

LUTON AND DUNSTABLE  
UNIVERSITY HOSPITAL NHS  
FOUNDATION TRUST

2017/18  
QUALITY ACCOUNT/REPORT  
Appendix to the Annual Report

DRAFT

25<sup>th</sup> April 2018

To send to Stakeholders 25<sup>th</sup> April  
2018

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## What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an **annual Quality Account**. This is a report that informs the public about the quality of the services that we deliver. They are published annually and are available to the public.

Quality Accounts aim to increase public accountability and drive quality improvement. They do this by requiring organisations to review their performance over the previous year, publish their performance and identify areas for improvement. Quality accounts will also inform you about how an organisation will make those improvements and how they will be measured.

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

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

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

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

### About our Quality Account

This report is divided into seven sections.

- The first section contains a statement on quality from the Chief Executive and sets out our corporate objectives for 2018/19.
- The second section looks at our performance in 2017/18 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 2018/19 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 Luton Annual Public Health Report 2015/16 focussed on school aged children and identified particular issues in relation to language, poverty, obesity and activity, looked after children and mental health.

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

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

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

Division	Specialties	
Medicine	Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine Respiratory Medicine Diabetes and Endocrinology Gastroenterology	Cardiology Dermatology Heptology Neurology Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery - Colorectal - Upper Gastrointestinal - Vascular	Plastic Surgery ENT Cancer Services Medical Oncology

Division	Specialties	
	- Bariatric Surgery	Ophthalmology
	Urology	Oral & Maxillofacial Surgery
	Paediatric Surgery	Anaesthetics
	Trauma & Orthopaedic	Pain Management
Women and Children's	Hospital at home	Orthodontics
	Critical Care	Audiology
	Obstetrics	Paediatrics
	Community Midwifery	Fertility
	Early Pregnancy	Neonatal Intensive Care Unit
Diagnostics, Therapeutics & Outpatients	General Gynaecology	Uro-gynaecology
	Gynae-oncology	Ambulatory Gynaecology
	Pathology Services	Imaging
	- Blood Sciences	Musculoskeletal Services
	- Cellular Pathology	Dietetics
	- Microbiology	Speech & Language Therapy
	- Phlebotomy	Clinical Psychology
	Haematology Care	Outpatients
	Pharmacy	Breast Screening
	Physiotherapy and Occupational Therapy	

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

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

Other Executive meetings are dedicated to the Clinical Operational Board that reviews the clinical performance of the Trust and Executive Seminars for

# 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. As reported last year we launched our Advancing Quality and Patient Safety Framework at our Staff Engagement Event in December 2016 where over 2000 staff were engaged in delivering our plans. We continued this work reporting back progress against the Quality Improvement programmes in July 2017 at our Engagement Events and again in December 2018.

As in previous years we delivered against most of the national and local quality and performance targets. We continued to be one of the best performing hospitals in the country for the waiting time targets in A&E and we achieved cancer performance. We also maintained a low number of C Diff with 9 cases. However, we had some challenges with waiting times for diagnostics in endoscopy that was resolved by March 2018 and in delivering the 18 week target due to the unprecedented winter pressures. Action plans are in place to recover this position and whilst not achieving the 92% we have continued to maintain a high percentage seen within 18 weeks.

Our quality priorities set out for 2017/18 have been embedded into our systems and processes and we made considerable progress. We:

- Maintained over 90% compliance with the 3 day anti-biotic reviews in all clinical areas.
- Maintained a high focus on mortality and implemented a new more intensive mortality review processes and we have seen a reduction in HSMR during 2017/18.
- Worked closely with our mental health provider, East London NHS Foundation Trust, we have seen a 47% reduction in A&E attendances of mental health patients who frequently attend.
- Maintained a falls rate of below the national average and a reduction in the number of falls that resulted in harm.
- Worked on a new model of care called Needs Based Care that will see patients directed to a ward based on their need rather than their age.
- Maintained a cardiac arrest rate below the national average and continued to learn from each incident to further strengthen our processes.
- Improved our provision of support for dementia patients that has received positive feedback from patients.
- Further improved our engagement with patients to include more feedback into our governance and strategies.

This Quality Account also focuses on how we will deliver and maintain our progress against our key quality practices in the coming year. These priorities have been developed from our own intelligence of where we need to improve, engaging with all stakeholders to develop a comprehensive Quality Strategy, commissioning quality goals (CQUIN) and our CQC report.

David Carter  
Chief Executive  
23<sup>rd</sup> May 2018

## **Corporate Objectives 2017/18**

The Trust's Strategic and Operational Plans are underpinned by seven Corporate Objectives. A report against these objectives is included in the Trust Annual Report 2017/18.

### **1. Deliver Excellent Clinical Outcomes**

- Year on year reduction in Hospital Standardised Mortality Ratio in all diagnostic categories

### **2. Improve Patient Safety**

- Year on year reduction in clinical error resulting in harm
- Year on year reduction in Hospital Acquired Infection

### **3. Improve Patient Experience**

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

### **4. Deliver National Quality and Performance Targets**

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

### **5. Implement our Strategic Plan**

- Deliver new service models:
  - Emergency Hospital
  - Women's and Children's Hospital
  - Elective Centre
  - Academic Unit
- Implement preferred option for the re-development of the site.

### **6. Secure and Develop a Workforce to meet the needs of our Patients**

- Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.
- Ensure a culture where all staff understand the vision of the organisation and are 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

## **Part 2**

### **2. Report on Priorities for Improvement in 2017/18**

Last year we identified three quality priorities. This section describes what we did and what we achieved as a consequence. All of these priorities continue to be relevant and will be further developed during this current year.

**We had key priorities each for patient safety, patient experience and clinical outcome.**

#### **Priority 1: Clinical Outcome**

##### **Key Clinical Outcome Priority 1**

- **Improve our approach to mortality surveillance, identifying and reducing avoidable deaths**

##### **Why was this a priority?**

The Trust maintained an extensive focus on hospital mortality during 2017/18 which was reflected in a comprehensive programme of work. It built on the report commissioned in 2016 for an independent review into the Trusts HSMR performance by Dr Bill Kirkup CBE. The report was supportive of the work undertaken to date and made further recommendation which was added to the programme.

Overall the program included, the review of all deaths using a standardised Mortality tool; improving the access to specialist palliative care; establishing Mortality and Morbidity meetings in all of the Divisions and changes to coding. The Mortality Board monitors the progress of the programme and ensures learning is shared across the Trust.

##### **What did we do?**

- The Trust Mortality Board has overseen the development and publication of the Trust Mortality Review Policy. The first draft was published on the Trust website before the September deadline set out in the Learning From Deaths agenda.
- We have changed the methodology of our mortality reviews, from one adapted from the East of England Mortality Review Tool, to the Structured Judgement Review introduced by the Royal College of Physicians. This entailed training all consultants in the new methodology, and supporting their first few notes reviews. The process is now embedded, and teams are familiar with the Potential Avoidability score being used as the end-point of the review.
- We now have an established two-stage process for reviewing notes of deceased patients. The data being collated is now much more robust, and learning themes are being presented to governance meetings to improve system performance.
- We have referred all Learning Disability deaths to the LeDeR co-ordinators since the scheme was launched in October 2017, and Child, Maternal and Neonatal deaths continue to be reported and investigated through the appropriate national review programmes.
- The number of patients dying in hospital within 72 hours of admission from a nursing home has increased, from 49 last year to 56 this year. We have established a process for individual cases identified through mortality reviews as a potentially inappropriate in-hospital death to be escalated to Primary Care for review. The next step is a focussed



piece of work trying to support a single care home to look after dying patients without the need for them to be admitted to hospital.

### **How did we perform?**

- We have seen our HSMR improve from a statistically significant high of 110 in Feb 2017 to its current level of 101.9, moving us out of lower quartile performance.
- HSMR continues on a downward trend, and the last five months have been within the expected range after two consecutive years of being “significantly above expected.” A considerable amount of work has gone into looking for systemic causes of our higher than expected mortality. Significant progress on the key issues of palliative care coding, Charlson score capture, VTE risk assessment and prophylaxis pathways, and DNACPR/Treatment Escalation Plans appear to be linked to this improvement, which has occurred on a background of significant activity increases over the same timeframe.
- In the first two months of the final quarter of 2017-18, we have achieved a primary review in 97% of all deaths (275/284). From these, we requested 74 full mortality reviews, of which to date, 51 (69%) have been completed. This is significant progress from the previous quarter, where only 35% of requests were completed.
- Key learning themes were identified around appropriate discussion of “Do Not Resuscitate” orders, recognition of the end of life phase, and the need for improvements in the completion rates of requested full mortality reviews.

### **Key Clinical Outcome Priority 2**

- **Reduce the impact of serious infections (Antimicrobial Resistance and Sepsis)**

#### **Why was this a priority?**

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these, it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. This quality improvement initiative (which is also a National CQUIN scheme), is aimed at embedding NICE guidance to improve sepsis management. Furthermore, the approach taken to combine a responsive approach to the detection and treatment of sepsis needs to be balanced with a rigorous approach to the stewardship of antibiotics. Antimicrobial resistance has increased in recent years and the Chief Medical Officer believes that it is a major risk for healthcare. Without a reversal of the trend, we may find we have no drugs to treat serious infections in the future. The approach to these two key areas for improvement is taken from the viewpoint that the issues of sepsis and antimicrobial resistance are complementary and that developing and implementing a joint improvement scheme (CQUIN) will support a coherent approach towards reducing the impact of serious infections.

#### **What did we do?**

The Trust has appointed a Medical Director as the Trust-wide Lead for Sepsis. Clinical Champions have been appointed to support the improvement work in all Divisions in conjunction with an additional Sepsis Improvement Lead.

We have revised and implemented Sepsis Screening tools which provide clear management strategies for patients who trigger for sepsis. These have been re-designed to align with the updated requirements for NICE and the CQUIN for 2017-19.

We have provided training and education to the multi-disciplinary team in the recognition and management of sepsis.

The CQUIN audit has highlighted some clear areas for improvement especially in the patients who develop sepsis whilst in patients. A newly appointed Sepsis Improvement Collaborative will be set up to lead this work in the year 2018-19.

To support improved antibiotic stewardship the antibiotic pharmacist in conjunction with the microbiologist has been conducting antibiotic ward rounds for targeted patients. In addition the antibiotic pharmacist has been providing on-going support and guidance to junior doctors to review antibiotic prescribing practice in line with best practice recommendations.

### **How did we perform?**

The Trust has demonstrated excellent compliance with sepsis screening as monthly audit has shown that on average over the last year 98% of patients have been screened appropriately for sepsis, both in the Emergency Department and for patients developing sepsis whilst in patients.

Monthly audit has shown that on average over the last year in the Emergency Department 90% of patients presenting with sepsis have been provided with antibiotics within 1 hour of diagnosis of sepsis. \*\*\*

Audit has shown an average of 90% of patients with sepsis have been having clinical antibiotic reviews within 72 hours of antibiotic administration.

### **Key Clinical Outcome Priority 3**

- **To improve services for people with mental health needs who present to Accident and Emergency**

### **Why was this a priority?**

People with mental health problems are three times more likely to present to A&E than the general population. Nationally, more than 1 million presentations are currently recorded as being directly related to mental health. Furthermore, evidence has shown that people with mental health issues have 3.6 times more potentially preventable emergency admissions than those without and that the high levels of emergency care used by people with mental health problems indicate that there are opportunities for planned care to do more. A large majority of the people with the most complex needs who attend A&E most frequently are likely to have significant physical and mental health needs and may benefit from assessment and review of care plans with specialist mental health staff and further interventions from a range of health and social services. This is a National priority and a CQUIN has been developed to support cross-provider working to deliver improvements in care to this group of patients by providing enhanced packages of care from the most appropriate services.

### **What did we do?**

- Regular monthly meetings were set up and are running successfully between the Trust and East London Foundation Trust. Further wider partnership sessions were also held in September 2017, January and March 2018 which included representatives from Bedfordshire Police, Luton Borough Council, Central Bedfordshire Council, Luton CCG, Bedfordshire CCG, MIND, CGL, East of England Ambulance Service, Herts Urgent Care as well as representatives from East London Foundation Trust and

the Trust where both system working was discussed as well as the individual management of the patients within the frequent attenders programme. These are continuing throughout 2018/19.

- Clinicians from the Trust and East London Foundation Trust identified a group of 20 patients who had attended A&E most frequently during 2016/17 and it was felt would benefit most from further interventions. A Frequent Attender Project Lead was appointed by East London Foundation Trust and 16 of those contacted agreed to engage in the Frequent Attenders Programme.
- Individual care plans were jointly drawn up with the patients and the Frequent Attender Project Lead, and links developed and strengthened with existing services that could support the patient with their mental health issues and offer an alternative to attendance at A&E. These are regularly reviewed and amendments made to suit the needs of the patient at that point in their life including patient experience and satisfaction.
- A number of audits were carried out on data samples from the two patient systems used by the East London Foundation Trust and the Trust to review current data quality and make sure processes are in place to improve the collection and accuracy of data in relation to mental health signs and symptoms.

#### **How did we perform?**

- A reduction in attendances of 47% has been seen in the group of frequently attending patients.

