The Trust aimed to respond to a minimum of 85% of complaints within 25 working days or an agreed extension. At the time of writing, the Trust has replied to 52% of complaints within this timescale, with 55 of the formal complaints still remain actively open (13%) and under investigation with an agreed plan made with the complainant.

The majority of complaints are made by service users who account for 240 (60%) of the formal complainants. 118 (29%) complaints were made by relatives and / or carers, or friends or advocates on behalf of service users the Trust has seen an increase since last year on this type of contact. The Trust received 4 contacts from the MPs directly raising issues on behalf of his constituents all of which required an investigation and a formal response.

As a learning organisation, there continues to be an emphasis on ensuring that we learn from complaints and that recommended changes to our systems and practice, are implemented. This is all the more important given that many of the complaints which are investigated reveal shortcomings in the delivery of care or in our services. Of the cases which have been investigated and closed to date, 36% were either upheld in part or fully upheld following a full investigation into the complaint.

As a result of lessons learned from complaints, the following actions have been taken to improve services for patients:

Community Health Newham

MSK

- Waiting list - now greatly reduced, due to increased staffing, re-allocation of GP clusters to more evenly distribute caseload amongst staffing/resources. So now able to prioritise and see urgent referrals in timely way.
- Team to continue to prioritise recruitment, speedy advertising of vacancies as soon as they arise.
- Team to continue to educate referrers on providing full information on referral to enable triage/prioritisation.

EPCT and VW

- Service has included information leaflets in the home notes
- Fact sheet for staff on recording keeping (face to face and non-face to face contact)
- At team meetings staff discuss ways in which they can help relieve some of the anxieties around catheter care and wound care for service users and family/carer through conversation and information leaflets
- Roll out of Positive Patient Experience Training – external provider with training objectives around first impressions, managing patient expectations, cultural awareness and verbal/nonverbal commination.

Vicarage Lane Health Centre

- Service has submitted a bid for screens to be installed at the reception areas across all CHN sites
- Health Safety and Security group integrated to invite GP services at Vicarage Lane

Foot Health

- The team now offers a walk in clinic once a week
- Service is working closely with Barts Health Transport Company to improve the service they provide for service users particularly around waiting times

MHCOP - Leadenhall Ward and Columbia Ward

- Managing Property Board set up to monitor incidents / process
- Training for staff away day

- Spot check carried out by counter fraud team
- CCTV to be set up on all ward areas
- Roll out of EHCC Patient Property Policy in MHCOP services

Luton

- Communication with service users' needs to improve in the following areas: receiving copies of care plans, discharge summaries, medication reviews, diagnosis, letters following appointments and when transferring between services
- Communication between the services and other external agencies G.P's particularly around discharge arrangements.
- In-patient teams to improve communications with the respiratory team to better manage respiratory issues on the ward. Training on physical health parameters to be offered to ward staff
- Improved communications with carers. This includes speedy responses when patient property goes missing or is lost Improved processes for recording patient property on the ward
- Risk management process around collecting chronology and family history and involvement in managing risk
- Appointment of People Participation Leads will ensure increased engagement and support
- Lessons Learned Group now established
- The launch of Q1 Projects for Bedfordshire 16/17. Feedback from complaints will be included for consideration of local projects
- Review of the local complaints process to minimise the risk of re-opened complaints and improve response times. Completion of action plans requested if recommendations/learning is identified in a complaint response. More frequent complaints training for Bedfordshire and Luton staff is required
- Operational guidance for staff on the handling of complaints is required to support the Trust's complaints policy

3.3 STAFF FEEDBACK

3.3.1 ELFT 2016 NHS Staff Survey

Over 2,070 employees took part in the 2016 NHS Staff Survey resulting in an improved response rate of 45% as compared to 35% in 2015.

The 2016 NHS Staff Survey results are encouraging with staff reporting high scores of staff reporting good communication with senior management, quality of non-mandatory training, learning or development, staff recommending the organisation as a place to work or receive treatment

Our overall staff engagement score remains high with a summary score of 3.95, well above the national average when compared with trusts of a similar type which is at 3.80. The results also indicate that staff engagement amongst BME staff is at 4.02 which is higher than amongst staff from White ethnic backgrounds.

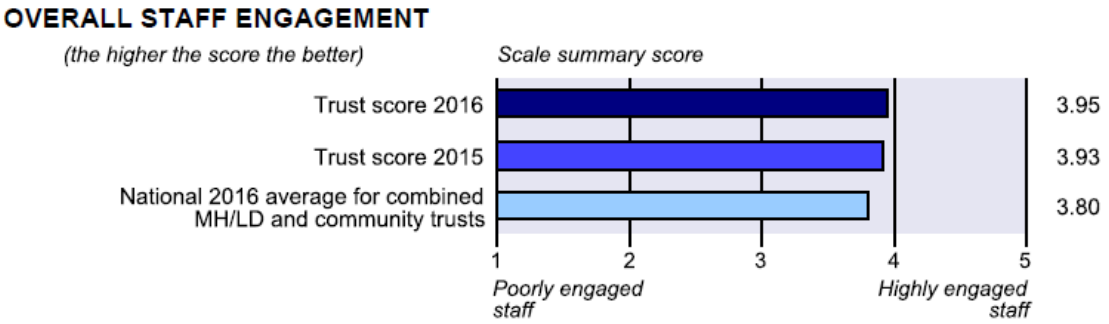
The Trust has achieved the best scores for 10 key findings amongst Trusts of a similar type in the entire country. These include the following:

- Staff recommendation of the organisation as a place to work or receive treatment
- Staff satisfaction with the quality of work and care they are able to deliver
- Staff agreeing that their role makes a difference to patients/service users
- Recognition and value of staff by managers and the organisation
- Staff reporting good communication between senior management and staff
- Staff able to contribute towards improvements at work
- Quality of non-mandatory training, learning or development
- Staff satisfaction with resourcing and support
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Effective use of patient/service user feedback

The results also highlights areas where further improvement is required and they include: staff experiencing discrimination at work, staff experiencing physical violence from patients, relatives or public, staff working extra hours and staff believing that the organisation provides equal opportunities for career progression or promotion. The HR Team along with the individual Directorates have already started working on delivering actions for a few of these areas in order to bring about an improvement.

Overall indicator of staff engagement for East London NHS Foundation Trust

The figure below shows how East London NHS Foundation Trust compares with other combined mental health / learning disability and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.95 was above (better than) average when compared with trusts of a similar type.

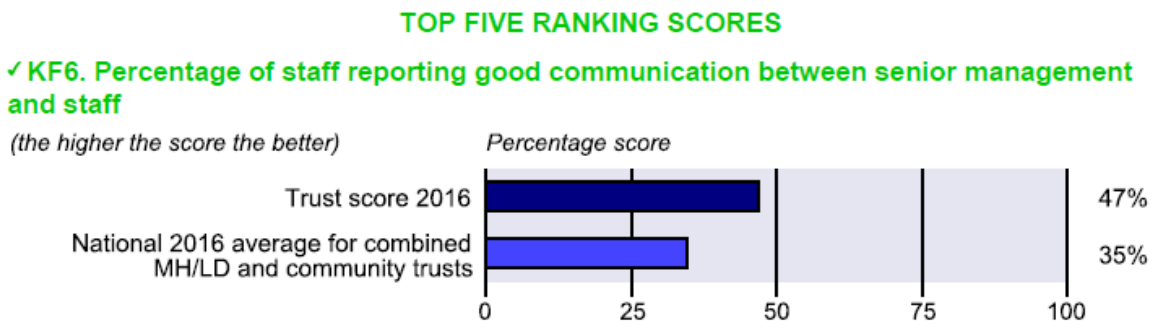


The below table shows how the Trust compares with other mental health/learning disability trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2015 survey.

	Change since 2015 survey	Ranking, compared with all combined MH/LD and community trusts
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	✓ Above (better than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Above (better than) average

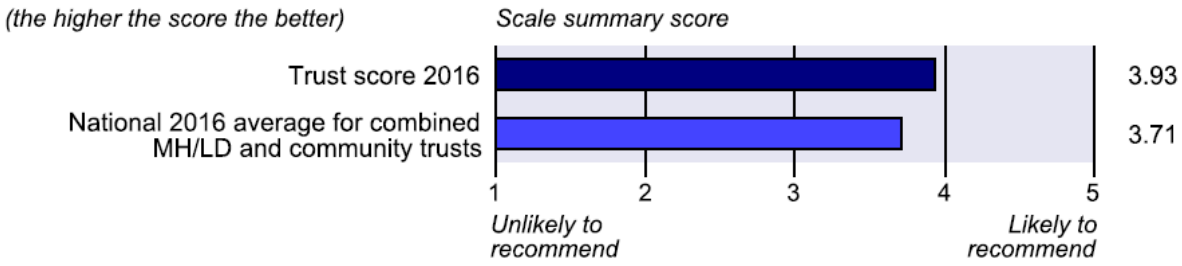
Summary of 2016 Key Findings for East London NHS Foundation Trust

Top and Bottom Ranking Scores

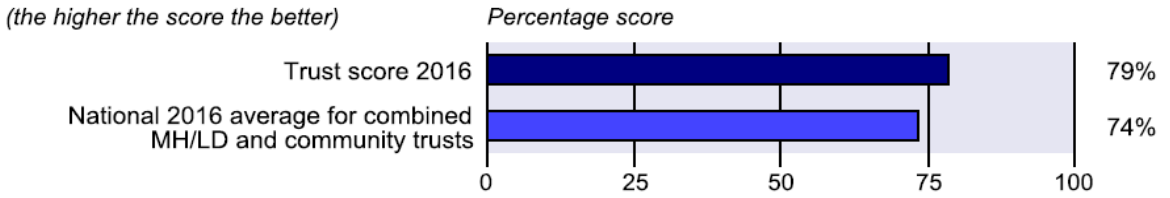


✓ **KF13. Quality of non-mandatory training, learning or development**

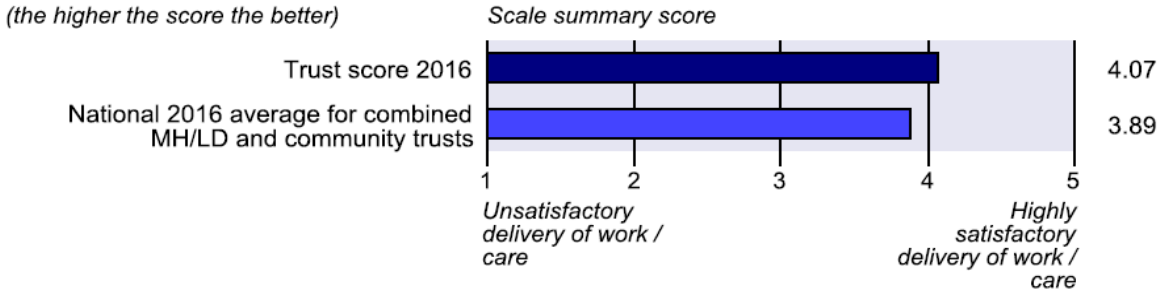
✓ **KF1. Staff recommendation of the organisation as a place to work or receive treatment**