#### **Key Clinical Outcome Priority 4**

- **To provide services to patients experiencing frailty in line with best practice**

#### **Why was this priority?**

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this quality improvement initiative is to implement best practice guidance to enable us to take action to prevent these adverse outcomes and help people live as well as possible with frailty. Appropriate services, delivered effectively to this group of patients will support a reduction in length of stay, reduced morbidity and mortality and a better experience for patients and their carers. Furthermore, the initiative will support the delivery of the Trust priority to deliver Continuity of Care and improve the flow of patients admitted as emergencies to the hospital.

#### **What did we do?**

Frailty is not an inevitable part of ageing and can be improved or can be prevented with early identification and long term co-ordinated care planning. The Directorate for Medicine of the Elderly (DME) Team and Luton CCG and other stakeholders have worked together to develop a Framework for Frailty which is divided into prevention (P1) and treatment (P2) whereby patients aged over 65 years of age are assessed. The DME team have regularly attended the Frailty and Falls Group Meeting and MDTs. New pathways have been completed and are being rolled out across the Trust for delivery of the Frailty Unit. Initially this will be led by ward 19a at the L&D but as the new Needs Based Care (see key patient

safety priority 1) rolls out it is planned to have the beds for Frailty within the Acute Assessment unit.

### **How did we perform?**

The work completed throughout 2017/18 enabled the frailty unit to become operational in February 2018, therefore have not been able measure the appropriateness of referrals as yet, or gained sufficient feedback from service users. However, we will be monitoring the following performance indicators over the next year to identify whether there has been:

- A reduction in the number of frail patients being admitted to hospital via A&E or EAU
- A reduction in the length of stay for patients with frailty
- A decrease in the proportion of patients with frailty who are admitted to hospital for an overnight stay

## **Priority 2: Patient Safety**

### **Key Patient Safety Priority 1**

- **Improving Continuity of Care and delivering Needs Based Care model**

#### **Why was this a priority?**

The delivery of 7 day consultant led services and early senior review and decision making for patients admitted to hospital as an emergency has been a significant area of quality improvement for the Trust, with significant increases in consultant presence out of hours and at the 'front-door' of the hospital over the last few years. However, as our model for emergency care has gradually evolved, an unintended consequence has been an increase to the number of consultants that have sequential input into a patient's care. It is not unusual for a patient admitted to a medical specialty as an emergency to receive care from a number of different consultants during their hospital stay. This can lead to confusion for the patient and their family as to what is happening, difficulties in co-ordinating the plan where the owning consultant is not following it through, and does not make it easy for senior medical staff to closely monitor a patient's progress and assess the effectiveness of treatment. By improving the continuity of consultant care for an individual patient, we will improve patient experience, reduce length of stay and minimise the clinical risk of patient management plans being handed over between senior clinical staff multiple times.

Within the range of emergency admissions to hospital, there will be some patients who will benefit from being cared for by physicians with a particular specialist interest, such as stroke, cardiology or respiratory. There are other patients who may be admitted with a straightforward medical issue, such as an infection or after a fall, but have very complex needs perhaps because of underlying long term conditions, poly-pharmacy, or extensive social or support needs. These patients require care from a senior general medical physician, with support from a wide range of professionals, and carefully managed transitions between hospital and usual place of residence. Getting the patient to the right specialty team as early in their admission as possible is really important to avoid unnecessary investigations, support the patient to be managed at home wherever possible and to enable rapid and targeted treatment and intervention without having to wait for advice from another specialist.

## **What did we do?**

The Medical Division have been working on developing a model of Needs Based Care since late 2015. The team had already embedded ambulatory care pathways running 7 days a week and opened a cardiac ward for patients to be admitted under cardiologists where appropriate, rather than being admitted under a general physician who would then seek advice from a cardiologist. This has shown a reduction in length of stay for patients with cardiac diagnosis, and the initial data review suggested that this change was saving up to 15 medical beds. The next steps for implementation of Needs Based Care are to;

- Deliver admission for patients directly to respiratory specialists 7 days a week, we have currently been delivering an in reach service to the EAU's Monday to Friday until 5.00pm, this will be expanding once we have substantive recruitment.
- Works to the lifts in the medical block to facilitate specialty ward moves and create a larger flexible EAU bed base at the front of the hospital has not yet started therefore we are unable to deliver a larger EAU environment, the plan for this will now be in 2018/19.
- The design of the complex and general medical senior medical model to enable movement to full needs based care for all specialties has been completed with a full business case going to the Board in November of last year for approval.
- The implementation phase is now in progress with recruitment to all Consultants, Pharmacy and Therapy posts.

## **How did we perform?**

The detailed work to support Needs Based Care resulted in extended time to develop the business case which was approved in November 2017. As this current time we have been taking the appropriate action to support the initiative and a programme of measures will be monitored through the Programme Board for Needs Based Care including a:

- Reduction in the number of consultant handovers within an inpatient episode
- Increase the % of patients discharged by the same consultant for a related re-admission
- Increase the % of patients discharged by their named outpatient consultant where applicable
- Reduction in length of stay for emergency medical patients
- Improved patient satisfaction regarding communication and involvement in decision making around their care
- Fewer non-value adding days to patient hospital stays due to improved co-ordination of the treatment plan

## **Key Patient Safety Priority 2**

- **To reduce the incidence of falls amongst patients staying in hospital**

### **Why was this a priority?**

Over the past five years, the Trust has shown a year on year improvement in the prevalence of falls with harm but the incidence of falls (rate per 1000 bed days) has remained relatively static. Whilst the Trust has a lower incidence of falls than the national average, we are committed to refocusing our multidisciplinary team efforts in order to reduce our rate of falls. When a patient has a fall in hospital, the effect can be both physically and psychologically detrimental and in many cases may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the efficiency of delivery of services

to patients by less effective use of beds. Research has shown that when staff such as doctors, nurses and therapists work more closely together, they can reduce falls by 20-30% (RCP 2016). The Trust plans to build upon the work already undertaken to strengthen our approach to the prevention of falls thereby improving patient safety and experience.

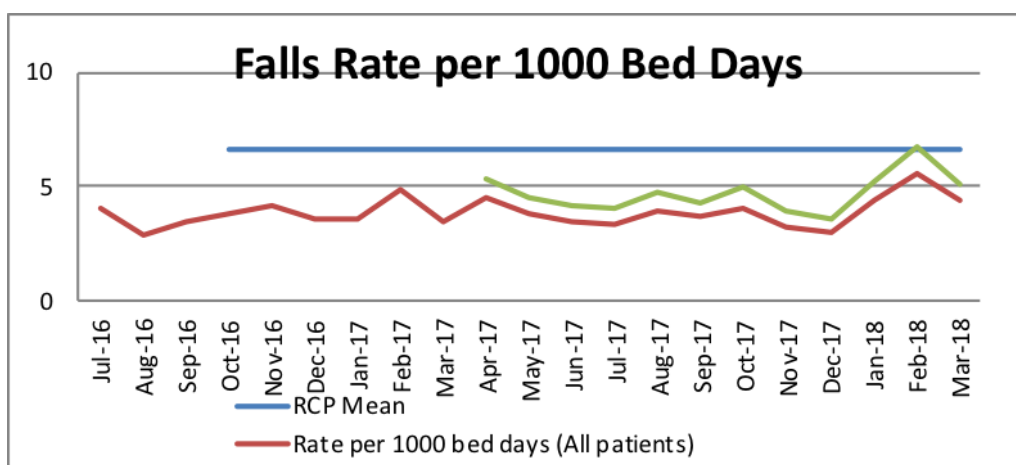
### **What did we do?**

- In October the Trust held an inpatient “Falls Summit” which was attended by all relevant stakeholders. A thematic analysis of inpatient falls with harm was presented by the Clinical Advisor to the Board. As a result of this report recommendations in line with NICE and Royal College of Physicians (RCP) were considered and supported.
- A “Falls Summit Action Plan” has subsequently been developed and is being managed through the Trust Falls Steering Group with the Director of Nursing as executive lead.
- The Trust took part in the 2<sup>nd</sup> RCP Inpatient Falls audit in May. Audit results show an improvement in 5 of the 6 key indicators with 1 remaining unchanged from previous audit in 2015. L&D results noted to be above national average.
- Following bedrail audit in April which revealed variable results across the Trust. The Wards now audit bedrail assessment and use on a monthly basis. These results are brought to Quality performance meetings led by Director of Nursing.
- The “Baywatch” enhanced observation initiative commenced in October. The scheme enables the wards to focus on their high risk patients and to co-hort vulnerable patients in bays with staff member present at all times.
- Patient information leaflet on Falls prevention in Hospital is available across the Trust.
- Posters highlighting falls risks in bathrooms and toilets are in place on all wards. This information is also included in the patient information leaflet.
- The nursing documentation which includes the falls multi factorial assessment has been reviewed and updated led by the Corporate Nursing team. The document is due to be piloted within the next 2 months.
- The bed contract is currently under negotiation with plan to agree new contract within the next 6 months. As part of the contract there will be an increased supply of low rise beds.

### **How did we perform?**

- In line with RCP Inpatient falls audit the Trust now collects two sets of falls rate per 1000 bed days data. One set for the all trust patients and one for patients aged 16 and over and excluding maternity patients.
- For patients over 16 excluding maternity figures show that apart from one month the Trust has remained below the RCP mean.
- The Whole Trust falls rate of below 4 per 1000 bed days has proved more challenging to achieve with just 7 months showing rate below 4. The increased activity and the opening of contingency areas for most of January, February and March has meant that staffing has been a challenge with senior staff moved to contingency areas and skill mix reduced on base wards.
- Reporting of falls associated with use of toilets and bathrooms continues. On review of datix reports it was found that the reports had not always been fully completed as “Where did the patient fall” question was not mandatory. This has now been updated and accurate data is now being collected. Results over the year have been variable and have not shown a significant reduction. The falls in Toilet /bathroom rate per 1000 bed days for 2017/8 was 0.63. This will continued to be monitored and reported to the board.
- The patient information leaflet on Preventing Falls in Hospital is now included in the Welcome Pack that is being given to patients on the acute admission wards and Ward 17. The leaflets are also available on all the adult wards.

- Action from the Falls Summit meeting has resulted in 3 consultants joining the Trust Falls Steering group.



### Key Patient Safety Priority 3

- **Improve the management of deteriorating patients**

#### Why was this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as “Failure to Rescue”. This in turn leads to further deterioration in the patient’s clinical condition and potential death. Although the Trust’s average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2016-17 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, there is a need to continue in our improvements to deliver more sensitive, appropriate care at the end of a person’s life. It is vital that for those patients, nearing the end of their life, that appropriate, timely decisions are made and care plans put in place to provide compassionate dignified care when aggressive treatment or resuscitation are not appropriate.

#### What did we do?

We continued to conduct reviews into all cardiac arrests to identify any learning points. As a result of the reviews a number of cases have required serious incident case reviews or directorate level investigations, and action plans put in place to minimise re-occurrence of any issues identified. Where it has been deemed following review of the case that there is local learning only, then clinical areas have been requested to devise a local action plan to address any issues.

As part of the cardiac arrest review process we have monitored: 1. Compliance with observations protocols for deteriorating patient, 2. Compliance with the correct process for escalating concerns, 3. Compliance with timely medical response. The review team in conjunction with the responsible clinicians critically analyse decisions made and action taken by medical and nursing staff prior to the arrest to identify whether management was optimal to prevent further deterioration. An improvement approach is then taken to in conjunction with the clinical teams to lessons learned, and action plans implemented to optimise future patient management. In addition as part of the reviews the team have monitored the setting of appropriate ceilings of care, and the use of Personal Resuscitation Plans and where appropriate and DNAPR orders. To support the setting of appropriate ceilings of care a

Treatment Escalation Plan has been designed and implemented in Spring 2017 by the Resuscitation team. In clinical practice the outreach team promote the use of appropriate ceilings of care, in conjunction with the responsible clinicians and the patient.

In the Emergency Department best practice interventions are used to optimise recovery for patients presenting with Acute Kidney Injury (AKI).

For in-patients a workstream has begun to support better practice in fluid monitoring in order to prevent 'avoidable' AKI in in-patients. This has included the design and pilot of an innovative fluid chart to provide guidance to clinical staff caring for patients 'at risk' of AKI.

#### **How did we perform?**

- On average the annual cardiac arrest rate has been maintained below the National cardiac arrest rate. Cardiac arrest reviews have highlighted a 50% reduction over the year in the numbers of concerns related to both timely and appropriate observations and escalation of concerns and timely end of life decision making. Thus reducing the incidence of 'Avoidable' arrests, and ensuring patients nearing the end of their life are appropriately assessed and provided with a careplan to ensure the most appropriate care delivery.

#### **Key Patient Safety Priority 4**

- **To reduce the incidence of medication errors for inpatients**

#### **Why was this a priority?**

Every step in the processes associated with the use of medicines has the potential for failure to a varying degree. Medication safety is therefore, the responsibility of all staff and most effective when underpinned by a culture of openness and honesty when things go wrong. It is vital that we learn and use our developing understanding of medication safety incidents to most effectively deal with the causes of failure. The reporting, analysis of and learning from medication safety incidents is vital even where no harm has occurred to a patient. This allows the best quality learning to take place as the 'what', 'how' and 'why' things went wrong, so that effective and sustainable solutions can be put in place to reduce the risk of similar incidents occurring.