✓ **KF7. Percentage of staff able to contribute towards improvements at work**



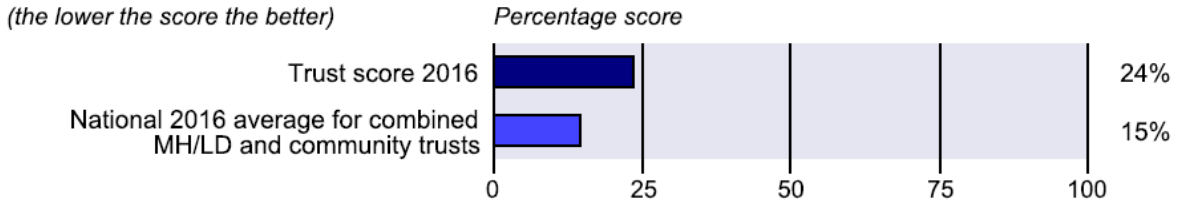
✓ **KF2. Staff satisfaction with the quality of work and care they are able to deliver**



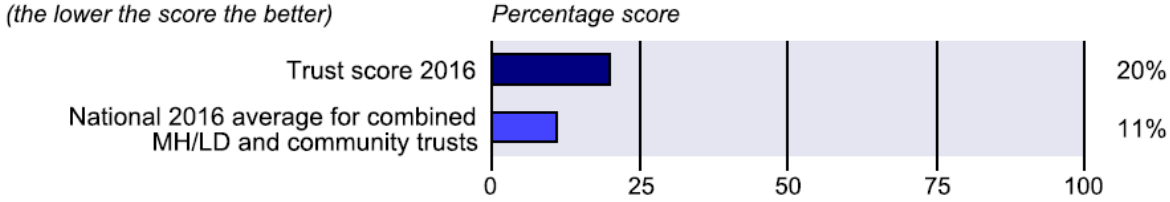
These data highlight the five Key Findings for which East London NHS Foundation Trust compares least favourably with other mental health/learning disability trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

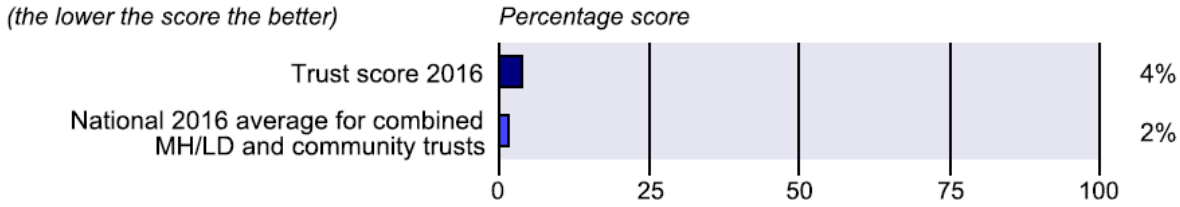
! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



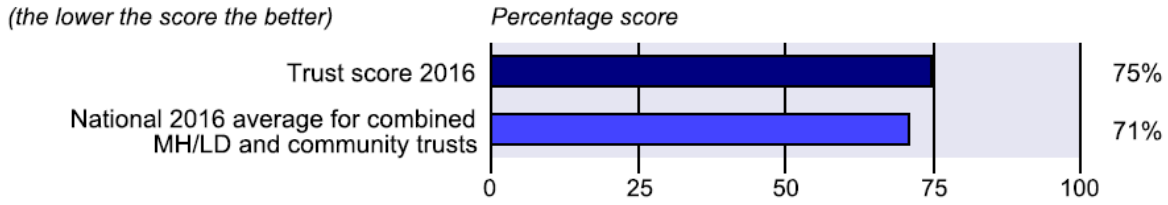
! KF20. Percentage of staff experiencing discrimination at work in the last 12 months



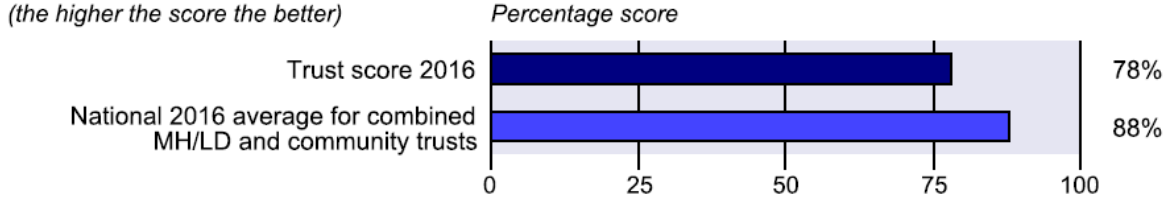
! KF23. Percentage of staff experiencing physical violence from staff in last 12 months



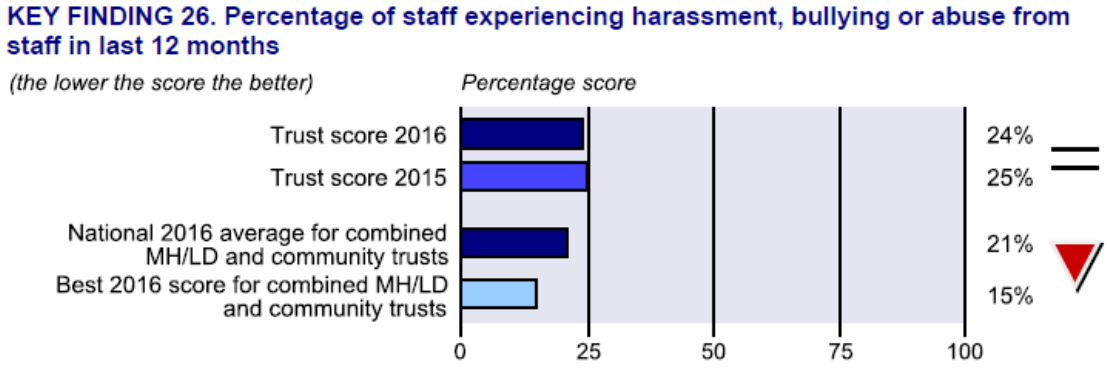
! KF16. Percentage of staff working extra hours



! KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



Key Finding 26

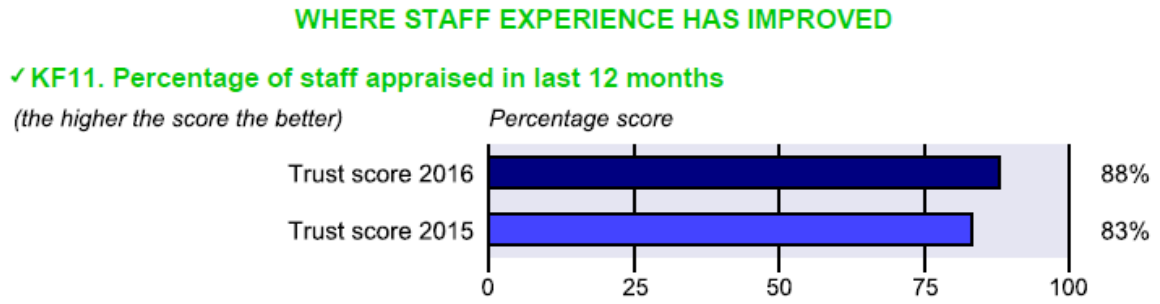


The internal Bullying and Harassment Advisory service is promoted extensively on the Trust intranet. There are plans to review the current service and assess if a recruitment drive is required to further increase the pool of Advisors to ensure that there is a presence across all sites.

As an additional resource, Trust employees can contact the free Employee Assistance Programme helpline in case they want to access confidential care service and free counselling sessions.

Largest Local Changes since the 2015 Survey

The following finding indicates where the trust has improved most since the 2015 survey. However, it is to be noted that when compared with other combined mental health/learning disability and community Trusts in England, the score is worse than average.



This feedback is extremely important in helping shape the actions we will take in the future to create a work environment that is not only productive but also rewarding for all our employees. Whilst the overall results indicate that the Trust's performance on various key factors is very positive, there are certain areas where the Trust can further improve.

We have started worked closely with a cross section of corporate and clinical staff to discuss the priorities that we should focus on in the coming year. We are currently collating a Trust-wide action plan which addresses the key tasks under each of these areas. Whilst the majority of the actions will be delivered in the forthcoming year, some of the actions are long term objectives. There will be an overlap of priorities that will be delivered locally in each of the Directorates and across the entire organisation.

We will have a dedicated area on the intranet for the NHS Staff Survey where you will find the Trust-wide action plan for 2016/17. This page will be updated on a regular basis and will include links to all related topics. You will be able to give your comments on the web page.

3.3.2 Feedback from NHS Staff Friends and Family Test 2016/17

The Trust will roll out the fourth quarter of the 2016/17 NHS Staff Friends and Family Test (FFT) in the end of February 2017. The Trust carries out the survey for Quarters 1, 2 and 4 and the results from the NHS Staff Survey provides the results for the Quarter 3.

The survey includes two mandatory questions along with a few local questions. 33% of our workforce across all directorates were randomly selected to take part in this survey:

1. How likely are you to recommend the Trust to friends and family as a place to work?

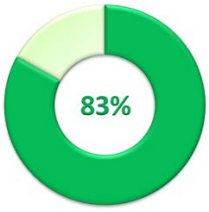
FFT Survey	Quarter 1 %	Quarter 2 %	Quarter 3 %	Quarter 4 %
Recommend	74%	75%	70%	N/A
Not Recommend	12%	10%	11%	N/A

2. How likely are you to recommend the Trust to friends and family if they needed care or treatment?

FFT Survey	Quarter 1 %	Quarter 2 %	Quarter 3 %	Quarter 4%
Extremely Likely	79%	80%	71%	N/A
Extremely Unlikely	6%	5%	9%	N/A

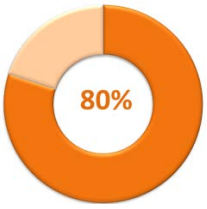
Additional Local Questions

In addition to the above mentioned mandatory questions, staff provided feedback on the following areas:



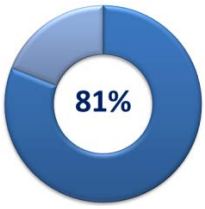
% staff believed that there was **effective team working** in their area of work

% staff said that there was **effective communication** with local senior management



% staff feeling that their **work was valued** by colleagues and their line manager