Research evidence (NHS England 2014) indicates the following medication error rates in the medicine use process nationally:

- Prescribing error rate in hospital, 7% of prescription items;
- Medicine administration errors in hospital, 3 - 8%;
- Dispensing error rate in hospitals, 0.02 - 2.7% of dispensed items;

Drug incidents accounted for 7% of all incidents reported on the Trust's patient safety incident reporting system during 2016/17, 95% of which caused no harm or low harm. However, there is opportunity to increase reporting rates of medication incidents following an apparent reduction in reporting during some parts of the year.

Since being chosen as one of the pilot sites for the 'Safer Patient Initiative' over a decade ago, significant progress has been made through an organisation-wide approach to patient safety and medication safety. The findings of the Francis Report also resulted in measures being put in place to address areas of concern relating to medicines use. The Trust Medication Safety Review Group (MSRG) reviews medication error reports each month, identifying themes and ensuring multidisciplinary, trust-wide learning is shared. This priority, aims to refocus attention across all professions to maximise the opportunities afforded by learning for quality improvements to further drive up our safety in medicines management.



### **What did we do?**

- Medication error sub-category on Datix was reviewed and streamlined as part of the incident categorisation project.
- Missed doses audit was completed – results and recommendations are yet to be shared with senior nurses. A robust high risk medicines monitoring system is being proposed.
- The Medication Safety Review Group (MSRG) continues to monitor trends and themes from the medication error analysis and this has formed the basis for various improvement work streams.
- Multi- professional insulin quality improvement (QI) work stream was undertaken to reduce insulin related errors.
- EPMA insulin drug-lines were reviewed to reduce selection errors by prescribers.
- High risk medicines alerts on EPMA - in response to a number of Datix incidents involving non-vitamin K oral anticoagulants (NOACs), the MSRG approved the introduction of high risk medication alert functionality on EPMA as a safety prompt for prescribers.
- Learning from recurring medication errors continue to be highlighted and disseminated through the MIST newsletter, a quarterly publication by the Pharmacy department.
- Junior doctors prescribing errors feedback sessions have continued with excellent feedback – an abstract was recently submitted to Health Education England (HEE).

### **How did we perform?**

- Medication error reporting declined in 2017(n=852) compared to the preceding year (n= 944). No errors resulted in a patient death or severe harm, 10 resulted in moderate harm, 90 resulted in low harm and the remaining 749 resulted in no harm.
- Administration errors continue to account for the highest number of medication errors reported and constitute about 32% of medication errors reported.
- Combined missed and omitted doses accounted for 17.5% and prescribing errors accounted for 15% of reported medication incidents, both of which were similar to the previous year.
- The results from the missed doses audit in August 2017 showed that 13% of doses due for administration were omitted however only 2% of these omissions were high risk medicines.
- Some reduction in the number of insulin related incident reports has been identified from the monthly medication error analysis in Q4 (2017/18) but more work is still ongoing to improve insulin use.

## **Priority 3: Patient Experience**

### **Key Patient Experience Priority 1**

- **Improve the experience and care of patients at the end of life and the experience for their families**

### **Why was this a priority?**

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and

not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. The last two years have seen improvements in communication with patients and families, improved symptom management and spiritual care, investment in training and education and reduction in inappropriate cardiac arrests through more timely decisions regarding DNACPR. This year, the focus will be on working with our community colleagues and our commissioners to ensure patients achieve their choice of 'place to die' and that this is achieved in a timely manner.

### **What did we do?**

- The Specialist Palliative Care Team have formed excellent working relationships with Wards and Clinical teams. The team has expanded to include a full time Palliative Care Consultant. Dr Herodotou is now available in the hospital Monday to Friday. Referrals are received from all areas. EOLC Nurse post is embedded across the Trust.
- The individual Care Plan for the Dying is now used across the Trust for all expected deaths when a patient is identified as imminently dying.
- "Small Things Make a Difference" – This continues to be promoted, with the patient linen property bags now in place.
- A working group has developed the concept of an End of Life Care Trolley with staff on Ward 15. The aim is to enhance the comfort and experience for family members and carers. The trolley is currently being trialled on Ward 15, if successful; the hope is to roll this out across the Trust. This will be evaluated and feedback obtained.
- In order to improve communication several initiatives have been successful
  - Review of all available information including information packs for families and carers in the EOLC trolley
  - A leaflet "information for families after a loved one is dying" has been developed
  - Bereavement Booklet has been redesigned
- Patients are regularly referred for Chaplaincy Service for spiritual support. Chaplains also attend the weekly Palliative Care MDT.
- Review of data collection has taken place to ensure monitoring of referrals and outcome of patient choice of place of death.
- Successful business plan for the implementation of System 1 – This is due to go live on 9<sup>th</sup> April. This will have a huge impact on patient care, enabling Health Care Professionals to communicate across all care settings.
- Care of the Dying – Guidelines have been reviewed and updated to include a last offices checklist – aim is to improve privacy and dignity.

### **How did we perform?**

The number of patients put on end of life care plan has improved and the Trust meets the national guidance.

## **Key Patient Experience Priority 2**

- **To improve the experiences of people living with dementia and their carers when using our outpatient services.**

### **Why was this a priority?**

Patients with Dementia can have complex care needs. This care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their care pathway, provide good quality patient care and experience whilst

they are attending hospital and communicate effectively with primary care in order to more effectively address their specific needs and provide a better quality experience. Service user feedback provided by the Alzheimer's Society has shown that there is an opportunity to improve the experiences of the person with dementia and their carer who attend our outpatient departments. The Trust is committed to focusing on this element of patient experience for the coming year.

#### **What did we do?**

- We used patient experience feedback to focus our improvements on specific Dementia related issues. A meeting was held with key department leaders to agree the improvement objectives, training was offered to clinic clerks and receptionists, opportunities to share new ideas and awareness training offered.
- We agreed to pre alert the outpatient department to those patients already known to be living with a dementia with future appointments.
- We invited attenders to alert reception staff if they have a memory loss or Dementia on arrival to the department and a poster is on display in these areas.
- We met with the eye clinic staff to raise awareness and gathered their thoughts and ideas for improvements.
- We developed a simple visual aid and prompt (a butterfly) to alert staff to consider the additional needs for the person with Dementia during their consultation period.
- We surveyed our clinic staff to establish their training needs and improvement ideas
- We identified a quiet area for those patients needing a calmer environment.

#### **How did we perform?**

- We now have eight Dementia champions working in the department. They are trained at an enhanced level to promote awareness and offer appropriate signposting and referrals. These staff act as role models and advocate for the person with dementia and their carers whilst in the department.
- All clinic clerks and receptionists have received awareness training.
- We have introduced four distraction boxes across the department. These are available for the person with dementia and the carer to utilise while waiting for appointments.
- Environmental improvements were carried out and we introduced calendar clocks and provided appropriate signage in outpatients which meets the national recommendations for dementia friendly design.
- Patients with dementia are offered the earliest consultation, where possible, to avoid delays and unnecessary distress.
- Staff are referring to/signposting to the hospital Dementia Clinical Nurse Specialist for advice and follow up.
- We have received positive feedback regarding staff in the department, praising their approach and management of the person with Dementia.
- A carer/patient feedback survey is planned for April –June 2018 to measure success.

### **Key Patient Experience Priority 3**

- **Ensure proactive and safe discharge in order to reduce length of stay**

#### **Why was this a priority?**

There is considerable national evidence for the harm caused by poor patient flow. Delays lead to poor outcomes and experiences for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has a serious impact across health and care systems, reducing the ability of emergency departments to most efficiently and effectively respond to people's needs, and increasing costs to local health economies.

Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend – between 2013 and 2015, recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million beds days. For older people in particular, long stays in hospital can lead to worse health outcomes and can increase their long term care needs.

This is a national issue and, as such, local A&E Delivery Boards are being asked to implement key initiatives to address some of the major underlying issues causing delayed discharges. The National CQUIN scheme builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways.

### **What did we do?**

- The Integrated Discharge Team have regular multi- disciplinary patient tracking sessions to look at complex patients and their length of stay. This incorporates and compliments the red to green work that has been implemented on the majority of wards across the Trust.
- The process for tracking patients is constantly reviewed and up-dated by the discharge team. There have been a number of changes made to pathways and processes for both the Trust and the community providers. This is an on- going piece of work. Patient tracking is now embedded into the discharge officer's daily routine and provides the Discharge Managers with the information required to problem solve and address complex issues that cannot be addressed by ward staff.
- The Integrated Discharge team have escalation processes in place supported by the Trust Executives and those from partner organisations and are regularly discussed in the A&E Delivery Board. There are a number of discharge pathways created by the local authorities and CCG's whose patients are admitted into the Trust. These pathways have been created to provide whole system working to reduce length of stay and provide better outcomes for patients leaving the L&D. The 'Delayed Transfers of Care' have reduced for both Luton and Central Bedfordshire and now both organisations are National Leaders in their performance. We are currently working collaboratively to support Hertfordshire to achieve better outcomes for their patient group. All the work that has been achieved relating to discharge has supported the flow of patients out of the Emergency Department.

### **How did we perform?**

- The L&D are recognised for the performance they achieve for the Emergency Department and Integrated Discharge; however this is only achieved with constant high performance of staff with all parties concentrating on achieving the flow required to keep patients safe.
- Although at a national level we appear to manage the situation well the intensity this places on all staff involved is not sustainable longer term. We are constantly looking at improving ways of working that are more sustainable for staff and have better outcomes for patients.
- There is an investment now across the Trust that discharging patients is the responsibility of all staff. The team are currently producing a new spread sheet that will be rolled out across all wards with all disciplines pro- actively being involved. We regularly monitor activity. The information below shows some reduction in bed days. Although this may

appear small changes a reduction of 0.1 days in the whole hospital length of stay gives a saving of 6 days every day.



## Key Patient Experience Priority 4

- Improving experience of care through feedback from, and engagement with, people who use our services

### Why was this a priority?

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. Patients and their carers are at the heart of what we do and seeking a better understanding of, and responding more effectively to, their experiences is a core element of how we deliver our services.

Furthermore, the NHS Five Year Forward View says that 'we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services' (2014). The concept of patient leadership is emerging as one important new way of working collaboratively with patients and carers. 'One new concept – patients as leaders – is beginning to gain popularity' (Kings Fund 2013). Nationally, initiatives are emerging which place high priority on involving patient leaders in the endeavours of NHS organisations to secure better information from service users and to support

In addition to this priority for our patients' experience, it is also a priority to improve the experiences of staff. The 2016 national staff survey results showed our Trust to be in the lower 20% of Trusts in England for effective use of patient/service user feedback. Our key priority therefore needs to be to ensure that we increase the opportunities to gain feedback from our patients and carers, that we seek to increase the usefulness and quality of the information we gather and that we increase the scale and pace of quality improvement initiatives which are directly responding to our patient experience feedback.

## **What did we do?**

- Increased the use of iPads on wards and in departments to collect feedback from more patients, using both the FFT and patient surveys.
- Supplemented the FFT question routinely asked on discharge, with a range of questions to provide a better understanding of patient experience and also changed the supplementary questions in light of feedback from the national inpatient survey.
- Ward managers and departmental managers receive weekly FFT reports and electronic notification of negative responses immediately they are posted by patients. This allows them to receive feedback in real time and enables them to put in changes immediately rather than waiting for a month end report.
- Patient experience findings and related quality improvements have been included on Divisional Boards and actions plans from the national patient surveys have been tabled and reviewed.
- Key findings of the national surveys have been presented and publicised at various meetings. Briefing papers have been provided to Boards and the Patient Experience Team has attended Divisional Meetings to monitor the actions in place following the results of their national surveys.
- Maximise the opportunities to make direct links between staff experience and patient experience by the Patient Experience Manager attending the Staff Involvement Group and to work alongside staff who are responsible for organising the staff survey.
- Continued to build on a culture where patient and carer experience is everybody's business by including presentations at learning and sharing events, as well as presenting to all new staff during their induction programme,
- We have re – introduced patient stories to inform the Board and Services Managers about patient's experiences and what lessons can be learned and shared.
- Assisted services to set up engagement events with patients and families to gather qualitative feedback and share their experiences.
- Assisted services to set up and facilitate service user groups in gather patient input and feedback to influence quality improvement and service development.

## **How did we perform?**

- We have an increased number of iPads available for use in services areas, and more teams are now requesting additional equipment to help them record other service specific feedback which they collect from patients.
- The FFT scores have been consistent, if not better throughout to the year, compared to national benchmarks, particularly in relation to Outpatients and ED 'recommend' scores. Also when weekly reporting was introduced we saw an improvement in scores in a number of areas and staff have found the early feedback useful enabling them to take action immediately rather than waiting for a monthly report.
- The additional questions introduced along with the FFT questions, which we asked patients on discharge, allowed us to monitor improvements throughout the year against last year's national inpatient survey. This resulted in improved results relating to those questions in the national inpatient survey for this year.
- NICU, the Integrated Pain Management Service and the Breast Care Support Group have undertaken engagement events and focus groups. Also the Patient and Public Participation Group has met regularly throughout the year to oversee and input into Trust wide improvement projects. This has included participating in a focus group to discuss the design of the new Trust website.

- Patient Stories have been very successful this year, highlighting issues to the Clinical Outcome and Safety Board, where we can improve services. By involving relevant service managers they have been able to hear first hand from patients about their experiences and can share this with their teams. It also shows to patients that their feedback is listened to and gets directly back to the frontline teams.

### **Key Patient Experience Priority 5**

- **To support the continued delivery of care within residential and nursing homes to patients nearing the end of their life**

#### **Why was this a priority?**

People nearing the end of their life who are living in nursing or residential homes are sometimes brought into hospital because of a failure in provision in the community. 30% of patients stay in hospital for less than one day and a significant number die within 48 hours of admission because they are patients who are at the end of their life. These two groups of patients particularly have the potential to receive more appropriate care if it were able to be delivered within their place of residence. Evidence suggests that staff within nursing homes and residential homes are often reluctant to call an ambulance because they are aware that the patients' needs could be adequately provided for within the community had the appropriate services been consistently available. The effect is that people may be dying in hospital unnecessarily and that some beds are being used for less appropriate admissions. Through this service we aim to provide an alternative to calling for an emergency ambulance when intervention in the home would effectively prevent the patient transfer.

#### **What did we do?**

We have had a number of recruitment challenges which has delayed the original implementation of this project. Therefore, the project scope was reviewed to be able to support the project within the current establishment. This resulted in one care home trailing the virtual equipment and concept of virtual support within hours of 8am – 8pm Monday to Friday. We:

- Engaged Alicia care home
- Ensured concept equipment was loaned to the care home
- Set up the care home with training for the Circuit virtual concept
- Put in place a secure email account for the care home
- Engaged IT project lead to support the IT side of the project
- Had positive engagement from the care home
- Agreed a contact process
- Agreed a daily call to the care home
- Engaged medical support from the L&D

#### **How did we perform?**

Due to the delays and the scoping of the revised project, during 2017/18 we succeeded in putting the processes in place to initiate the project in April 2018. Audit tools have been drawn up to measure performance and this will be measured over the next year.

### 3. Priorities for Improvement in 2018/19

The Trust's overarching quality strategy was updated and launched for 2018-2021. There are now four key priority areas:

1. Improving Patient Experience
2. Improving Patient Safety
3. Delivering Excellent Clinical Outcomes
4. Prevention of Ill Health

These are based on local, STP and national priorities and are set within a broader three year strategy for quality and improvement. Within each of the key priority areas listed above, there are a range of ambitious programmes of work to ensure that the Trust continues on the journey to become an outstanding organisation for people who both use and work within our hospital.

#### Priority 1: Improving Patient Experience

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

##### **Why is this a priority?**

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

##### **What will we do?**

The values will be launched by the Board which will then enable a range of developments:

- Revision of Corporate Induction for all new starters that encompasses the values and what they mean to the Trust linked to comprehensive guidance for managers on local induction.
- Development and delivery of a communication campaign that launches the values to all our stakeholders, both internal and external.
- Review and development of a refreshed set of appraisal documentation that will ensure that all staff covered by Agenda for Change reflect on how they contribute to ensuring that we work to our values for the benefit of both staff and patients.
- Introduction of recruitment practices that enable us to judge how candidates match up to our values.

##### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

##### **Success Criteria**

- Staff will be recruited into the Trust having been judged to hold shared values.
- New starters will understand what the values mean and how they will be used to support effective team behaviours and a conducive working environment.
- Appraisals will include discussion and review of the up to date values with each member of staff.

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

##### **Why is this a priority?**



Always Events® is a tried and tested improvement methodology using co-production and really ensures that patients and families are true partners in designing improvements to services. We want to use co-production with patients and families to ensure that patients have the best possible experience of care. Always Events® improvement methodology will help us to make sure that care is focused on what matters most to patients.

#### **What will we do?**

- We will sign up to the NHS England campaign and select one area to join the programme in May 2018.
- Through the national programme, benefit from the coaching and support to implement the toolkit within the Trust.
- After using the methodology in one area, rollout and spread to other areas.
- Work with patients, families and carers to develop the Always Events® using findings from national and local surveys to help provide direction.
- Assess impact through the evaluation of local patient experience surveys.
- Roll out a high profile communication campaign to share the developments and create interest from other areas to join in.

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

- At least one ward has developed an Always Events® which has been evaluated.
- Patients have been involved in supporting the quality improvement.
- Patient experience has been shown to improve in respect of the issue being addressed.
- At least 3 other areas are implementing Always Events by the end of the year.

### **1.3. Support continued delivery of care within residential and nursing homes to patients nearing the end of their life.**

#### **Why is this a priority?**

People nearing the end of their life who are living in nursing or residential homes are sometimes brought into hospital because of a failure in provision in the community. 30% of patients stay in hospital for less than one day and a significant number die within 48 hours of admission because they are patients who are at the end of their life. These two groups of patients particularly have the potential to receive more appropriate care if it were able to be delivered within their place of residence. Evidence suggests that staff within nursing homes and residential homes are often reluctant to call an ambulance because they are aware that the patients' needs could be adequately provided for within the community had the appropriate services been consistently available. The effect is that people may be dying in hospital unnecessarily and that some beds are being used for less appropriate admissions. The service we aim to deliver 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?**

- Provide an outreach service as an alternative to calling an ambulance to one care home in Luton and one in Bedfordshire.
- 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 to ensure that appropriate screening and referral criteria are established and implemented to enable an effective, safe referral pathway to be put in place.
- Work with UNIFY to prove the concept of virtual equipment/IT platform to help deliver a more responsive service.

#### **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 outreach service is in place providing interventions in selected nursing and residential homes which result in reduced conveyances to ED.

### **1.4 Continue to improve the end of life care offering and experience to patients and their carers**

#### **Why is this a priority?**

Improving End of Life (EOL) care continues to be a priority if we are to ensure the best possible quality of care to our patients and families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. Further, it is difficult to get meaningful feedback from the families and carers of those patients who are dying because of the sensitive nature of the situation. However, we understand from the analysis of complaints and anecdotal evidence, that there is more we can do to improve the end of life care experience for both patients and their families and carers.

#### **What will we do?**

- Employ a second End of life Care Nurse and continue to raise the profile of the team
- Continue to present at clinical multidisciplinary meetings to promote the end of life individualised care plan and embed national guidelines for EOL care.
- Improve communication with partner provider organisations by implementing SystmOne in the Trust.
- Focus on the quality of discharge for patients nearing the end of their life
- Introduce special trollies for use by patients and their families to help provide a more conducive environment and helps to address the small things which make a big difference (music/toiletries/accessories/information).
- Relaunch the referral process for Meaning Centred Counselling and Therapy (MCCT) and Partnership in Excellence in Palliative Support (PEPs.)
- Seek feedback through the newly updated bereavement booklet which includes a feedback section for families and carers.
- Embed the updated care of the dying guidelines to promote and improve dignity after death.

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

- That issues identified in complaints are used to make a positive difference.
- Positive changes to feedback received from relatives and carers of EOL patients.
- Reduction in the incidents and complaints relating to end of life care.
- New initiatives implemented are in use by wards across the Trust.

- Improved performance shown through local feedback – bereavement booklet includes a family/carer feedback section.
- Improved results from the national 'Care of the Dying' audit (due in June 2018).

## **Priority 2: Improve Patient Safety**

### **2.1 Improve continuity through the delivery of Needs Based Care**

#### **Why is this a priority?**

The delivery of 7 day consultant led services and early senior review and decision making for patients admitted to hospital as an emergency has been a significant area of quality improvement for the Trust, with significant increases in consultant presence out of hours and at the 'front-door' of the hospital over the last few years. However, as our model for emergency care has gradually evolved, an unintended consequence has been an increase to the number of consultants that have sequential input into a patient's care. It is not unusual for a patient admitted to a medical specialty as an emergency to receive care from a number of different consultants during their hospital stay. This can lead to confusion for the patient and their family as to what is happening, difficulties in co-ordinating the plan where the owning consultant is not following it through, and does not make it easy for senior medical staff to closely monitor a patient's progress and assess the effectiveness of treatment. By improving the continuity of consultant care for an individual patient, we will improve patient experience, reduce length of stay and minimise the clinical risk of patient management plans being handed over between senior clinical staff multiple times.

Within the range of emergency admissions to hospital, there will be some patients who will benefit from being cared for by physicians with a particular specialist interest, such as stroke, cardiology or respiratory. There are other patients who may be admitted with a straightforward medical issue, such as an infection or after a fall, but have very complex needs perhaps because of underlying long term conditions, poly-pharmacy, or extensive social or support needs. These patients require care from a senior general medical physician, with support from a wide range of professionals, and carefully managed transitions between hospital and usual place of residence. Getting the patient to the right specialty team as early in their admission as possible is really important to avoid unnecessary investigations, support the patient to be managed at home wherever possible and to enable rapid and targeted treatment and intervention without having to wait for advice from another specialist.

#### **What will we do?**

The Medical Division have been working on developing a model of Needs Based Care since late 2015, and has already embedded ambulatory care pathways, which are now running 7 days, and opened a cardiac ward for patients to be admitted under cardiologists where appropriate, rather than being admitted under a general physician who would then seek advice from a cardiologist. This has shown a dramatic reduction in length of stay for patients with cardiac diagnosis, and the initial data review suggested that this change was saving up to 15 medical beds. The next steps for implementation of Needs Based Care are to;

- Deliver admission for patients directly to respiratory specialists 7 days a week
- Complete works to the lifts in the medical block to facilitate specialty ward moves and create a larger flexible EAU bed base at the front of the hospital
- Complete the design of the complex and general medical senior medical model to enable movement to full needs based care for all specialties

In terms of facilitation of increased continuity, there are three transitions of care to be considered:

- When a patient with a long term medical condition comes into hospital, they should be cared for by a consultant who has been managing their outpatient care with their GP
- When a patient is admitted to hospital, they should have the same consultant for as much of their stay as possible, with no avoidable handovers.
- When a patient comes into hospital for a second time, they should return to the care of the consultant who discharged them, so that the treatment and plan can be reviewed in the context of the patient's prior admission

It is our intention to remodel the way the consultant care of inpatients is delivered to maximise consultant continuity for patients against each of these three elements of the pathway. This will require changes to consultant timetables, to enable ongoing care of patients rather than the traditional 'on-ward, off-ward' patterns of work.

Furthermore, by continuing to deliver reductions in length of stay through delivery of the Red to Green initiative\* and focussed management of patients with length of stay in hospital of over 7 days, we will reduce the number of patients that are not admitted to the right bed first time, and so will reduce avoidable handovers that result from patient movement between wards.

\* a visual management system to assist in the identification of wasted time in a patients journey. If it is red, the patient has not progressed, green they have.

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

- Reduction in the number of consultant handovers within an inpatient episode
- Increase the % of patients discharged by the same consultant for a related readmission
- increase the % of patients discharged by their names outpatient consultant where applicable
- Reduction in length of stay for emergency medical patients
- improved patient satisfaction regarding communication and involvement in decision making around their care
- Fewer non-value adding days to patient hospital stays due to improved coordination of the treatment plan

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

### **Why is this a priority?**

Over the past five years, the Trust has shown a year on year improvement in the prevalence of falls with harm but the incidence of falls (rate per 1000 bed days) has remained relatively static. Whilst the Trust continues to have a lower incidence of falls than the national average, we remain committed to continuing to focus on reducing our rate of inpatient falls. When a patient has a fall in hospital, the effect can be both physically and psychologically detrimental and in many cases may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the efficient delivery of services to patients by less effective use of beds. Research has shown that when staff such as doctors, nurses and therapists work more closely together, they may prevent 20-30% of falls (NICE 2013). Whilst we have shown an improvement in our RCP audit results (RCP 2017), the

Trust will continue to build upon the work already undertaken to strengthen our approach to the prevention of falls thereby improving patient safety and experience.

#### **What will we do?**

- Roll-out and embed the updated multifactorial risk assessment for all patients aged 65 and over and for those aged 18-64 who are have a clinical risk factor for falling.
- Educate staff, audit practice and undertake targeted improvement work to ensure that the best practice guidelines of NICE and the Royal College of Physicians is consistently implemented for all our patients.
- Ensure that all patients receive the Falls Prevention Leaflet which has been published for patients in hospital and their families and carers
- Undertake focused quality improvement initiatives to reduce the number of falls associated with use of bathrooms and toilets
- Evaluate the impact of Baywatch on the incidence of falls
- Continue to investigate and analyse themes and trends from falls to inform the implementation of appropriately targeted actions for improvement
- Following the outcome of the RCP 2017 audit, to focus on the improvement of three key indicators:
  - Delirium – embed use of standardised tools and link assessments to related clinical issues (such as falls).
  - Medication review – ensuring that medication is reviewed for all patients 65 and over specifically around falls risk, working with pharmacists.
  - Lying and Standing blood pressure – to be checked on all patients aged 65 and over as appropriate.

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

- A reduction in the rate of falls to a consistent rate of less than 6.0 per 1000 bed days (RCP methodology).
- A reduction in the rate of falls specifically associated with patient use of toilets and bathrooms.
- Learning from root cause analysis investigations is disseminated across all areas of the Trust.