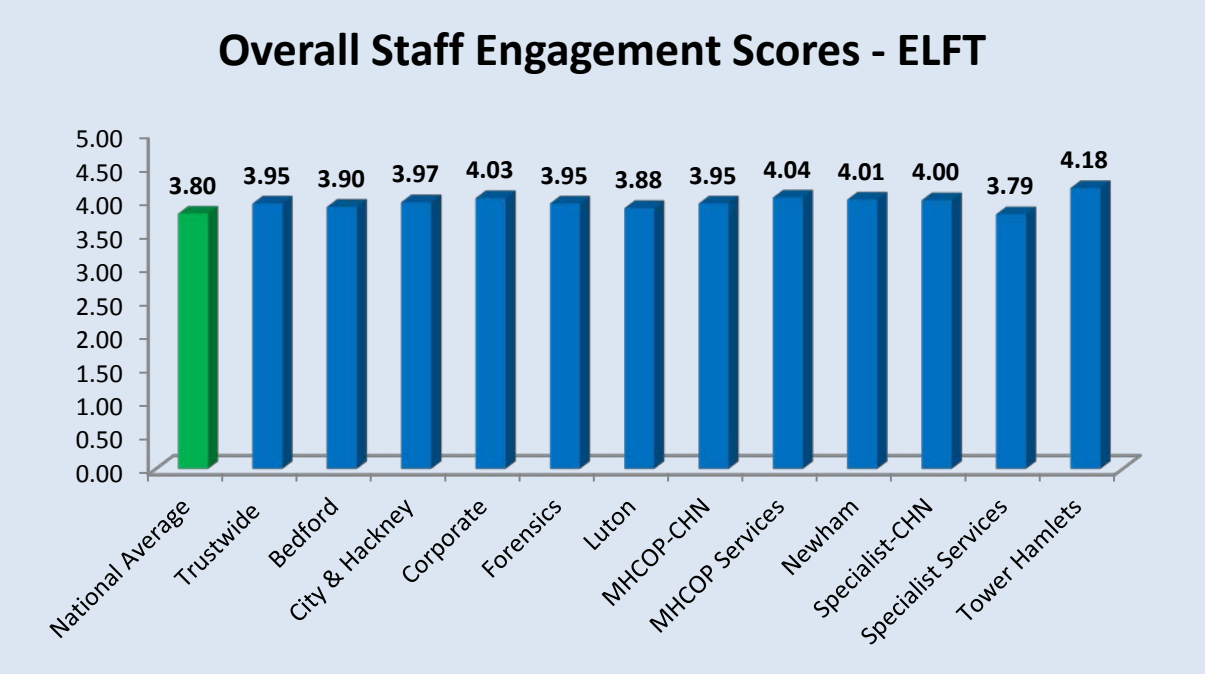
% staff agreeing that they were **treated fairly** by their colleagues and managers at work



The Trust maintained its generally high scores. The Trust's score for the overall staff engagement indicator was 3.95 across combined mental health/learning disability and community trusts in England. The national results for all NHS Trusts are currently not available and we will only be able to compare our Trust's results with the others once the national results for all the Trusts are released. The Trust's ranking over the least three years is therefore as follows:

Year:	National ranking:
2014	1st=
2015	4th=
2016	N/A

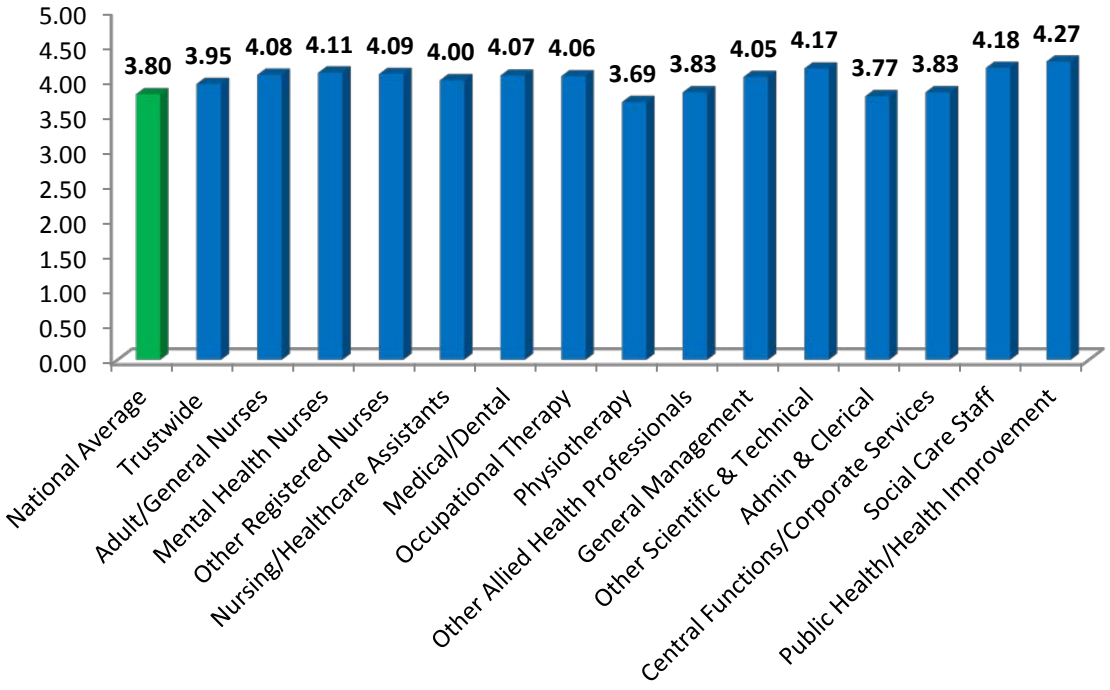
The graph below shows the scores in relation to other directorates (and compared to the national average and lowest score nationally):



The table below shows the levels of engagement in Luton & Bedfordshire which are well above the national average, and have slightly increased since 2015 (as shown below) This is positive given the short time that the Trust took over the services in Bedfordshire and Luton in April 2015 and the amount of organisational change that the services are undergoing.

	2015	2016
Bedfordshire	3.88	3.90
Luton	3.85	3.88

Scores are also broken down by profession, which also shows variation, although all groups are above the national average. The Trust-wide action plans will incorporate strategies to address concerns affecting various staff groups.



The Trust's approach to improvement

The Trust's approach to improving staff experience and engagement can be summarised as follows:

- Improvement action to focus on a small number issues most relevant to staff satisfaction, rather than a "deficit model" approach of trying to improve all indicators that are low and/or below the national average.
- To link with existing work streams/quality improvement project where appropriate, in order to avoid duplication of effort and maximise impact
- Wide dissemination and consideration of results, so that improvement can also be planned and owned at a local level (directorate and sub-directorate, professional group and equalities).

The 2016 results have been recently published by the NHS Staff Survey Coordination Centre and the results have been discussed at the Trust Board. The summary of the results will be circulated to all staff and discussed at the various Trust meetings including Service Delivery Board, Directorate Management Teams, professional groups and the Joint Staff Committee. Presentations will also be made to the staff equalities networks and other relevant forums.

Improvement plan

As stated above, the 2016 results will be widely distributed, and each directorate and professional group have been asked to consider the results and develop an improvement plan, in line with the framework set out above. This work is being monitored by the Service Delivery Board.

A Trust-wide improvement plan was developed last year, and has been refreshed. This is a detailed project plan that pulls together many areas of work relevant to staff experience, and links to the Quality Improvement programme and other related work streams. The plan seeks to balance the need to continue improvement in areas that are most relevant to staff experience, regardless of whether the Trust's score is above or below the national average.

3.5 An Explanation of Which Stakeholders Have Been Involved

The Trust has a long history of working collaboratively with our service user and carer groups, the Trust Governors and local stakeholder groups. There is significant service user and carer participation in all of the Trusts key overview and reporting mechanisms, e.g. the bi-monthly Quality Committee, Patient Participation Committee and the Patient Experience Committee meetings.

3.6 Statements of Clinical Commissioning Groups (CCGs)

3.7 Statement from Tower Hamlets Healthwatch

3.8 Statement from Tower Hamlets Overview and Scrutiny Panel

3.9 An Explanation of any Changes Made

3.10 Feedback

If you would like to provide feedback on the report or make suggestions for the content of future reports, please contact the Director of Corporate Affairs, Mr Mason Fitzgerald, on 020 7655 4000.

A copy of the Quality Accounts Report is available via:

- East London NHS Foundation Trust website (http://www.eastlondon.nhs.uk/)
- NHS Choices website (http://www.nhs.uk/Pages/HomePage.aspx)

3.11 2016/17 Statement of Directors' Responsibilities in Respect of the Quality Report

TBC

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that 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*;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes for the period 1 April 2016 – 31 March 2017
  - Papers relating to Quality reported to the Board over the period; April 2016 – April 2017
  - Feedback from governors dated March 2017
  - Complaints & PALS Annual Report 2016/17
  - Mental Health Community Survey 2016 service users survey, issued in September 2016
  - National NHS staff survey 2016, issued in February 2017
  - Care Quality Commission Intelligent Monitoring Report, dated [February 2016]
  - The Head of Internal Audit's annual opinion over the trust's control environment, dated April 2017.
  - Statement from Tower Hamlets Healthwatch received [insert date]
  - Statement from Tower Hamlets Overview and Scrutiny Panel received [insert date]
  - Joint Statement from NHS Newham, NHS Tower Hamlets, and NHS City and Hackney Clinical Commissioning Groups (CCGs) received [insert date]
  - Statement from Luton CCG received [insert date]

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

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

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

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

xx May 2017

.....Date.....Chair

xx May 2017

.....Date.....Chief Executive

Glossary

Term	Definition
Admission	The point at which a person begins an episode of care, e.g. arriving at an inpatient ward.
Assessment	Assessment happens when a person first comes into contact with health services. Information is collected in order to identify the person's needs and plan treatment.
Black and minority ethnic (BME)	People with a cultural heritage distinct from the majority population.
Care Co-ordinator	A care co-ordinator is the person responsible for making sure that a patient gets the care that they need. Once a patient has been assessed as needing care under the Care Programme Approach they will be told who their care co-ordinator is. The care co-ordinator is likely to be community mental health nurse, social worker or occupational therapist.
Care pathway	A pre-determined plan of care for patients with a specific condition
Care plan	A care plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy. (See Care Programme Approach).
Care Programme Approach (CPA)	The Care Programme Approach is a standardised way of planning a person's care. It is a multidisciplinary (see definition) approach that includes the service user, and, where appropriate, their carer, to develop an appropriate package of care that is acceptable to health professionals, social services and the service user. The care plan and care co-ordinator are important parts of this. (See Care Plan and Care Co-ordinator).
Care Quality Commission (CQC)	The Care Quality Commission is the independent regulator of health and social care in England. They regulate care provided by the NHS, local authorities, private companies and voluntary organisations.
Case Note Audit	An audit of patient case notes conducted across the Trust based on the specific audit criteria outlined by CQC.
Child and Adolescent Mental Health Services (CAMHS)	CAMHS is a term used to refer to mental health services for children and adolescents. CAMHS are usually multidisciplinary teams including psychiatrists, psychologists, nurses, social workers and others.
CAMHS Outcome Research Consortium (CORC)	CORC aims to foster the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and emotional wellbeing difficulties.
Community care	Community care aims to provide health and social care services in the community to enable people to live as independently as possible in their own homes or in other accommodation in the community.
Community Health Newham (CHN)	Community Health Newham provides a wide range of adult and children's community health services within the Newham PCT area, including continuing care and respite, district nursing and physiotherapy.
Community Mental Health Team (CMHT)	A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and the community.
Continuing Care	The criteria for assessing long term care eligibility
DATIX	Datix is patient safety software for healthcare risk management, incident reporting software and adverse event reporting.
Discharge	The point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan. (see Care plan)
East London NHS	East London NHS Foundation Trust