### **2.3 Improve the management of deteriorating patients**

#### **Why is this a priority?**

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as “Failure to Rescue”. This in turn leads to further deterioration in the patient’s clinical condition and potential death. Although the Trust’s average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2017-18 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, there is a need to continue in our improvements to deliver more sensitive, appropriate care at the end of a person’s life. It is vital that for those patients, nearing the end of their life, that appropriate, timely decisions are made and care plans put in place to provide compassionate dignified care when aggressive treatment or resuscitation are not appropriate.

## **What will we do?**

- Continue to embed the implementation of the Treatment Escalation Plans
- Continue to deliver training and support to clinical teams in the assessment of patients nearing the end of their life and in having effective, sensitive conversations with the patient and their family or carers.
- Continue to audit the observation and treatment of patients who deteriorate and implement learning from the findings.
- Embed the implementation of 'Best practice Interventions' for patients presenting to the Emergency Department with Acute Kidney Injury (AKI).
- Reduce the incidence of in-patient deterioration as a result of AKI, by implementing a systematic approach to fluid intake and output monitoring.

## **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

## **Success Criteria**

- Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline.
- To continue to sustain improvements all along the deteriorating patient pathway ensuring:
  1. Timely and appropriate observations
  2. Timely escalation of concerns to medical staff
  3. Timely medical response times,
  4. Improvement in timely and appropriate decision making by medical staff.
- Patients nearing the end of their life are appropriately assessed and provided with a careplan to ensure the most appropriate care delivery.
- 90% of patients presenting to the Emergency department with AKI are provided with 'best practice interventions' to optimise their renal recovery. The implementation of a systematic approach to fluid intake and output monitoring.

## **2.4 To improve our reliability in ensuring that patients receive timely VTE assessment and thromboprophylaxis where appropriate**

### **Why is this a priority?**

"Venous Thrombo-Embolic (VTE) is a significant cause of mortality, chronic ill health and disability in England". An estimated 25,000 people in the UK die from preventable hospital-acquired thrombosis every year (House of Commons Health Committee, 2005). A national audit showed that 71% of patients, at medium or high risk of developing DVT did not receive any form of mechanical or pharmacological VTE prophylaxis (NICE 2010, updated 2015) In the past year the Trust has had a number of Serious Incidents related to Hospital Acquired Thrombosis and the non-adherence with 'Best Practice' recommendations. As a consequence an improvement programme has been set up to address these.

House of Commons Health Committee (2005) The prevention of venous thromboembolism in hospitalised patients. London: The Stationery Office

NICE (2015) Venous thromboembolism in adults: reducing the risk in hospital NICE CG 92 (2010, updated 2015).

## **What will we do?**

Optimise the use of technology to ensure prompt and reliable risk assessments are carried out on admission and that patients are reassessed as appropriate throughout their stay.

Ensure that all high risk patients are reliably provided with appropriate prophylaxis and use technology to support the timely review of patients whose conditions are changing in order to ensure appropriate prophylaxis is always provided for those patients most at risk.

Ensure that patients are reliably informed of the risks of VTE and preventative measures, by provision of verbal and written patient information on admission and at discharge so that they can be more involved in helping to prevent clots.

Raise awareness of the risks of VTE through a Trust-wide “Stop the Clot” campaign, providing education and training to the multidisciplinary team.

Continue to undertake the HAT audits and root cause analysis in order to highlight any themes which need to be addressed.

## **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

## **Success Criteria**

No avoidable hospital acquired thrombosis experienced by any of our patients

VTE risk assessment compliance remains consistently above 95% on admission

Patients routinely receive patient information leaflets and advice

Prophylaxis is provided to all patients who require it

## **2.5 To reduce the incidence of medication errors for inpatients**

### **Why is this a priority?**

Every step in the processes associated with the use of medicines has the potential for failure to a varying degree. Medication safety is therefore, the responsibility of all staff and most effective when underpinned by a culture of openness and honesty when things go wrong. It is vital that we learn and use our developing understanding of medication safety incidents to most effectively deal with the causes of failure.

Drug incidents(n=866)accounted for 9% of all incidents reported on the Trust’s patient safety incident reporting system during 2017/18, 98% of which caused no harm or low harm. The reporting, analysis of and learning from medication safety incidents are vital even where no harm has occurred to a patient. This allows the best quality learning to take place as the ‘what’, ‘how’ and ‘why’ things went wrong, so that effective and sustainable solutions can be put in place to reduce the risk of similar incidents occurring.

In line with the launch of the WHO third Global Patient Safety Challenge: *Medication without Harm*, our aim is to reduce avoidable medication related harm. Although medication errors are inevitable and avoidable, they occur when weak medication systems and/or human factors (e.g. fatigue, poor environmental conditions or staff shortages) affects all/or part of the medicine use process (prescribing, transcribing, dispensing, administration, monitoring and use) and can result in severe harm. The Trust Medication Safety Review Group (MSRG) will continue to review medication error reports each month, identifying themes and ensuring multidisciplinary, trust-wide learning is shared. Our strategy therefore will focus on:

- Reducing the incidence of avoidable medication errors with the potential to cause harm to patients

- Strengthening measurements and safety monitoring systems

### **What will we do?**

The Trust Medication Safety Review Group (MSRG) will oversee and monitor the following actions:

- Promote a good safety culture by encouraging more reporting, learning and sharing of medication errors and near misses.
- Develop and launch the L & D Medication Without Harm strategy.
- Promote MDT collaboration in identifying and addressing system design weaknesses within the medicine use process.
- Promote safer medicine use through engagement with frontline staff .
- Effective dissemination of lessons learned from medication errors using various mechanisms e.g. newsletter, safety briefings, clinical governance meetings, error sessions. The Pharmacy Department quarterly publication MIST will continue to be used to highlight risks identified from Datix.
- Leverage on EPMA and new technologies to reduce medication errors especially for high risk medicines.
- Implement the best practice recommendations from the Royal College of Physicians (RCP) on supporting junior doctors in safe prescribing e.g. error feedback and learning sessions and a trial introduction of pharmacy buddies with the next cohort of junior doctors.
- Encourage active patient/carer involvement in their medicines through the provision of appropriately tailored medicine information.
- Support the effective implementation of self-administration of insulin process for adult inpatients.

### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

### **Success Criteria**

- An increase in the rate of reporting of no harm medication safety incidents
- A reduction in the rate of avoidable medication errors due to errors in prescribing
- A reduction in the rate of avoidable medication errors due to administration errors
- A reduction in the incidence of missed or delayed doses involving high risk medicines

## **Priority 3: Deliver Excellent Clinical Outcomes**

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

#### **Why is this a priority?**

In March 2017, the NHS Quality Board published a paper entitled “National Guidance on Learning from Deaths.”<sup>1</sup> The paper outlines the principles behind Mortality Reviews, their methodology, and how their conduct and the learning from them needs to be reported. The guidance made a number of recommendations which have since been incorporated into the Trust Mortality Review Policy (LDH 2017). There is national focus on improvement that can come from mortality reviews and therefore, the recommendations of the national paper, included amongst other things that:



- Structured Judgement Reviews have been introduced as a new methodology for mortality reviews
- There should be a Board-level Executive lead for the Mortality Review Process, and a non-Executive lead charged with oversight and challenge.
- There is a requirement for the outcomes of the Mortality Reviews to be shared quarterly through the Board Quality report (which took effect from September 2017). This has been contractually enforced through changes at a national level to the Quality Accounts regulations.

The Trust's Mortality Board continues to focus on HSMR and SHMI and provide direction and monitoring of the Trust's mortality review policy.

National Guidance on Learning from Deaths, First Edition, March 2017 National Quality Board. Available at <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

### **What will we do?**

- Review the Learning from Deaths policy by September 2018
- Agree improved processes for mortality reviews in the surgical division and implement these by September 2018
- Configure Datix Cloud IQ to deliver an electronic mortality review process
- Feedback to the CCG, any deaths that require a review of the community care

### **How will improvement be measured and reported?**

- Quarterly report of "Avoidable Deaths" to the Trust Board
- Quarterly update of figures published on the Trust website
- Annual summary report of key themes from mortality reports to the Mortality Board every July (based on deaths April – March)
- Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

### **Success Criteria**

- Improvement in HSMR
- Fewer deaths within 24 hours of admission

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

### **Why is this a priority?**

The purpose of this initiative, which is also a national CQUIN, is to embed a systematic approach towards the prompt identification and appropriate treatment of life threatening infections, while at the same time, reducing the chance of the development of strains of bacteria that are resistant to antibiotics.

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these, it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. This quality improvement initiative, is aimed at embedding NICE guidance to improve sepsis management. Furthermore, the approach taken to combine a responsive approach to the detection and treatment of sepsis needs to be balanced with a rigorous approach to the stewardship of antibiotics. Antimicrobial resistance has increased in recent years and the Chief Medical Officer believes that it is a major risk for healthcare. Without a reversal of the trend, we may find we have no drugs to treat serious infections in the future. The approach to these two key areas for improvement is taken from the viewpoint that the issues of sepsis and antimicrobial resistance are

complementary and that developing and implementing a joint improvement scheme (CQUIN) will support a coherent approach towards reducing the impact of serious infections.

### **What will we do?**

The Trust will build on the work undertaken since 2015/16 with a particular focus on:

- Continuing to deliver and improve upon the timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Continuing to deliver and improve upon the timely treatment of sepsis in emergency departments and acute inpatient settings
- To continue to deliver upon the 24-72 hour review of antibiotics for patients with sepsis who are still inpatients at 72 hours and to continue to improve upon the quality of those reviews
- Ensure that Trust guidelines and protocols continue to meet best practice standards and are in line with CQUIN requirements.
- To reduce total antibiotic consumption per 1,000 admissions in two domains:
  - Total antibiotics
  - Carbapenems
- Increase the proportion of antibiotic consumption within the specified group in accordance with best practice

### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

### **Success Criteria**

- To consistently screen 90% or more of the relevant patients for sepsis.
- To deliver antibiotics within one hour of identification of sepsis to at least 90% of those patients.
- To undertake clinical antibiotic reviews between 24-72 hours in at least 90% of patients with sepsis.
- To reduce antibiotic consumption per 1000 admissions within two specific categories: [1] total antibiotic usage [2] carbapenems and increase the usage for the antibiotics within the Access group the AWARe category to either 55% or by 3%.

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

### **Why is this a priority?**

People with mental health problems are three times more likely to present to AA&E than the general population. Nationally, more than 1 million presentations are currently recorded as being directly related to mental ill health. Furthermore, evidence has shown that people with mental ill health have 3.6 times more potentially preventable emergency admissions than those without mental ill health and that the high levels of emergency care use by people with mental ill health indicate that there are opportunities for planned care to do more. A large majority of the people with most complex needs who attend AUE the most frequently are likely to have significant health needs including physical and mental comorbidities and may benefit from assessment and review of care plans with specialist mental health staff and further interventions from a range of health and social services. This is a National priority and the CQUIN has been developed to support cross-provider working to deliver improvements in care to this group of patients by providing enhanced packages of care from the most appropriate services.

### **What will we do?**

- The Trust will continue to work in partnership with East London Foundation Trust, the provider of our mental health services and a range of other partners including ambulance service, primary care, police, substance misuse services, 111
- A group of patients who attend A&E most frequently will be reviewed in order to identify those who would benefit from assessment, review and care planning with specialist mental health staff
- Appropriate models of service delivery will be considered and adopted in order to provide specialist input for people who frequently attend A&E with primary mental health problems
- To co-produce, with the patients, a care plan and ensure that these are shared, with the patient's permission, with partner care providers across the system
- Continue to best use our IT systems to ensure that information about the conditions of our patients is accurately collected in order to help target improvements to the most appropriate patients

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

- To maintain the reduction in A&E attendances for a group of patients with whom we worked during 17/18 by providing appropriate mental health services outside of the A&E setting (maintaining at least 20% reduction when compared to their 16/17 attendances)
- To reduce the number of attendances for a second group of frequently attending patients by 20% over the next year, amongst the patients who would benefit from mental health and psychosocial interventions
- To have collected patient experience feedback in order to further develop the service

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

#### **Why is this a priority?**

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this quality improvement initiative is to implement best practice guidance to enable us to take action to prevent these adverse outcomes and help people live as well as possible with frailty. Appropriate services, delivered effectively to this group of patients will support a reduction in length of stay, reduced morbidity and mortality and a better experience for patients and their carers. Furthermore, the initiative will support the delivery of the Trust priority to deliver Continuity of Care and improve the flow of patients admitted as emergencies to the hospital.

#### **What will we do?**

- To establish models of care and service delivery in line with standards set by the British Geriatric Society "Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings"
- Identify and develop/provide the resources required to deliver a high quality service
- Establish referral criteria and care pathways
- Ensure that there is rapid access to appropriately trained and skilled staff to undertake a comprehensive, early assessment and care planning in order to deliver early intervention by the multidisciplinary team

- Ensure that clinical navigation is embedded within the service delivery plan

### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

### **Success Criteria**

- That a frailty service is operational and receiving appropriate referrals
- That patients and their carers are satisfied with the service and that feedback is used to help further improve and develop the service
- A reduction in the number of frail patients being admitted to hospital via A&E or EAU
- A reduction in the length of stay for patients with frailty
- An increase in the proportion of patients with frailty who, following comprehensive assessment and care planning, are able to be discharged to their usual place of residence
- A decrease in the proportion of patients with frailty who are admitted to hospital for an overnight stay

## **Priority 4: Prevention of Ill Health**

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

#### **Why is this a priority?**

- This is a national CQUIN scheme which seeks to deliver on the objectives of the NHS Five Year Forward View, particularly around the need for a radical upgrade in prevention and to be supporting healthier behaviour.
- Smoking is estimated to cost £13.8bn to society – of which £2bn cost to the NHS through hospital admissions. Smoking is England's biggest killer, causing nearly 80,000 premature deaths a year and is also the single largest cause of health inequalities. Evidence shows that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis, and contributes to reduced wound infection rates and improved healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. The quit rates amongst those with a referral to stop smoking services are between 15-20% compared to those without a referral at 3-4%.
- Nationally, the coverage of advice and referral interventions for smokers are patchy. In secondary care, not all patients are asked if they smoke and fewer are given brief advice to stop as an inpatient.
- For alcohol, evidence shows that in England, 25% of the adult population consume alcohol at levels above the UK low-risk guideline and increase their risk of alcohol-related ill health. Alcohol is estimated to cost society £21bn per year – of which £3.5bn are costs to the NHS. Around three quarters of the NHS cost is incurred by people who are not alcohol dependant, but whose alcohol misuse causes ill health. This is the group for whom Identification and Brief Advice (IBA) is most effective.
- Currently IBA delivery in secondary care is patchy and needs to be improved to optimum levels so that large scale delivery will impact most significantly on the population.

#### **What will we do?**

- Identify and provide training to staff in how to assess tobacco and alcohol use and in how to give brief advice.
- Conduct baseline and ongoing audits in line with the national CQUIN requirements.

- Screen at least 90% of patients, aged 18 and over, who are admitted for at least one night) for tobacco and alcohol use.
- Provide brief advice to appropriate patients in respect of tobacco or alcohol use.
- Provide an offer of medication and referral to smoking cessation services and make those referrals.
- Ensure that screening, advice and referrals for both tobacco and alcohol are recorded in a clear and consistent way in patients' records.

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

- At least 90% of patients are screened for tobacco use and 50% are screened for alcohol intake (age 18 and over, admitted for one night or more, excluding maternity).
- At least 90% of smokers are given very brief advice to help them quit.
- At least 30% of smokers are offered stop smoking medication and 30% are referred to smoking cessation services.
- At least 80% of patients are given brief advice or offered a specialist referral if the patient is potentially alcohol dependant.
- Records are kept clearly and consistently in the patients records.

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

#### **Why is this a priority?**

PHE's report "sugar reduction – the evidence for action" published in October 2015 outlined the clear evidence behind focusing on improving the quality of food on offer. It is important for this Trust, as part of a campaign across the NHS in England, to lead the way in ensuring that all food and drink outlets on NHS premises provide healthier options for staff, patients and visitors.

25% of adults in England are obese, with significant numbers also overweight. Treating obesity and its consequences alone costs the NHS £5.1bn every year. High proportions of NHS staff are also obese or overweight leading to an increase in musculoskeletal problems and mental health issues – two of the key drivers of sickness absence rates in the NHS. By supporting staff, patients and visitors to make healthier choices when on NHS sites, the aim of lowering sugar consumption will support staff, patients and visitors in managing their own health and wellbeing.

#### **What will we do?**

- Ensure that our food and drink outlets refrain from advertising and offering price promotions on food and drinks high in fat, sugar and salt
- Work with all of the Trust outlets to ensure that they deliver the balanced requirements of healthy food and drink in line with the national CQUIN

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

- At least 90% of drinks sold on site are free from added sugar
- At least 80% of confectionary and sweet lines available are no more than 250kcal

- AT least 75% of pre-packed sandwiches and other savoury pre-packed meals are 400kcal or less and contain no more than 5% saturated fat

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

##### **Why is this a priority?**

Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season - a much higher incidence than expected in the general population. Influenza is also a highly transmissible infection. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected.

The green book recommends that healthcare workers directly involved in patient care are vaccinated annually. It is also encouraged by the General Medical Council and by the British Medical Association.

##### **What will we do?**

- Vaccine will be administered by the Occupational Health team, with additional assistance.
- All staff will be actively encouraged to have the vaccine during visits to wards, talks, attendance at stat training, induction, grand round, various meetings, emails, posters.
- Drop in clinics will be held in Occupational Health every week day.
- Banner posters will be displayed within various areas of the Trust.
- During our Annual Christmas staff engagement event, part of the programme will include flu vaccination promotion.
- Publicity and role modelling by senior members of staff who had already received their vaccine.
- Display the jab 'o 'meter, giving regular updates on how many staff have received their vaccine.
- Staff who indicate that they do not wish to receive the vaccine will be asked to complete a declination form stating their reasons via a selection of tick box options.

##### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

##### **Success Criteria**

- By 28<sup>th</sup> February 2019, at least 75% of frontline clinical staff will have received their flu vaccination or will have signed a declination form indicating informed withholding of consent.

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

##### **Why is this a priority?**

Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients. The Five Year Forward View made a commitment 'to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy'. Linked to this commitment the Health & Wellbeing CQUIN

introduced in 2016 encourages providers to improve their role as an employer in looking after employees' health and wellbeing. The 2018-19 CQUIN rewards organisations who make a sufficient impact on staff perceptions about the changes organisations make to improve health and wellbeing– via improvements to the health and wellbeing questions within the NHS staff survey.

To help organisations meet the CQUIN target NHS England has developed a new 'Staff Health and Wellbeing Framework' which will be launched in Spring 2018. The Framework sets out the support that all NHS organisations should provide to their staff in order to promote health and wellbeing. The framework is based on evidence based best practice and has been jointly developed working with leading NHS organisations as well as NHS Employers, NHSI and PHE. The framework covers the following areas:

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

#### **What will we do?**

- The Trust will review the NHS England "Staff Health and Wellbeing Framework" following its launch in Spring 2018
- Identify and implement appropriate actions to address the health and wellbeing areas that showed scope for improvement in the 2017 staff survey

#### **How will improvement be measured and reported?**

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board.

#### **Success Criteria**

A 5% improvement (in the 2018 survey as compared with the 2016 survey) in two of three questions within the national staff survey which relate to:

1. Does your organisation take positive action on health and wellbeing?
2. In the last 12 months have you experienced musculoskeletal problems as a result of work activities?
3. During the last 12 months have you felt unwell as a result of work related stress?

## 4. Statements related to the Quality of Services Provided

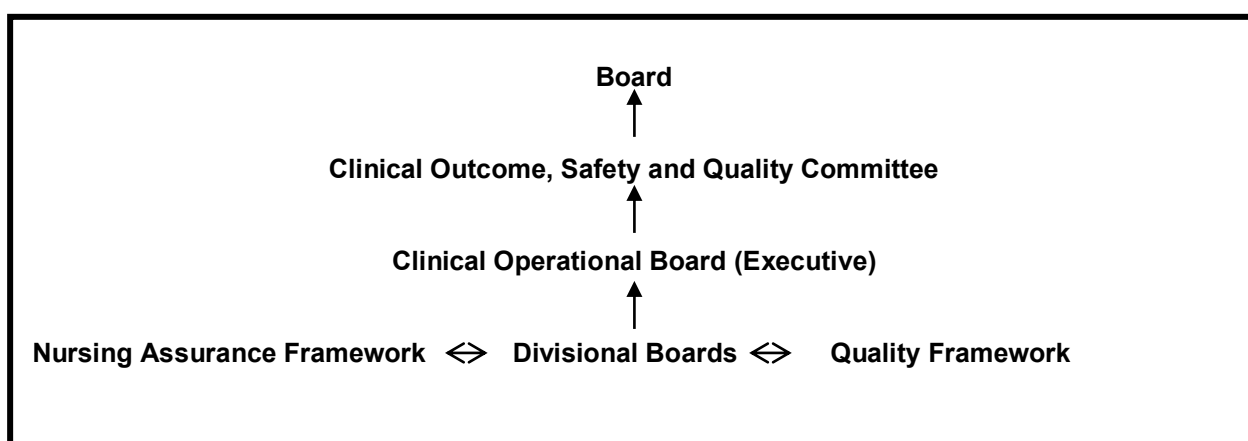
### 4.1 Review of Services

During 2017/18 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes. The Board of Directors considers performance reports quarterly including progress against national quality and performance targets. The Board also receives reports from the Clinical Outcome, Safety and Quality sub committee. Quality is managed by the Divisional Boards and the Clinical Operational Board providing assurance to the Clinical Outcome, Safety and Quality Committee. These reports include domains of patient safety, patient experience and clinical outcome. During 2017/18 the Executive Board commissioned external experts and assisted with external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- External reviews of Serious Incidents
- GIRFT

In addition, the Board receives reports relating to complaints and serious incidents.

#### Quality Assurance Monitoring



The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2017/18.

### 4.2 Participation in Clinical Audits and National Confidential Enquiries

Some final data submission information to be received

Trust was eligible to participate in 57 of the 2017/2018 National Clinical Audits that was applicable to the Trust and met the Quality Accounts inclusion criteria.

Over the financial year the Trust participated in 50 of the eligible national audits, 5 have not yet started and 2 where the Trust had not participated although were eligible.

The two National Clinical Audits that the Trust had not participated are listed below:-

BAUS Urology Audits: Female stress urinary incontinence, this was due to lack of staffing in collecting data.



BAUS Urology Audits: Urethroplasty, this audit was not included in the 2017/2018 Urology Clinical Audit Forward Plan and action has been taken to ensure participation.

Clinical audits are a mixture of National and local priorities which each directorate is responsible for as part of their Clinical Audit Forward Programme. The data collected for Quality accounts includes mandatory audits on the National Clinical Audit and Patient Outcomes Programme which directorates must participate in.

The National Audit of Breast Cancer in Older People (NABCOP) 2017/18 was a scoping exercise looking at national variation. We submitted a questionnaire about our unit and what treatment approach our MDT would take for 5 vignettes. There will be no data collected on Luton patients until 2018/19. This will be taken directly from the cancer registry.

### **Local Clinical Audits**

The reports of 22 local audits, some of which were project managed by the Trust's Clinical Audit Department were reviewed by the Clinical Audit and Effectiveness Lead and Clinical Director. & Quality Depart. Clinical audit results are discussed at Clinical Audit Committee meetings and Directorate Governance meetings. National and clinical audit results are used primarily by Luton & Dunstable NHS Foundation Trust to improve patient care where gaps are found but are also used as assurance that the hospital is following best practice guidance. Staff undertaking clinical audit are also required to report any actions that should be implemented to improve service delivery and clinical quality.

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	April 2017 to March 2018	All cases diagnosed with MI in a financial year.	So far only approx 200. Aiming for approx 600 by end of May. Data submission ongoing.
Adult Cardiac Surgery	National Institute of Cardiovascular Outcomes Research (NICOR)	Eligible No Participated No	April 2017 to March 2018	<b>Not undertaken at Centre</b>	
BAUS Urology Audits: Cystectomy	British Association of Urological Surgeons	Eligible Yes Participated Yes	April 2017 to March 2018	<b>BAUS audits operate a continuous data collection model.</b> All patients eligible	
BAUS Urology Audits: Nephrectomy	British Association of Urological Surgeons	Eligible Yes Participated Yes	April 2017 to March 2018		Total of 105 cases. Excellent outcomes despite higher risk patient group than national average.
BAUS Urology Audits: Percutaneous	British Association of Urological	Eligible Yes	April 2017 to March 2018		Nephrectomy cases: 0 - PCNL: 6

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Nephrolithotomy	Surgeons	Participated Yes			
BAUS Urology Audits: Radical prostatectomy <b>BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec</b>	British Association of Urological Surgeons	Eligible No  Participated No	April 2017 to March 2018	<b>We do not perform radical prostatectomy here as the patients are sent to the Lister</b>	
BAUS Urology Audits: Urethroplasty <b>BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec.</b>	British Association of Urological Surgeons	Eligible Yes  Participated No	April 2017 to March 2018	All eligible cases	Not on Audit Forward Plan 2017/2018
BAUS Urology Audits: Female stress urinary incontinence <b>BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec.</b>	British Association of Urological Surgeons	Eligible Yes  Participated No	April 2017 to March 2018		No data submission on BAUS website due to lack of staffing for data collection.
Bowel Cancer (NBOCAP)	Royal College of Surgeons of England	Eligible Yes  Participated Yes	April 2017 to March 2018	All patients with a confirmed cancer diagnosis for 'tumour group'	The data for the current year 01/04/17 to 31/03/18 is not required to be submitted until October 2018 – exact date yet TBC. Not all data will have been recorded for this year as yet. Dependent on the patient's pathway, it may take some weeks before all data is recorded.  The data for the previous year (all diagnoses from

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
					01/04/16 to 31/3/17) was submitted in Oct which consisted of 17 cases and comprises the of the following successfully imported records:  Patient records: 184 Tumour records: 184 cases Surgical records: 130 cases Surgery prior to diagnosis: 16 cases Pathology: 107 cases Pathology prior to diagnosis: 14 cases Chemo Rad: 44 cases Chemo prior to diagnosis: 1 cases
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible	
Case Mix Programme (CMP)	Intensive Care National Audit Research Centre (ICNARC)	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible	ICU=417 cases HDU=777 cases
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible No Participated No	Not relevant to the Trust		
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	January 2017 to March 2018	All eligible cases	418 cases
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Eligible Yes Participated	April 2017 to March 2018	All eligible cases	173 cases ERPT: 1 cases

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
		Yes			
Elective Surgery (National PROMs Programme)	NHS Digital	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible cases	500 cases
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	Eligible Yes Participated Yes	April 2017 to March 2018		
Falls and Fragility Fractures Audit programme (FFFAP) - Inpatients	Royal College of Physicians	Eligible Yes Participated Yes	May 2017	30 cases	30 cases
Falls and Fragility Fractures Audit programme (FFFAP) – National Hip Fracture Database	Royal College of Physicians	Eligible Yes Participated Yes	April 2017 to March 2018	All NOF cases aged 60 and above	Approximately 300 plus cases
Fractured Neck of Femur	Royal College of Emergency Medicine	Eligible Yes Participated Yes	August 2017 to January 2018	<50 for all eligible cases	51 cases
Head and Neck Cancer Audit (HANA) (TBC)	Saving Faces - The Facial Surgery Research Foundation	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible cases	As at 23/04/2018 the final dataset has not been supplied by the providers, Saving Faces. In the meantime, the Trust is collecting all mandatory data known for all diagnoses from 01/11/16 to-date(23/04/2018). Once the final dataset is known, Info flex will be adjusted accordingly and users will collect the new dataset items. At some point we will be required to submit our data but at this time, no data has been submitted.