Foundation Trust (ELFT)	
General practitioner (GP)	A family doctor who works from a local surgery to provide medical advice and treatment to patients registered on their list
Mental health services	A range of specialist clinical and therapeutic interventions across mental health and social care provision, integrated across organisational boundaries.
Multidisciplinary	Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.
Named Nurse	This is a ward nurse who will have a special responsibility for a patient while they are in hospital.
National Institute of Health Research (NIHR)	The goal of the NIHR is to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
National Institute for health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
(NCI / NCISH)	The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI / NCISH) is a research project which examines all incidences of suicide and homicide by people in contact with mental health services in the UK.
Patient Advice and Liaison Service (PALS)	The Patient Advice and Liaison Service offers patients information, advice, and a solution of problems or access to the complaints procedure.
PREM	Patient Reported Experience Measures. Indicators on patient levels of satisfaction regarding the experience of care and treatment.
Prescribing Observatory for Mental Health (POMH-UK)	POMH-UK is an independent review process which helps specialist mental health services improve prescribing practice.
Primary care	Collective term for all services which are people's first point of contact with the NHS. GPs, and other health-care professionals, such as opticians, dentists, and pharmacists provide primary care, as they are often the first point of contact for patients
Primary Care Trust (PCT)	Formerly the statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions
Quality Accounts	Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.
QI	Quality Improvement. A systematic method for identify and testing change ideas to improve the quality of services.
RiO	The electronic patient record system which holds information about referrals, appointments and clinical information.
Service user	This is someone who uses health services. Other common terms are patient, service survivor and client. Different people prefer different terms.
Serious Mental Illness (SMI)	Serious mental illness includes diagnoses which typically involve psychosis (losing touch with reality or experiencing delusions) or high levels of care, and which may require hospital treatment.

Contact us

The Trust's postal address is:

Trust Headquarters

9 Alie Street

London

E1 8DE

Switchboard Telephone Number: 020 7655 4000

Fax Number: 020 7655 4002

Email: webadmin@elft.nhs.uk

Your opinions are valuable to us. If you have any views about this report, or if you would like to receive this document in large print, Braille, on audio tape, or in an alternative language, please contact the Communications Department on phone 020 7655 4066 or email Janet.Flaherty@elft.nhs.uk

This page is intentionally left blank

Central Bedfordshire Council

Social Care Health and Housing Overview and Scrutiny Committee

Monday 05 June 2017

The Integration of Health and Social Care in Central Bedfordshire (Recommendations of Overview and Scrutiny Enquiry)

Report of Cllr Peter Hollick (Chairman of the Enquiry)

Advising Officer: Paula Everitt, Scrutiny Policy Adviser
(paula.everitt@centralbedfordshire.gov.uk)

Purpose of this report
To provide Members with the outcomes of the scrutiny enquiry into the integration of health and social care in Central Bedfordshire.

RECOMMENDATIONS

That the Committee receive the report of the enquiry at Appendix 1 and agree the recommendations for referral to Executive.

Background

1. In September 2016 the Social Care Health and Housing Overview and Scrutiny Committee (SCHHOSC) agreed to undertake an enquiry to support the Council to deliver one element of the Five Year Plan relating to Protecting the Vulnerable; Improving Wellbeing.
2. The enquiry involved Cllrs Hollick (Chairman), Goodchild (Vice-chairman), Downing, Duckett, Firth, Ghent and Saunders who met with officers from a range of services, advisers and partners.
3. The enquiry sought to understand the national strategic drivers, barriers and risks and receive evidence, advice and information from sector experts to agree an emerging approach to redesign how residents access health and care services.
4. The detailed report attached contains details of the findings of the enquiry and recommendations that are proposed to be provided to the Executive for consideration.

Council Priorities

5. The recommendations of the enquiry are aimed to support the Council's approach to protecting the vulnerable and improving wellbeing.

Corporate Implications

Legal Implications

6. There are no legal implications arising directly from this report although should proposals be prepared in light of the recommendations contained in this report proposing the integration of services a full review will be necessary.

Financial and Risk Implications

7. There are potential significant cost implications for delivery of integrated health and care Hubs but anticipate that some of these could be mitigated through partnership engagement on the developments. Currently officers have secured One Public Estate Funding and additional funding from the NHS to pay for the development of Business cases. Individual costs of the Hubs will be derived from the Business cases.

Equalities Implications

8. Central Bedfordshire Council has a statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. This includes identifying opportunities to encourage people with protected characteristics to participate in public life or in other activities where their participation is low.

9. Research indicates that vulnerable groups struggle to understand and navigate the complexity of health and social care services. Closer working across agencies and improved locality working provides potential opportunities to improve access to services. There will also be a need for services to be proactive in identifying and targeting sections of the community experiencing poorer health outcomes who may not be accessing preventative and early intervention services.

Conclusion and next Steps

10. The Committee is asked to consider and support the recommendations so that they may be referred to the Executive for further consideration.

11. If the recommendations are supported it is suggested that the Committee requests an update from the Executive on the implementation of the recommendations within 6 months of their consideration,

Appendices

Appendix 1 detailed report of the enquiry

Background Papers

None

This page is intentionally left blank

Central Bedfordshire Council
www.centralbedfordshire.gov.uk

Central Bedfordshire

Appendix 1

Outcomes of the scrutiny enquiry on integration of health and social care (May 2017)

Grasp the nettle – but the dock leaf no longer eases the reaction

Chairman's Introduction

This enquiry has been undertaken in response to the considerable concern about the ability of health and care services to meet the future needs of our population. Central Bedfordshire is an area of growth and has an ageing population. Funding for health and care services is not keeping pace with demand. The Government states that health services funding has increased year on year, however, local funding challenges remain for our area. The Council's social care budget is also under great funding pressures. Although there is some additional funding for social care this year, it is unlikely to close the gap in the funding shortfall.

How money is used and how health and social care services are organised in the future is key to the provision of a viable service which must meet the needs of an increasing population, an ageing population and one where there are increasing complex health needs.

It has become clear that the public do not always use the health service in the most appropriate way with one clear example being the use of A&E when a visit to the GP Surgery would be more appropriate for e.g. a minor injury. The role of the local pharmacist needs also to be a part of an improved education programme about the use of the health service by the public.

There needs to be a determined effort to ensure people do not find themselves admitted to hospital when such could have been avoided. A programme of self health care, emphasising prevention, is axiomatic.

When a patient has rightly been admitted to hospital and is ready for discharge this has to be done more efficiently. There must be a seamless transition between what we currently see as the responsibility of the health service and that of the social services when the involvement of the latter is necessary to support the patient back in their own home or in a nursing or care home or at a 'step-up step-down' facility.

The way the services are funded is not always seen to be conducive to integrating health and social services. Discharge from hospital with the effective co-operation of social care saves the health service money. When people can be 'treated' elsewhere, than in hospital that also saves the health service money. It is said to be three times more expensive to treat a person in hospital than in the community or at Home. I have asked the question whether social care has come to be seen as the saviour of the health service. On discharge from hospital to convalescence where does the health responsibility end and social care begin or should there be no demarcation?

These boundaries mean nothing to people receiving health and care services; they expect the services to work together. As such should monies be seen as a pooled resource across health and social care? Investment to build capacity in social care to enable more people to be supported in the community should be a key consideration. The idea of a 'personal care

service' covering both health and social care from a single budget is no longer a distant one.

So, how might the future look?

The Enquiry has been informed through many interviews and papers including the NHS New Care Models: Vanguards – developing a blueprint for the future of NHS and care services. Many words of support have been given for a programme of integration to meet the needs of our local Central Bedfordshire population. One hopes that this is not simply 'lip service' to a transformation programme and that positive steps will be taken by all concerned to achieve a new model of care.

The integration of health and social care must be the way forward. A coordinated service at the primary stage is essential to help avoid where possible access to the secondary stage of care. The development of a 'hub and spoke' approach bringing together local GPs acting alongside community and social care professionals and the voluntary sector with appropriate services devolved from the local hospital would see an integrated approach at the primary stage. The spokes would bring aspects of integrated care into the rural areas.

The impetus to move forward has been embodied in the Care Act 2014 which inter alia lays a general duty on local authorities to promote an individual's well being. This includes an individual's physical and mental health and emotional well being. The Better Care Fund which seeks to join up health and care services so that people can manage their own health and well being and live independently for as long as possible and finally the Sustainability and Transformation Plan which will help to ensure health and social care services are built around the needs of the local population embed this further.

We have set out a number of recommendations in this report on which Members expect action to be taken. I hope that this work we have undertaken as an enquiry team would not have been a 'talking shop' with no practical impact. I have set out further conclusions at the end of this report.

I do thank my fellow Councillors who have given up much time to be a part of this Enquiry together with the Portfolio Holder, Officers, and the many interviewees who gave evidence.