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	Inflammatory Bowel Disease Registry	Eligible Yes Participated Yes	April 2017 to March 2018 (managed by BSG via IBD Registry)		
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	Eligible Yes Participated Yes	October 2017 onwards.	All L&D patients who have died (n=10)	10 cases
Major Trauma Audit	The Trauma Audit & Research Network (TARN)	Eligible Yes Participated Yes	April 2017 to March 2018 Hospital site level data x3 Clinical report submissions per annum  National Quarterly Dashboard data is collected with differing deadlines and circulation dependent on hospital type.		
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity confidential enquiries (reports every second year)	Eligible Yes Participated Yes	April 2017 to March 2018		
	Perinatal Mortality Surveillance (reports annually)				Late Fetal losses –5 Terminations of pregnancy - 4 Stillbirths – 20 Early neonatal deaths – 22 Late neonatal deaths – 3
	Perinatal Mortality and Morbidity confidential enquiries (reports every second year)				

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
	Maternal Mortality surveillance and mortality confidential enquiries (reports annually)				
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	N/A			
National Audit of Anxiety and Depression	TBC – to be commissioned by HQIP in 2017	N/A			
National Audit of Breast Cancer in Older Patients (NABCOP)	Clinical Effectiveness Unit, The Royal College of Surgeons of England	Eligible Yes  Participated Not Yet	Data submitted by hospitals to National Cancer Registration services: 1 Apr 2017 to 31 Mar 2018; Data supplied to audit in this year will be the most recent available from Registration services	No set number required.	Nil
National Audit of Dementia	Royal College of Psychiatrists	Eligible Yes  Participated Yes			
National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	N/A			
National Audit of Psychosis	TBC – to be commissioned by HQIP in 2017	Eligible No  Participated No	TBC	TBC	The HQIP audit was not collecting patients in this time period.
National Audit of Rheumatoid and Early Inflammatory Arthritis	TBC – to be commissioned by HQIP in 2017	Eligible No  Participated No	TBC	TBC	The HQIP audit was not collecting patients in this time period.

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
National Audit of Seizures and Epilepsies in Children and Young People	TBC – to be commissioned by HQIP in 2017	Eligible No Participated No	TBC	TBC	The HQIP audit was not collecting patients in this time period.
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible	117 cases
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Royal College of Physicians	Eligible Yes Participated Yes	April 2017 to July 2017 <i>(collection from January 2017 to July 2017 spanning 16/17 and 17/18 financial years)</i>	63 pts were eligible, but only 59 patients consented.	59 cases
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	London North West Healthcare NHS Trust	Not collecting 2017/2018 data			
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	Eligible Yes Participated Yes	April 2017 to March 2018	40	40
National Diabetes Audit - Adults	NHS Digital	Eligible Yes Participated Yes	25 to 29 September 2017		
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Eligible Yes Participated Yes			
National End of Life care audit	TBC – to be commissioned by HQIP in 2017	Eligible Yes Participated Not yet	No set date	Not Known	Nil - The national care of the dying audit does not start until the summer. The Trust is awaiting National Guidance to start the audit.

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	The cut off for data entry is 8/6/2018	All eligible cases	233 cases as at 23/04/2018. It is anticipated there will be 380- 400 by cut off in June.
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	Eligible Yes Participated Yes			
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Eligible Yes Participated Yes	April 2017 to March 2018	All patients with a confirmed cancer diagnosis for 'tumour group'	
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	Eligible Yes Participated Yes	April 2017 to March 2018	All eligible cases	500
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Royal College of Paediatrics and Child Health				
National Ophthalmology Audit	The Royal College of Ophthalmologists	Eligible Yes Participated Not yet	Data collection will run from 1 September 2016 to 31 August 2017	50 cases	Nil
National Vascular Registry	Royal College of Surgeons of England	N/A			
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	N/A			
Non-Invasive Ventilation - Adults	British Thoracic Society	Eligible Yes Participated Not yet			
Oesophago-gastric Cancer (NAOGC)	Royal College of Surgeons of England	Eligible Yes Participated Yes	April 2017 to March 2018	All patients with a confirmed cancer diagnosis for 'tumour group'	
Paediatric Intensive Care (PICANet)	University of Leeds	N/A			



Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Paediatric Pneumonia	British Thoracic Society	Eligible Yes  Participated Not yet			
Pain in Children	Royal College of Emergency Medicine	Eligible Yes  Participated Yes			
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	N/A			
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes  Participated Yes			
Prostate Cancer	Royal College of Surgeons of England	Eligible Yes  Participated Yes	This data is submitted on a monthly basis to the Cancer Registry (Public Health England).	No set number required.	HGD: 0 - The data for the year Jan to Dec 2017 comprises: 200 new cases
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	Eligible Yes  Participated Yes		No set number required.	780 cases, which is an increase on the previous year of 759.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Serious Hazards of Transfusion	Eligible No  Participated Yes			
UK Parkinson's Audit	Parkinson's UK	Eligible Yes  Participated Yes			

#### **Additional (non-mandatory) National Audits undertaken during 2017/18**

##### Local Clinical Audits

In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of seventeen local clinical audits were completed during the reporting period which were project managed by the Trust's Clinical Audit Department (Appendix A).

### **4.3 National Confidential Enquiries**

	Topic/Area	Database/ Organiser	% return*	Participated Yes/No
1	Chronic Neurodisability	NCEPOD	20%	Yes
2	Young People's Mental Health	NCEPOD	83%	Yes
3	Cancer in Children, Teens and Young Adults	NCEPOD	100%	Yes
4	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

\* The number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry

#### 4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2017/2018 and who were recruited during that period to participate in research approved by a Research Ethics Committee was **809**. This research can be broken down into **185** research studies (**154** Portfolio and **31** Non-Portfolio).

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

#### 4.5 Goals agreed with Commissioners of Services – Commissioning for Quality and Innovation

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. During 2017/18, a number of CQUIN schemes were agreed – some of which were national schemes and the remainder, locally agreed quality improvement initiatives.

Scheme	Description	% value	Q1	Q2	Q3	Prediction for Q4
1. Health and Wellbeing	Improvement of health and wellbeing of NHS staff		**	**		
	Healthy food		**	**		
	Improve uptake of flu vaccine to 70% frontline clinical staff		**	**		
2. Reducing the impact of serious infections	Timely identification of sepsis in ED and acute inpatient settings					
	Timely treatment for sepsis in ED and acute inpatient					
	Clinical review of antibiotic prescriptions					
	Reduction in consumption of antibiotics per 1000 admissions		**	**	**	
3.	Improving services for people with mental health needs who present to A&E					
4.	Offering Advice and Guidance					
5.	NHS e-Referral Service					
6.	Supporting Proactive and					

	Safe Discharge					
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The Trust monetary total for the associated CQUIN payment in 2017/18 was £ and the Trust achieved % of the value. The 2016/2017 value was £5,900,000 and the Trust achieved 97% of the value.

Final figure to be confirmed

## 4.6 Care Quality Commission Registration

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

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

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

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

### CQC Assessments

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

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?
- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?
- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.
- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.
- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

The Care Quality Commission's (CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. The Foundation Trust and Hospital received a rating of 'Good' from the inspection report in June 2016. There has been no further inspections by the CQC during 2017/18 and the Trust has continued to engage with any queries raised through monthly CQC engagement calls and meetings.

#### **Non-Executive Assessments (3x3)**

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

#### **Transforming Quality Leadership 'Buddy' System**

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

### **4.7 Statements on Relevance of Data Quality and Action to Improve Data Quality**

The accuracy and completeness of the data we use to support the delivery of high quality care is of the utmost importance to the Trust.

The Trust has been making progress with data quality during the year 2017/18. There are many processes carried out by the Information Team, which identify data quality issues.

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

- CCG challenges
- Monthly and weekly Outpatient data quality reports sent out to users e.g. attendance not specified
- Theatre reports
- Inpatient reports
- Referral reports
- Patient Demographics
- Benchmarking analysis – SUS dashboards
- Data Quality Improvement Plan
- Data Accuracy checks
- Completeness and Validity checks
- A&E wait - arrival – departure times

During 2017/18 we have taken the following actions to improve data quality:

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

- Continued to work with Commissioners to monitor and improve data quality pro-actively in key areas.

### **NHS Code and General Medical Practice Code Validity**

Luton and Dunstable University Hospital NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS number was:

- 99.3% for admitted patient care; 99.7% for outpatient care and 97.3% for A&E care.

The percentage of records in the published data which included the patient's valid General Medical Practice was:

- 100% for admitted patient care; 100% for outpatient care and 100% for A&E care

### **Action Plan for Data Quality Improvement for 2018/19**

#### **Information Governance**

- **Data Quality Accuracy Checks** - Maintain the number of audits on patient notes.
- **Completeness and validity checks** - Remind staff about the importance of entering all relevant information as accurately as possible via Email and liaising with IT Applications Training Team for individual ad hoc refresher training.

#### **1) CCGs Challenges**

- Continue to work with Outpatients, IT & Divisions to improve other areas of known data issues (Admission Method vs A&E Attendance)
- Continue to communicate with users the importance of recording the current GP at time of attendance or admission.
- Continue to improve the NHS Number coverage
- Continue to monitor Multiple Firsts and highlight areas that are consistently creating first appointments
- Monitor the additional 18/19 DQIP metrics and ensure improvements made are reflected in reporting
  - Non pre-booked outpatient attendances
  - Non pre-booked day cases
  - Incorrect emergency admission method

#### **2) Outpatients**

- Continue to produce weekly and monthly lists identifying those patients with an attendance status of 'not specified'. Also work with the Outpatients, IT and Divisions to reiterate the importance and financial impact of not recording information accurately
- Continue Regular Outpatient Data Quality meetings.

#### **3) Inpatients**

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

#### **4) Waiting List**

- Continue Regular Waiting List Data Quality meetings.

#### **5) Theatres**

- Changes in General Management has resulted in the current DQ reports stopping and new Theatres reports to be considered with the department and Finance

## **6) Referrals**

- Continue to send out referrals to users to rectify the referral source and highlight within the Outpatient Data Quality Meeting the importance of the source being entered

## **7) Patient Demographics**

- Continue to monitor and update Invalid Postcodes, DBS errors and missing NHS numbers. Highlight within DQ meetings the importance of QAS and up to date GP information.

## **8) A&E**

- Continue to improve the NHS Number coverage
- Continue Regular Outpatient Data Quality meetings.

## **9) SUS dashboards**

- Work with Divisions to improve the completeness of the fields where the National Average is not being met
- Use the dashboard to identify areas that require improvement (e.g. Ethnic Group Collection in Outpatients and NHS Number in AE needs to improve)

## **Other Data Quality meetings**

The Information Team are holding regular data quality meetings with A&E, Theatres, Inpatients and Maternity (still to be confirmed).

## **Clinical coding error rate**

The Luton and Dunstable University Hospital NHS Foundation Trust was subject to an audit during 2017/18, carried out in by an established coding agency.

An error rate of 9.5% was reported for primary diagnosis coding (clinical coding) and 7.75% for primary procedure coding. This demonstrates good performance when benchmarked nationally and achievement of level 2 attainment in the Information Governance Toolkit.

## **Information Governance toolkit attainment levels**

The Luton and Dunstable University Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2017/18 was 68% and was graded as satisfactory.

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes within an organisation.

## **Learning from Deaths**

During July – December 2017 599 of Luton and Dunstable University Hospital NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 281 in the second quarter;
- 318 in the third quarter;

By 31<sup>st</sup> March 2018, 546 case record reviews and 61 investigations have been carried out in relation to 599 of the deaths.

In 61 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 34 in the second quarter;
- 27 in the third quarter;

2 representing 0.3% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 2 representing 0.7% for the second quarter;
- 0 representing 0% for the third quarter;

These numbers have been estimated using the Structured Judgement Review Tool.