Cllr Peter Hollick
Enquiry Chairman

Table of contents

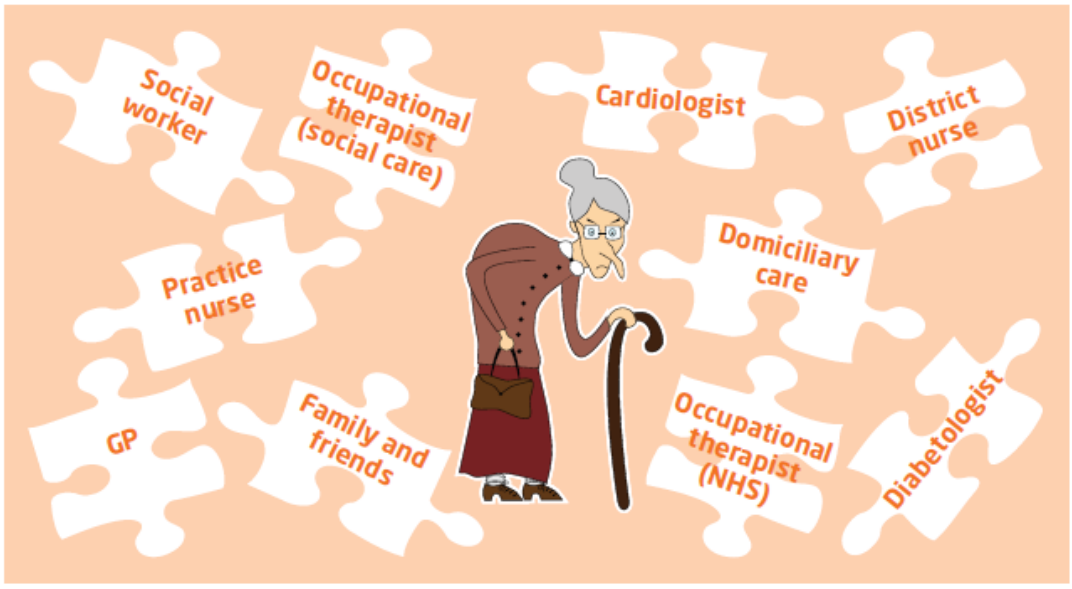
Page	Sections
02	Chairman's Introduction
05	Background and reason for the Enquiry
07	Approach to research
10	National Message
12	Local Strategic Context
15	Findings of the Enquiry
28	Chairman's conclusion
29	Appendix 1 - Background papers
31	Appendix 2 – Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan Partners

Background and reason for the enquiry

Central Bedfordshire Council is committed to ensuring that its residents have access to timely and best quality health and social care. The Overview and Scrutiny Enquiry Team recognise the need to work closely with other health and care partners so that local people are served by services that are integrated, seamless and where possible less fragmented. This requires a shared vision across the health and social care system. This view is consistent with legislation, the Care Act 2014 and more recently, the NHS Planning document Five Year Forward View which emphasises the need for integration and new ways of delivering health and care services that is fit for the future and sustainable.

Health and social care is often referred to in one breath. It is not always clear, for example where the responsibility of health organisations end and the social care organisations begins? We have put place a bewildering array of small disconnected services particularly for older people (as demonstrated below for Mrs Smith – Kings Fund). People receiving care do not necessarily distinguish between organisations. What is important to people is that they receive timely and appropriate care and support. Organisational boundaries should be less visible when person-centred health care is provided.

Mrs Smith's Story



This important need for care to be better coordinated around people's needs and delivered as locally as possible has been a key driver for the work of the Enquiry Team. Central Bedfordshire with its growing and ageing population faces a number of challenges, which are centered on the impact of demographic change, shrinking resources and workforce.

In September 2016 the Social Care Health and Housing Overview and Scrutiny Committee (SCHH OSC) agreed to undertake an enquiry to:-

- To understand the national strategic drivers, barriers and risks
- To receive evidence, advice and information from sector experts to agree an emerging approach to redesign how residents access health and care services.
- Gather evidence, appreciate and learn from existing best practice across the country including integrated health and care hubs.
- Understand resident's existing experiences
- What is feasible for Central Beds and how we deliver it

It was felt that successful and effective integration of health and social care could deliver seamless and person centered services for people, leading to improved outcomes and a better experience of health and care services. Importantly also, it could help to reduce duplication and maximise resources, therefore saving money. Consequently he Enquiry also agreed to:

- Examine the emerging approach for delivering integrated health and social care in Central Bedfordshire with a particular focus on integrated health and care hubs; and
- To agree an approach that sets out in an open and transparent manner how all partners will plan for integration and delivery of locality based health and social care hubs across the four localities in Central Bedfordshire.

The enquiry team sought within the time frame, to interview as many representatives from health and care organisations as possible and to learn from the many studies, papers, seminars, Vanguard sites and reports on health and social care integration to answer some of these questions. From these the enquiry team would focus primarily on developing a set of principles for the approach to delivery of the integration of health and social care in Central Bedfordshire.

Members received a wealth of information to consider and attended relevant workshops to study best practice in the country. A list of these background papers appear at Appendix A.

Approach to the Research

The Enquiry Team was made up of the following:-

Member	Committee	Ward
Cllr Peter Hollick (Enquiry Chairman)	Social Care Health and Housing OSC	Dunstable Watling
Cllr Susan Goodchild (Enquiry Vice-chairman)	Social Care Health and Housing OSC	Houghton Hall
Cllr Frank Firth (from second meeting)	Non-Executive Member	Northill
Cllr Paul Downing	Social Care Health and Housing OSC	Ampthill
Cllr Brian Saunders	Corporate Resources and Sustainability Communities OSC	Stotfold and Langford
Cllr Paul Duckett	Social Care Health and Housing OSC and Corporate Resources OSC	Ampthill
Cllr Eugene Ghent	Deputy Executive Member	Dunstable Manshead

Other attenders included:-

- Cllr Maurice Jones Executive Member for Health (until 10.03.2017)
- Cllr Carole Hegley Executive Member for Social Care and Housing and
- Julie Ogley Director of Social Care Health and Housing.
- Donna Derby, Director of Commissioning, Bedfordshire Clinical Commissioning Group.

The review was supported by Paula Everitt (Scrutiny Policy Adviser) and Patricia Coker (Head of Service Lead for Integration and BCF, Social Care Health and Housing)

The Enquiry Team met on 12 occasions with the following partners:-

Date	Consultee	Specific Interest
14 October 2016	None	
02 November 2016	None	
18 November 2016	• Richard Carr Chief Executive	Sustainability and Transformation Plans (STPs)
23 November 2016	• Ben Collins – Kings Fund	National Context

Date	Consultee	Specific Interest
09 December 2016	• Stephen Conroy Chief Executive Bedford Hospital • Mark England, Director of Re-Engineering - Luton and Dunstable Hospital • Sarah Brierley Director of Business Development & Partnerships East and North Herts Hospital	Health
19 January 2017	• Matthew Tait – Chief Accountable Officer, Bedfordshire Clinical Commissioning Group	BCCG
19 January 2017	• Dr Peter Graves Chief Executive - Local Medical Committee • Judith Chappell, Deputy Dean of Health and Social Sciences, University of Bedfordshire	Stakeholders
27 January 2017	• Michelle Bradley - Director of Mental Health and Wellbeing services in Bedfordshire ELFT • Richard Fradgley - Director of Integrated Care ELFT • Malcolm McCann, Executive Director of Community Services and Partnerships, SEPT • Stuart Mitchelmore Assistant Director, Adult Social Care	Stakeholders Officer
06 February 2017	• Julie Ogley – Director of Social Care, Health and Housing • Sue Harrison - Director Children's Services • Marcel Coiffait – Director Community Services • Celia Shohet – Assistant Director Public Health • Cllr Maurice Jones Deputy Leader and Executive Member for Health • Cllr Carole Hegley Executive Member for Social Care and Housing	CBC Officers and Executive Members

Date	Consultee	Specific Interest
09 February 2017	Locality Chairs including • Dr Alvin Low – Chairman BCCG • Emma Barter – West Mid Beds Locality Lead • Dr Chris Marshall – Leighton Buzzard Locality Lead	Partners
20 February 2017	• Caroline Holman Chief Operating Officer and Deputy to the Chief Executive - MIND, • Yvonne Clark Chief Executive Officers - Purple Trust • Jon Boswell Chief Executive BRCC	Partners
22 February 2017	• Diana Blackmun Chief Executive Healthwatch, • Dr William Hollington Friends of Biggleswade Hospital and GP Locality Lead for Ivel Valley • Ruth Featherstone Older People's Network • Linda Johnson Chief Executive - Homestart	Partners
27 February 2017	• Paul Tisi - Medical Director Bedford Hospital • Junaid Qazi - Consultant & Interface Geriatrician East and North Herts Hospital • Sarah Brierley - Director of Business Development & Partnerships East and North Herts Hospital • Sheran Oke - Director of Nursing Luton & Dunstable Hospital	Partners

National Message

With an ageing population and people suffering with multiple complex needs, the strain on the NHS system has been covered daily by the media. In preparing for this enquiry, the Team considered the national messages and challenges around health and social care, and reviewed a number of national strategic documents from the NHS, The Kings Fund and the Nuffield Institute. These strategic documents all set out common national messages which should shape the future commissioning and provision of health and social care. These messages suggest the need for the following in order to secure a fit for purpose and sustainable health and care system:

- Need for collective leadership for health and care services
- Need for closer alignment of primary (GPs), community and social care services.
- Role of the voluntary sector and multi disciplinary working
- Pooled budgets to deliver cost efficiency and better care
- Changing payment systems

The current fragmented response to the challenges of demography, finance, workforce and complex health and care needs of the population means that across the country, health and care systems are facing very similar issues.

People often receive their health and social care through a complex range of organisations, professionals and services. Both nationally and locally this can mean uncoordinated and fragmented care particularly for people who have multiple needs.

Such fragmentation has the potential to lead to:

- multiple and uncoordinated assessments from health and social care, resulting in delay to provision of services;
- multiple and uncoordinated visits from health and social care professionals;
- multiple trips to hospitals for tests, diagnostics and treatment;
- unreliable transitions through care pathways, including from childhood to adult care;
- emergency admissions to hospital, for example after avoidable worsening of a condition or an avoidable fall; and
- delayed discharges from hospitals.

A recent national audit report into integration noted that performance and outcomes in the health and social care sectors are worsening. Much has been said in the national press about the delays in discharging people from hospital, particularly affecting frail older people.

The Audit report noted that across the country, community health and care services face very similar challenges….

- Ad hoc development of community health and care services typically adding new services for particular groups without thought for how they relate to the wider system.
- As a result, a pattern of small, narrowly defined and poorly coordinated services based around historic but unhelpful dividing lines of primary, community and social care.
- People with multiple chronic conditions and a mix of physical health, mental health and social care problems interact with multiple specialist teams – with multiple care plans and an absence of holistic whole person care.
- Patients receive multiple visits from different professionals with duplication and poor communication and coordination. Both patients and professionals find the system hard to understand and are unsure who to contact or who is in charge.
- Initial solutions such as care navigators, care coordinators, single point of access and other interventions address symptoms of a poorly designed system but do not address the root cause.

.

The Care Act April 2014 was introduced to make care and support clearer and fairer for everybody. It aimed to help prevent people's care needs getting more serious by providing more services and more information to help people stay healthy and independent for longer. It also set the legislative framework for integrating health and social care service, through the Better Care Fund Plan.

Since then, NHS England published its Five Year Forward View in October 2014 and set out a shared vision for the future of the NHS based around new models of care.

The structure of the NHS is challenging. It is clear that supporting the complex needs of the local population requires concerted efforts. Nationally the integration of health and social care has been introduced at a strategic level firstly with the implementation of the Better Care Fund plan and more recently Sustainability and Transformation Plan (STPs) to try and respond to growing trends. The STP sets out a number of priorities which must address current and future challenges within the health and care system by delivering NHS England's triple aim:

I. Sound health and wellbeing of the local population
II. High quality health and social care supplied to local people, with service users, their family carers and others in receipt of care, acknowledging a positive experience
III. Living within the resources available.

Central Bedfordshire is part of the Bedfordshire Luton and Milton Keynes STP which is one of 44 health and care 'footprints' in England. The plans will show how local services will evolve, develop and become clinically and financially sustainable over the next five years

Local Strategic Context

CBC is an area with a growing and ageing population, a rural environment without a hospital within its boundary. These and other issues pose challenges for the system. The Joint Strategic Needs Assessment (JSNA) provides a comprehensive picture of what we know about the health and wellbeing of the people living in Central Bedfordshire. The intelligence has helped us shape our whole systems approach to date.

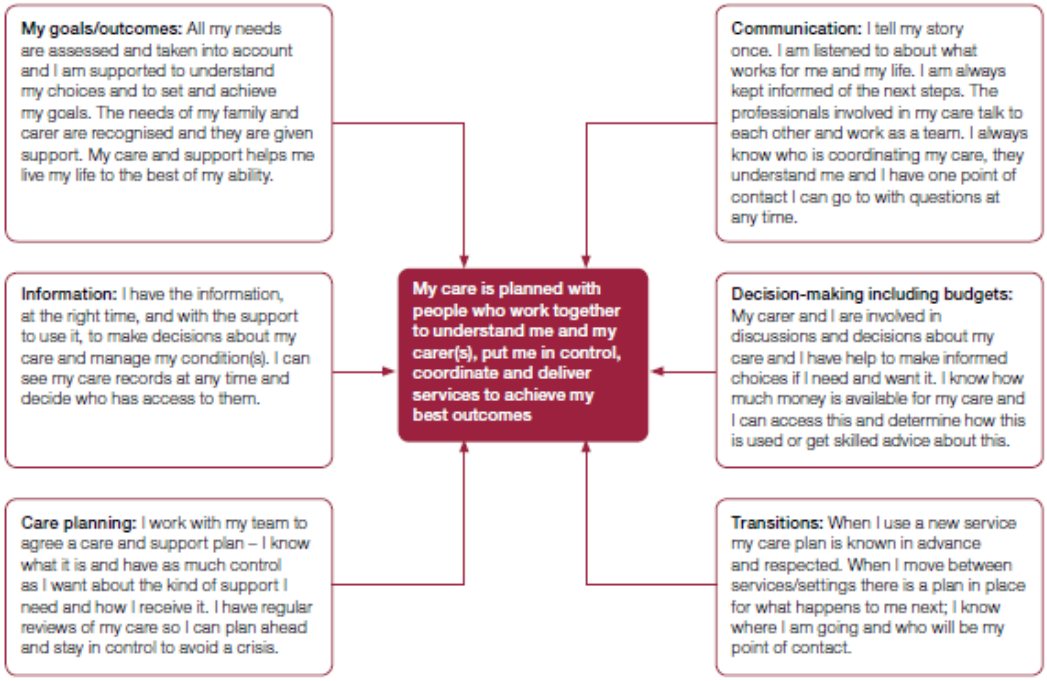
Our Better Care Fund plans set out a shared vision for health and social care in Central Bedfordshire, set in a locality-based delivery model. It describes the agreed strategic approach based on four key priorities for delivering integrated care. The Better Care Fund plan is central to the ambition for the integration of health and care services in Central Bedfordshire. The overarching ambition is to secure a fundamental shift in the ways in which care and support is provided to residents of Central Bedfordshire, in their localities, so that people can experience equitable and timely local services tailored to their needs.

The Better Care Fund Plans describe an agreed approach to develop integrated health and care hubs which will see the co-location of primary, community health, mental health and social care colleagues and provide access for a range of diagnostic services and assessments.

Central Bedfordshire's approach to integration, as set out in the BCF Plans, is focused on the 'person' and delivering what good quality integrated care looks like, from the point of view of anyone who needs access to multiple services over time, as set out below.

Figure 5
Definition of integrated care

The Department of Health and national partners have defined what integrated care and support looks like from a user's perspective



Source: National Collaboration for Integrated Care and Support

Local progress on integration to date

Although some joint working and planning for integration is already taking place, it is however clear from the evidence given to the Enquiry Team that integration in Central Bedfordshire is limited and at best patchy. The Enquiry panel received evidence on key areas and activities taking place to achieve integrated outcomes; these included some of the locality arrangements and multidisciplinary working taking place in some parts of Central Bedfordshire.

Members were informed of the ambition for four separate locality hubs in Central Bedfordshire. Significant progress had been made to establish the case for integrated health and care hubs in the Chiltern Vale and Ivel Valley areas. Proposals for hubs in West Mid Beds, Leighton Buzzard and discussions for a fifth hub in Houghton Regis are also planned. Without exception the concept of these hubs in Central Bedfordshire was supported by partners and stakeholders.

Members heard about the successful applications for funding to the One Public Estate and the NHS Estates, Technology and Transformation Funds to support the development of the Integrated Health and Care Hubs. Locality Hubs are currently planned for Chiltern Vale (Dunstable), Ivel Valley (Biggleswade), West Mid Beds, Leighton Buzzard with a further hub being considered for Houghton Regis.

In carrying out their review Members heard about some of the joint working initiatives already underway. A group of GPs in the Ivel Valley area have moved to a new Medical Centre in Biggleswade and have social care teams co-located in the premises.

Findings of Enquiry

The Enquiry team asked each representative from organisations, partners or stakeholders for their view on the integration of health and social care, what barriers existed and how the Council might help to overcome these barriers. There was unanimous support for the integration of health and social care services in order the save the National Health Service for future generations and agreement that a clearly defined set of principles for all partners to work to would promote a consistent approach.

In order to fully understand the implications of the national strategic drivers, such as the STP, which will have significant influence on the transformation of health and care services over the next five years, the enquiry team met with Richard Carr, Chief Executive and Deputy STP lead.

In order to address health inequalities along with financial and clinical challenges, NHS England established a Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). Members learnt that engagement between partners was strong.

In the BLMK STP submission to NHS England, five priorities for the transformation of health and social were established. Three 'front line priorities focus on:-

STP Principles	
P1	Prevention, encouraging healthy living and self care, supporting people to stay well and take more control of their own health and well being.
P2	Primary, community and social care services building high quality, resilient, integrated primary, community and social care services across BLMK. This includes strengthening GP services, delivering more care closer to home, having a single point of access for urgent care, supporting transformed services for people with learning disabilities and integrated physical and mental health services.
P3	Sustainable secondary care, making our hospital services clinically and financially sustainable by working collaboratively across the three hospital sites, building on the best from each and removing unnecessary duplication

A further two ‘behind the scenes’ priorities focus on:-

STP Principles	
P4	Technology transforming our ability to communicate with each other, for example by having shared digital records easily accessible by patients and clinicians alike, using mobile technology (e.g. apps), for better coordinated care.
P5	System redesign improving the way we plan, buy and manage health and social care services across BLMK to achieve a joined up approach that places people’s health and wellbeing at the heart of services.

There is a drive to shift the balance of care from hospitals to community based solutions; improving access to out of hospital services to reduce pressure on acute care. The ambition for integrated locality health and care hubs aligns particularly with P2 and P5 of the STP principles.

Given the importance of the STP process as the national initiative designed to give local NHS organisations and councils the opportunity to work together to improve the way health and social care is planned and delivered, there was a call for all partners to engage with the STP process and align working practices with it.

Members noted that the three hospitals in the BLMK footprint do not represent the full experience of Central Bedfordshire residents, who access other hospitals outside the footprint. Members supported the process of delivering improved quality of care through joint working, sharing resources and more sustainable financing. Joint working with partners and the building of relationships is fundamental and throughout the Enquiry evidence there was a commitment to work towards a seamless health and care service that is equitable in Central Bedfordshire.

Throughout the enquiry, Members gathered information and developed five key principles. Each principle represented an area of focus for successfully achieving integrated outcomes:

1. **Our residents will be at the centre of decision making**
2. **Health and care will be accessed as close to home as possible**
3. **Residents will be able to self serve and manage their health and care**
4. **Funding and resources should be available at the right time and right place, particularly in relation to locality working.**
5. **Health, care, and housing colleagues will work together to deliver one plan to meet the needs of our residents**

Strategically the implementations of these principles rely on the commitment to this way of working and a change in culture within the workforce. Members

reflected on the critical importance of looking at services from a person's point of view and are clear that this is the responsibility of all partners.

The remainder of the report is organised around these principles and provides the rationale and evidence received for each of them. It highlights some of the good practice examples shared with the enquiry. Further specific recommendations are outlined as necessary below:-

Recommendation

That all partners of the health and social care sector adopt and demonstrate a commitment to delivering the five principles outlined above.

Principle One:
Our residents will be at the centre of decision making

Members felt that this principle is about seeing the whole person and not just their condition. Ensuring people are at the centre of the decisions made about their care, would ensure that the system is focusing on 'what matters to people', as opposed to 'what is the matter with them' Members agreed that this is a key principle for ensuring people have access to the right services. The focus should be on supporting people to take greater responsibility and manage their own health and wellbeing better.

Julie Ogley Director of SCHH explained to Members that as part of the reforms we should encourage people to ask for the support they need. Involving people would ensure that resources are allocated appropriately, giving people the care and support they want, not the care and support we think they should have.

Members received evidence from service user representatives and organisations on the current complexity of access to services, especially for those patients with multiple conditions. Ruth Featherstone representing the Older Peoples' Network advised some patients received diagnosis and treatment from as many as four hospital consultants.

Judith Chappell Deputy Dean of Health and Social Sciences, University of Bedfordshire, explained the joint working taking place to provide the right training and qualifications for health and social care workers together for a flexible workforce for the future. With a multi-skilled workforce, information flow would improve and patient time would be saved. A super carer qualification was in development and gave carers the ability and skills to support patients in their homes and care homes.

Dr Peter Graves, Chief Executive, Local Medical Council highlighted the importance of 'saving patient time', a principle that had been adopted in Canterbury, New Zealand.

The Enquiry panel observed that the emerging consensus was that there needed to be a shift in the relationship between health and care services

providers and those who are using the services. It is important to recognise the outcomes the individual wishes to achieve.

Recommendation(s)

- Services should be developed to support people to stay well and take increased responsibility for their own health and wellbeing.
- All partners and stakeholders should adopt the principle that, where appropriate care is planned with a mix of care professionals working together. People should feel they are in control and able to coordinate delivery of services to achieve the best outcome for them. (National Voices 2013).
- As one of the front line priorities in the STP is prevention – there be a greater focus on early intervention and promotion of self management.

Principle Two:
Health and care being accessed as close to home as possible

Members learnt that the current provision of health and social care across Central Bedfordshire is fragmented and often leads to uneven access to good care. The population uses several hospitals, none of which is in our area. The lack of a hospital within our boundaries, the geography and rural nature of Central Bedfordshire presents challenges in understanding and managing patient flows into and out of hospitals. This makes it difficult to access a cohesive supporting range of services.

The demographic pressures and economic challenges facing the health and care economy means a radical rethink of how services are provided. It is important to reduce demand on hospital services. Achieving this requires health and social care services to be better coordinated to ensure that the right care is offered at the right time, in the right place and by the most appropriate person. Witnesses agreed that the aim should be for high quality accessible services made available locally with community based integrated multi-disciplinary teams.

There are examples of health, social care, community and voluntary groups working together to enable residents to improve their wellbeing, using their own informal support network and increase self-care eg Village Care Scheme

Members discussed the importance of shifting the cultural focus from one where treatment is provided in hospitals to one where health and care is available in local communities as close to the patient as possible. People should be enabled to stay well in their own homes and communities. The need to deliver more services out of the hospital was noted.

Members learnt of plans to build on existing locality structures to address care pathways, from prevention and early intervention right through to integrated pathways and support for people at home. Support for carers, intervening at the right point to maintain independence, physical health and mental wellbeing, and using housing options and equipment effectively to deal with

increasing volumes and complexity of older people's conditions, is fundamental.

ELFT has taken the lead in developing an integrated team of physical and mental health workers to support the needs in localities. The focus for these teams included:

- Continued care assessment of patients
- Greater early intervention
- Self care
- Patient responsibility to seek help for themselves at the earliest opportunity
- Joint working with village agents and community workers
- Possibility of one organisation delivering these services.

The teams have supported the delivery of outcomes that include a reduced flow of patients to hospital and care homes.

Malcolm McCann (Executive Director of Community Services and Partnerships at EPUT) also advised that integrated teams were currently working in Essex and informed Members that a dedicated senior operations person to lead operations was essential to help guide and develop an approach and gave each partner a sense of ownership. Services working together included community services and dementia nursing services working with GP's, social workers and CPN's and the voluntary sector.

ELFT explained they had instigated cultural change by adding a social care aspect to the training of mental health nurses. Cases involving children and young people were studied by practitioners to pick up early signs of problems, for example self harming or drug and alcohol problems. Members supported the work of public health colleagues and ELFT to support patients that would require a commissioned pathway to support patients.

The concept of locality working and services wrapped around social care was supported by Malcolm McCann, EPUT (formally known as SEPT) Members were informed that if GP practices were given the ability to probe the age of the local population it would enable them to get a sense of the needs of the locality. Accompanied by the intelligence available in the Joint Strategic Needs Assessment this would enable more effective planning for services for localities.

In an attempt to ensure health and care services can be delivered closer to home, the initial requirement is that patients and their carers are able to state what services are need to be provided to keep them in their home. It has been common practice for GPs to refer a patient with complex multiple needs for consultant advice on an individual basis. With an integrated approach, professionals and the patient would identify and plan a care package together.

This information would be provided to a mix of care professionals working together to understand the needs of the patient and carers and puts them in control to ensure care is coordinated and to achieve the best outcomes.

The issue of transport, particularly access to services in rural areas was highlighted. Concerns were raised about transport from some rural villages to the main population centres, which are likely to be the focal point for the integrated health and care hubs. This was also a concern for the Older People's Network. The work of the Village Care Schemes, which provides support in the rural villages, was noted.

Dr Hollington emphasised the important need to understand transport requirements and to grasp the opportunity to keep people well and out of hospital. Cllr Maurice Jones advised the Enquiry Team that a review of Community Transport had been undertaken; however, a further look at the use of the Council's Community Buses to shuttle residents to hubs and spokes in each locality with BCCG colleagues is pertinent at this time.

All agreed that services should be more accessible to people in their localities and especially those in predominantly rural areas. Having a focal point, such as an integrated health and care hub with associated spokes across Central Bedfordshire will provide residents with access locally to health and care such as diagnostics and out-patient appointments in a manner, which can be flexed to meet the needs of the local population. The successful delivery of this approach requires effective partnership working to drive this proposal forward.

In most cases the establishment of hubs requires a physical building, although Dr Chris Marshall raised the possibility of creating a virtual hub supported by the different professions such, GP's, Hospital Clinicians as well as service providers ie Essex Partnership University Trust (EPUT), ELFT and all voluntary organisations, potentially on a 24/7 basis. The important benefits of co-locating teams to foster a culture of joint working were continuously emphasised.

Representatives from the Acute Hospitals agreed that integrated health and care hubs could facilitate closer working, and networking between consultants and GPs, as well as upskilling GPs as a softer benefit of co-location.

Recommendation(s)

- Primary, community, mental health and social care should be developed to support people in community based setting and ensure continuity of care in their localities remains a primary focus.
- Complexity of access to hospital services should be addressed through development of more local and appropriate health and social care services that are less dependent on acute hospital provision.
- Integrated health and care hubs should be developed to provide a focal point for the provision of out of hospital care services in each of the localities.

- The Council and the CCG should explore the opportunity to use local assets to support the development of Integrated Health and Care Hubs.
- Integrated Health and Care Hubs should provide services across the age spectrum and other community related services for children and older people.
- Discussions with partners including the BCCG on how the Council's community transport facilities can be used to supplement the needs of localities should be reopened.
- There should be closer alignment of mental health with physical health care and the relationship between health providers and social care/mental health teams must be enhanced through improved communication and joint care delivery.

Principle Three:
Residents will be able to self serve/manage their health and care

The limitation of current technology in the NHS is well documented. Attempts to share medical records electronically amongst partners have not materialised and patients and carers are continually required to provide personal and medical history.

Through multi-agency working, people ought to be encouraged and supported to stay well and healthy. This should start in the early stages of life, educating our children and young people and their families to take more control of their own health and well-being. This education could include delivery from local community groups and outreach workers as well as, for example, schools, children's centres and GPs.

It is also important for people to have access to information that will enable them to manage their conditions and be involved in their care. There should be greater links with other factors which impact and influence people health and life experience. This includes things like housing, community and leisure services. The STP proposes the growth of 'social prescribing' by GPs and clinicians through referrals to appropriate support groups, community groups, counselling and voluntary organisations for help and support in making informed choices, improving confidence and self-esteem etc.

Models of community and social care are already established in some areas across the STP footprint, and by sharing best practice, these models can be adapted and delivered in other areas to meet the specific needs of local communities.

Priority four of the STP aims to transform our ability to communicate with each other and would give the patient access to their own records too. A system that allowed professionals to access records and add information was required and Junaid Qazi Emergency Director at the East and North Herts Hospital Trust raised the importance of communication and that Hospitals were embracing new technology. Julie Ogley advised new software system

for social workers would be procured that would replace the current Swift system by 2020. One of the main criteria of the new system would include an interface with NHS systems and to liberate staff and allow them to work in a modern less bureaucratic way.

To be able to deliver self management, Stephen Conroy, Chief Executive, Bedford Hospital described the Airedale telemedicine model, based on the use of wide ranging digital healthcare solutions to support the delivery of out of hospital services. Carers and patients would be able to seek advice using this service. Bedford Hospital Trust is looking at integration with GPs, to provide outreach for patients with specific need from hospital. A roll out of out of hospital services, consultant led, with a specialist nurse service following patients home from hospital and providing specialist rehabilitation at home or in the community was being established.

Mark England from the Luton and Dunstable Hospital noted that there is increasing urgency to address the pressures on Acute Hospitals. More episodes of care should be managed outside the hospital. A single location for care locally at scale is very important. An out of hospital care service lead by hospital clinicians had been rolled out successfully to patients in some areas. There was an opportunity for enhanced care in the community or in care homes, however, this would need to be a pooled budget and all providers to sign up to delivery care in this way.

There has been considerable effort to encourage residents to live a healthy life style. Public health colleagues have gathered evidence that a healthy life style and some physical activity lead to good mental health and avoided in many cases a cocktail of medical conditions like diabetes, stroke and heart attacks from occurring. Much has been done to educate the public

There was a clear message from Paul Tisi, Medical Director at Bedford Hospital that residents should advise quickly if they feel unwell. By early intervention, symptoms can be treated and the risk of complications and urgent or emergency care avoided. NHS 111 and pharmacists are available and GP's advice sought in more serious cases. Innovative ways to educate the public on keeping themselves well have been introduced by NHS England and Public Health colleagues, and Cllr Carole Hegley, Executive Member for Social Care and Housing, suggested the idea of a television channel dedicated to health and care or at GP's waiting rooms. Marcel Coiffait, Director of Community Services mentioned that consideration was being given to the use of libraries as community learning centres.

Julie Ogley, Director of SCHH advised that data sharing agreements had been created to overcome this issue, however, evidence obtained during the Enquiry indicated that not all partners were aware of these agreements.

Recommendation(s)

- Continue to involve the public in managing their own care through public health information on lifestyle, health and wellbeing.
- A single point of contact for residents to ensure that care needs can be assessed once and save patient time should be established.
- Ensure that where appropriate telemedicine, telehealth and support for Carers is aligned with self management. Consider ways in which people can be empowered to better manage their own care needs.
- Explore the potential added value of universal services, both council led and voluntary sector, to support social prescribing.
- Address the issue of data sharing to enable integrated working.

Principle Four:
Making sure that funding and resources are available at the right time and right place. This is particularly important around locality working.

This principle is key to ensuring people receive timely and appropriate complex care, when needed.

Matthew Tait, Accountable Officer at Bedfordshire Clinical Commissioning Group advised Members that to overcome the issue of a pooled funding an integrated care system, the development of an accountable care organisation, based on local authority boundaries, has been a focus for the STP. The STP gives the strategic overview to deliver out of hospital care models. Once such an organisation has been established, a new tariff system would need to be created to ensure services are sustainable for the future. BCCG is committed to negotiating a joint commissioning model with Social Care, hospitals and primary care services and is working with GP's to help alleviate pressures on them. Evidence was provided where GP surgeries worked together in localities, shared clinics or by providing different specialist appointments for patients not on their register. Back office support was also shared in some cases to cut costs and provide efficiencies.

The Luton and Dunstable Hospital had successfully introduced a GP presence within A&E and patients that required urgent care were signposted to this service.

Members identified funding issues that could be resolved with the implementation of pooled budgets. Stephen Conroy, Chief Executive, Bedford Hospital explained all partners would need a pooled budget similar to that for the Better Care Fund along with appropriate governance arrangements for joint commissioning to be established. The importance of robust governance arrangements was raised at the interview with Sarah Brierley (North and East Herts NHS Trust).

Sarah Brierley North and East Herts Hospital Trust advised Members of the importance of designing new pathways of care around the patient.

Paul Tisi, Medical Director Bedford Hospital advised that plans to provide GP presence at Bedford Hospital were advanced and would see those patients in need of urgent care directed to the Cauldwell Surgery adjacent to the hospital.

Workforce challenges were also highlighted. Shortages and vacancies in primary, community and social care services were also brought to the attention of the Enquiry. In order to deliver care in the communities, staffing resources are needed. Judith Chappell, Deputy Dean at Bedfordshire University advised the Enquiry Team about funding changes to health care education. With the removal of a bursary, students are treated in the same way as other students and require a loan for fees and maintenance. On a more positive note, new ideas to educate doctors and nurses have been identified including a joint Mental Health and Social Worker degree and apprenticeship schemes. A super carers qualification (SEN equivalent) is now available to help with integrated health and social care skilled workforce.

The shortage of GPs had inspired some innovative thinking to attract young GPs not wishing to take on a traditional practice. Emma Barter Locality Chair for West Mid Beds advised that new GPs wishing to work in the locality could study for an MBA at Cranfield University, practice at local GP surgeries as well as work with Clinical Commissioning Group colleagues.

GPs support patients during a period of social wellbeing break down. With the proposal that GPs are situated as part of a multi-disciplinary team in a locality hub, support from partners or the third sector would be on hand to help.

The importance of working together with other service providers including voluntary organisations both national and locally to deliver services should not be under estimated. Members learnt of examples in Alaska and Canterbury, New Zealand where this model had been successfully achieved, albeit that achievement took several years.

Recommendation(s)

- Through the STP, continue to focus on increasing investment in community based interventions and the development of integrated health and care hubs.
- The Council and CCG should explore the opportunity of joint commissioning to deliver improved and integrated outcome for people.
- Using the STP priorities to transform services and free up hospital based specialist resources to provide complex care and support in the localities.
- Provide community geriatrician in put into the multidisciplinary place based or neighbourhood teams.

Principle Five:
Health, care and housing services working together to deliver one plan to meet the needs of our residents

The fragmented approach to providing services was evident in the conversations with witnesses. The Council, as a unitary authority is uniquely placed to align universal services with health and care provision to improve wellbeing and promote independence.

Julie Ogley advised the Enquiry Team that social stability and good housing enabled families to live a healthy life style and was vital to prevent poor health. Housing had not previously been a consideration in this context but was raised as an important element.

Health and social care services have over the years provided services in isolation to patients. A huge barrier has been the inability of services to share data and the data protection act has been used as a deliberate block in some cases. In order to overcome this obstacle, hospital services and GP's in line with the STP p4 supports the aim for a 'one stop approach' and a locality co location hub with a single point of access for patients. It has been evident during the process of this enquiry that quietly and under the radar in a lot of cases joint working is taking place. Member recalled the slide below which showed the number of organisations providing health and care services to people in Central Bedfordshire.

In an interview with Matthew Tait, Chief Accountable Officer, Bedfordshire Clinical Commissioning Group, he highlighted the need to build relationships and work towards an understanding of what integrated services means in practical terms. Multi disciplinary teams working in hubs across Central

Bedfordshire is the vision and there is a need to clearly define what the next steps are and what commissioning model is needed to support this.

Jon Boswell, Chief Executive at Bedfordshire Rural Communities Charities talked about the Village Care Scheme and their role in supporting people, particularly older people in the rural communities. Village care and community agents work hard to identify residents who need help at an early stage and refer them to the services that can help them. On many occasions, isolation is the biggest issue to cause a decline in health and well being. Initiatives including walks for health network and a local initiative provided at the Warden Abbey Vineyard.

Jon Boswell observed that, in the past the voluntary sector had not been good at talking to each other, however, this situation was improving and events like the Older People's Festival was a useful networking opportunity. Examples of joint working were given and MIND and Carers in Bedfordshire colleagues shared facilities in Leighton Buzzard referred patients to each other where appropriate.

Funding remained a big concern for voluntary organisations along with an overlap in some of the services they provide. In Milton Keynes the voluntary organisations work well together and provided a better coverage of services to residents. Some self help groups had been formed in rural areas for families as well as older people.

It is fundamental that Voluntary groups are kept informed with regards to integration, cultural change and new ways of working. Voluntary groups welcomed the opportunity to work at a hub environment or in a 'day centre' environment to help support the very young to the elderly resident. An opportunity was identified for the Purple Trust group to provide services within the day care homes and this would be followed up by officers.

Enabling staff to work together across: primary care, community health, social care, mental health based around population clusters in the localities of Central Bedfordshire delivering a prevention agenda, promoting independence and ensuring that people are signposted to the most appropriate support at the appropriate time.

It was also felt that an Integrated Health and Care Hub should provide care for the whole population including children and the services they require. These Hubs should become community assets and focal points for lifestyle education, support to families

Recommendation(s)

- The Council and the CCG should continue to bring together voluntary groups with community and social care providers at events like the Older People's festival.
- Continue to educate staff, professionals and residents in the change of culture and new approach to health and social care services.

- Ensure that appropriate Governance arrangements and negotiations with partners are developed
- Use funding across the health and care and system to drive a greater investment in prevention
- Explore the opportunity to widen the role of the Village Care Scheme to work closely with primary care services and the multidisciplinary teams in the locality hubs.

Chairman's conclusion

The above recommendations are seen to be essential to move health and social care forward to meet the needs of our residents – greater accessibility to more local health services; the integration of health and social care to more efficient and effectively develop personal pathways; local health and social care hubs to bring together GP's, social and mental health care workers; sexual advice clinics; obesity advice; and aspects of the voluntary sector.

A summary of observations to be considered are:-

That an integrated health and social care hub, built to ensure flexibility of accommodation and room for expansion to meet any changing needs, could also include rentable accommodation above to make better use of the land and provide an income for the Council.

That hub spokes need to be considered in village locations to help bring aspects of health and social care into the heart of our rural communities.

One raises the profile of education programs run by Public Health that encourages residents to take care for ones' own health with an emphasis on stopping smoking, drinking excess alcohol, taking illegal drugs, obesity and to encourage healthy eating and an active lifestyle, needs to be actively considered.

That there has to be a review of how funding for health and social care is organised – it can be done as it has in Plymouth where Plymouth Council and the CCG have set up an integrated system for wellbeing, covering a large range of services.

That the role of pharmacies being so important, they need to be able to add value to local health care. That pharmacies could close as a result of a new funding regime is a matter for great concern. They must be seen as an important part of primary care.

There has been no specific recommendation as to what services could/should or might be devolved from the local hospital to a hub and indeed whether there could be some virtual services accommodated within a hub. That will be a matter for the consultants and other clinicians. However, given the need to develop an improved and better accessible local health service running alongside social care, there needs to be a serious review of how many services current accessed through the General Hospitals which Central Bedfordshire residents use, can be devolved to a hub or accommodated in a spoke location.

This report is now set before the Social Care Health and Housing Overview and Scrutiny Committee on Monday 15 May 2017 for its consideration and then on to Executive for its deliberation on Tuesday 6 June 2017.

Appendix 1

SCHH OSC Enquiry Background Reading List:

1. NHS England - Sustainability and Transformation Plans CEOs Briefing
2. CBC Better Care Fund Plan – 2016-17 http://www.centralbedfordshire.gov.uk/health-social-care/better-care-fund/plan-2016-17.aspx
3. NHS England General Practice Forward Viewhttps://www.england.nhs.uk/ourwork/gpfv/
4. Kings Fund – New Care Models: http://www.kingsfund.org.uk/publications/new-care-models
5. One Public Estate – LGA/Cabinet Office: http://www.local.gov.uk/onepublicestate/-/journal_content/56/10180/6678286/ARTICLE **LINK ONLY**
6. Nuffield Trust – The Evidence Base for Integrated Care: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjL__TDrOnPAhWsLMAKHWv7AG4QFggvMAA&url=http%3A%2F%2Fwww.nuffieldtrust.org.uk%2Fsites%2Ffiles%2Fnuffield%2Fevidence-base-for-integrated-care-251011.pdf&usg=AFQjCNGOLlv7C1J9P9_jE6mrydo28ptj8Q&bvm=bv.136499718,d.bGg
7. Delivery the Forward View : NHS Planning Guidance 2016-17 to 2020/21 https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjyg5SIrenPAhUhBMAKHaZ1C8gQFggqMAA&url=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2015%2F12%2Fplanning-guid-16-17-20-21.pdf&usg=AFQjCNEL3Y7tUP78PQhPUOqiFc6IPGAsyA
8. NHS Operational Planning Contracting Guidance 2017-2019 https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjN3bmOrunPAhXMD8AKHdlzAYoQFggjMAA&url=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2016%2F09%2FNHS-operational-planning-guidance-201617-201819.pdf&usg=AFQjCNG3YsxGbnc73_jU6lsGe5D4JQ5weA&bvm=bv.136499718,d.bGg
9. New Care Models – Vanguards https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/
10. Vanguards – recommended reading: **LINKS ONLY**
    - Integrated primary and acute care systems – joining up GP, hospital, community and mental health services:- My Life a Full Life (Isle of Wight)
    - Multispecialty community providers – moving specialist care out of hospitals into the community:- Tower Hamlets Integrated Provider Partnership, Lakeside Healthcare (Northamptonshire)
    - Enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services:- East and North Hertfordshire Clinical Commissioning Group
11. Think Tank – Unblocking: Securing a health and social care system that protects older people. http://www.localis.org.uk/research/unblocking-securing-a-health-and-social-care-system-that-protects-older-people/

12. Public Finance – Pooling Pioneers, Health and Care Integration, Plymouth http://www.publicfinance.co.uk/case-study/2016/06/pooling-pioneers-health-and-care-integration-plymouth
13. Kings Fund commissioned report commissioned through the BCF Plan regional support for HWB**. To follow.**
14. Centre for Public Scrutiny - Piecing it together - Effective scrutiny of health and social care integration
15. LGA briefing – debate on STPs in the NHS
16. Kings Fund – Policy changes to implement the NHS five year forward view: progress report https://www.kingsfund.org.uk/projects/five-year-forward-view-progress-report?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=7677109_NEWSL_The%20Weekly%20Update%202016-10-27&utm_content=fyfvbutton&dm_i=21A8,4KJP1,FLXG36,GYK4Y,1
17. Social Care Health and Housing OSC report 20 September 2016, the Integration of Health and Social Care in Central Bedfordshire
18. Executive Report 2 August 2016 the Integration of Health and Social Care in Central Bedfordshire

Appendix 2 – Sustainability and Transformation Plan Partners

There are 16 organisations within the footprint of the BLMK STP area including Central Bedfordshire Council as follows:-

- Central Bedfordshire Council
- Bedfordshire Clinical Commissioning Group
- Luton Clinical Commissioning Group
- Milton Keynes Clinical Commissioning Group
- Bedford Borough Council
- Luton Borough Council
- Milton Keynes Council
- Bedford Hospital
- Luton and Dunstable University Hospital
- Milton Keynes Hospital
- Cambridgeshire Community Services NHS Trust
- Central and North West London NHS Foundation Trust
- East of England Ambulance Service Trust
- South Central Ambulance Service NHS Foundation Trust
- South Essex Partnership University Trust (now known as Essex Partnership University NHS Foundation Trust EPUT.

Central Bedfordshire

A great place to live and work

Contact us…
by telephone: 0300 300 8028
by email: customer.services@centralbedfordshire.gov.uk
on the web: www.centralbedfordshire.gov.uk
Write to Central Bedfordshire Council, Priory House,
Monks Walk, Chicksands, Shefford, Bedfordshire SG17 5TQ