The first death occurred as a result of a delayed discharge following surgery for a fractured neck of femur. It would have been more appropriate for the patient to die in a more comfortable and appropriate alternative setting which the health care system was unable to provide. Following a Serious Incident Panel, this incident did not meet the serious incident criteria. The integrated discharge team have been made aware of this incident to work with care teams to improve the end of life discharge pathways.

The second death followed an elective total knee replacement and following a fall at home following discharge, underwent a second surgery. However, sadly the patient died due to a hospital acquired pneumonia. Following a Serious Incident Panel, this incident did not meet the serious incident criteria. However, it was acknowledged that the decision to discharge on the first post-operative day may have been changed with the benefit of hindsight. This was discussed at the fractured neck of femur mortality meeting where the personal protective equipment of infection control was discussed. It was agreed that prophylaxis was not required for all patients with a fractured neck of femur but that early consideration should be given to gastric acid management where re-establishment of feeding is delayed post operatively. This has been shared with the orthopaedic and orthogeriatric teams.

0 case record reviews and 0 investigations completed after 31<sup>st</sup> March 2018 which related to deaths which took place before the start of the reporting period.

## Part 3

### 5. A Review of Quality Performance

#### 5.1 Progress 2017/18

##### A review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness indicators selected by our stakeholders. These indicators were selected in 2009/10 through a survey and the most popular indicators were selected. We have continued to follow the selected data sets and any amendments have been described below the table as they are still considered relevant and are reviewed annually by the Council of Governors through their External Audit review indicator section.

Performance Indicator	Type of Indicator and Source of data	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	3 **	1	1	1	N/A	The Trust has a zero tolerance for MRSA. During 17/18 there was an isolated case.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	106*	112*	108.7*	105.1*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	10	11	8	9	N/A	Demonstrating an stable position. Remains one of the lowest in the country
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	19	11	3	12	N/A	This has been a challenging year with winter pressures and the acuity of the patients.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	3	2	4	5	N/A	Maintaining low numbers
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.6	1.04	1.4	1.08	1.3 Apr-Oct 17 1.2 Oct 17-Mar 18	Maintaining good performance below the national average
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.4 days	3.2 days	3.2 days	3.2 days	N/A	Maintaining the LOS



Performance Indicator	Type of Indicator and Source of data	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	National Average	What does this mean?
Rate of falls per 1000 bed days for all patients  Rate of falls per 1000 bed days for 16+ no maternity***	Clinical Effectiveness  Trust Board Report	4.25	4.32	4.06	3.97  4.73***	6.63	Maintaining good performance.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (to November)	Clinical Effectiveness	79.5%	69.4%	78.3%	85.3%	Target of 80%	The Trust is now consistently achieving this target.
% of fractured neck of femur to theatre in 36hrs	Clinical Effectiveness  Dr Foster	75%	78%	62%	76%	N/A	There is an increasing trend.
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness  Dr Foster	79*	69.7*	70.79*	50.8*	100	This is demonstrating the Trust as a positive outlier and improved performance on the previous year.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness  Dr Foster	109*	112.8*	89.56*	100.3*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness  Dr Foster	6.7%	7.2%	7.09%*	7.00%*	N/A	The Trust is maintaining the position.
% Caesarean Section rates	Patient Experience  Obstetric dashboard	27.8%	28.3%	32.9%	30.1%	25%	The Trust is starting to see a reduction in the C Section rates.
Patients who felt that they were treated with respect and dignity**	Patient Experience  National in patient survey response	8.9	9.0	8.8	Not available until May 2018	Range 8.5 – 9.8	Demonstrating an improving position.

Performance Indicator	Type of Indicator and Source of data	2014* or 2014/15	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	National Average	What does this mean?
Complaints rate per 1000 discharges	Patient Experience  Complaints database and Dr Foster number of spells for the year	7.12	6.29	6.64	5.50	N/A	The Trust continues to encourage patients to complain to enable learning.
Patients disturbed at night by staff (n)	Patient Experience  CQC Patient Survey	7.8	7.4	7.6	Not available until May 2018	Range 7.1 – 9.2	Demonstrating a slightly poorer position but still within range.
Venous thromboembolism risk assessment	Patient Experience  Commissioning for Quality National Goal since 2011	Achieved >95%	Achieved >95%	Achieved >95%	Achieved >95%	N/A	Maintaining a good performance.

(n)

Denotes that this is data governed by standard national definitions

\*

Denotes calendar year

\*\*

Public Health England Healthcare Acquired Infection Surveillance Group identifies the number of MRSA bacteraemia “allocated” to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.

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The Royal College of Physicians requires the Trust to report this figure to be 16+ and non-maternity cases. This new result is now included.

## 5.2 Major quality improvement achievements

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

### Improving Quality

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

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

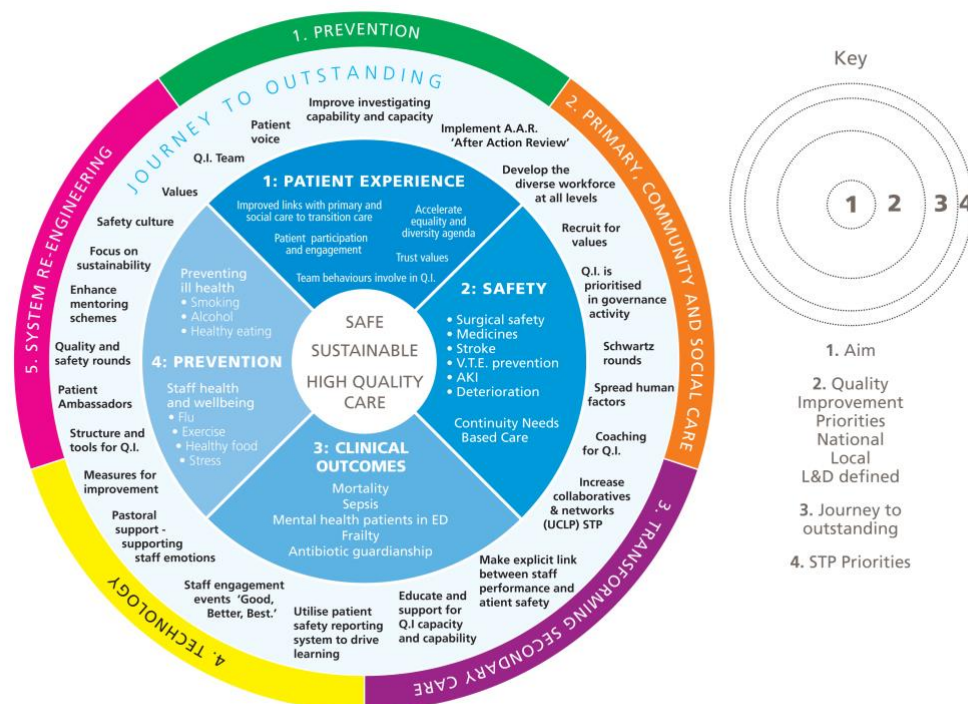
The L&D prides itself in the delivery of high quality, safe and sustainable services to our diverse, local community and those for whom we provide tertiary services. We aim to be the first choice provider for people who need to use local, acute hospital services. As a Trust with a track record for achieving success in our performance measures and targets, we have

taken time since our 'good' CQC inspection to reflect on how we can grow in a different way to help create and build a hospital where quality, and the advancement of quality, is everyone's business. We commissioned a safety diagnostic from the Institute of Health Improvement (IHI) to assist us in doing this.

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

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

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



Around this aim sits four quality priorities:

- Patient Experience
- Patient Safety
- Delivering excellent clinical outcomes
- Prevention of ill health

**To achieve the above we must also:**

- Accelerate our 'Journey to Outstanding' through improving staff experience and engaging and enthusing staff in promoting a culture of continuous learning and quality improvement

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

**Our Quality Impact Assessment process**

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

The CIP / QIA processes:

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

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

**The triangulation of quality with workforce and finance**

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

Quality, Workforce and Financial indicators are shared and discussed at the Quarterly Public Board of Directors meeting and published on the Trust website [www.lth.nhs.uk/boardpapers](http://www.lth.nhs.uk/boardpapers). Furthermore, each month, there is detailed scrutiny of triangulated data by the membership of The Clinical Outcome, Safety and Quality Committee (COSQ - a sub-committee of the Trust Board and Chaired by a Non-Director lead for Quality). Membership of COSQ and the

Finance, Investment and Performance Committee include cross membership to ensure that there is oversight of each of the agendas through any decision making process.

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

## **Our Quality Improvement Implementation**

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

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

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

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

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

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

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

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

1. *Leading improvement*
2. *Project management*
3. *Measurement for improvement*
4. *Sustainability of improvement*
5. *Engaging and understanding others*
6. *Creativity in improvement*

### *7. Process mapping*

### *8. Demand and capacity*

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

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

### ***Engagement Events – ‘Good Better Best’***

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

### ***Raising Concerns and Freedom to Speak Up Guardian***

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

## **5.3 Friends and Family Test**

The organisation continues to participate in the Friends and Family Test (FFT), submitting information on a monthly basis to NHS England. We are also able to view other Trust’s scores which enable us to benchmark our scores against both regional and national scores. As well as reporting on a monthly basis to NHS England we provide staff with weekly feedback from our patients and carers using the FFT scores. This enables staff to react in a timely fashion to what our patients are telling us rather than waiting for the monthly score to be reported. With the increased frequency, issues can be addressed quickly reducing the likelihood of them escalating to more serious issues. The information continues to be reviewed for trends and themes across the organisation and at ward and department. There were no particular trends or themes noted from the information collected.

Response rates to the FFT have remained constant throughout the year and we continue to use varied methods to record the data, such as survey cards and iPads. Our volunteers continue to be a valued source to help collect the feedback, and as demand for the use of iPads has increased we have purchased additional units for the wards and departments. The challenge of collecting feedback in areas such as the Emergency Department has made us look at other ways of gathering the feedback from patients. We are investigating the use of text messaging, evidence from other organisations suggests that this might help to increase response rates by as much as 10%.

The FFT question has remained unchanged:

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

And we continue to collect information from the same clinical areas as last year for adult and paediatric services. Those are;

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

A quarterly report of the patient experience feedback is reviewed at the Clinical Outcomes, Safety and Quality Committee and by the Patient and Public Participation Group.

Tables 1-4 show the percentage recommend scores across all areas of the Trust. These statistics are reported monthly to NHS England.

2017/18 has seen variable recommend rates for Friends & Family. The percentage of patients who would recommend our services has consistently shown that we equal or exceed the England NHS average, for all areas except maternity. Within maternity services, we have exceeded the England average for most months of the year and scores are currently rising. Where we have seen a drop in scores for a month teams have been notified and additional effort has been made and results have subsequently improved the next month. Weekly reporting has made it easier for teams to identify the change in score promptly, which allows improvements to be made to prevent the overall monthly score remaining lower.

Table One: Trust Comparisons to National Inpatient Recommend FFT Results

Comparison	Total Responses	Total Eligible	Response Rate	Percentage Recommend	Percentage Not Recommend
England excluding independent providers (Q1)	665,338	2,617,975	25.3%	96%	1%
Trust (Q1)	3,012	14,339	21%	96%	1%
England excluding independent providers (Q2)	667,099	2,634,048	25.3%	96%	2%
Trust (Q2)	3,491	16,262	21.5%	93.3%	2.3%
England excluding independent providers (Q3)	619,738	2,598,033	23.8%	95.6%	2%
Trust (Q3)	3,776	18,180	20.8%	95.3%	1.6%
England excluding independent providers (Q4)*	400,909	1,722,018	23.3%	95.5%	2%
Trust (Q4) *	2,995	11,565	26.1%	96.5%	1%

**Note Q4 only contains data for January and February, March data will not be published by NHS England until 10<sup>th</sup> May 2018**

Table 2 Inpatients Percentage Recommend Scores 2017/18

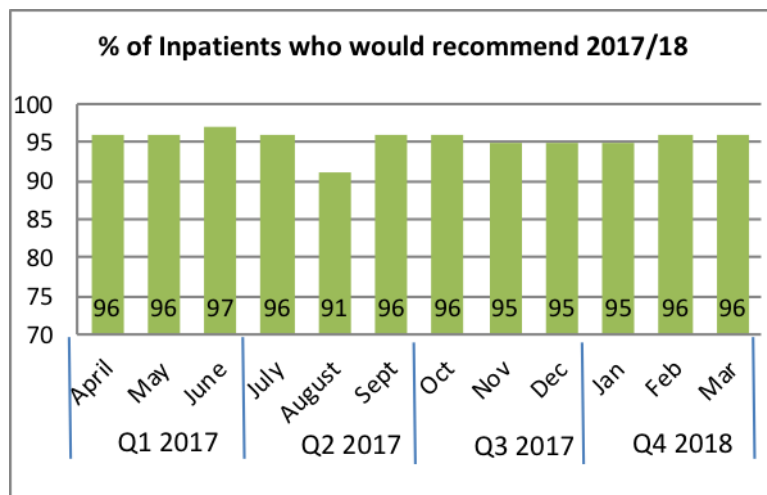


Table 3 Accident and Emergency Percentage Recommend Scores 2017/18

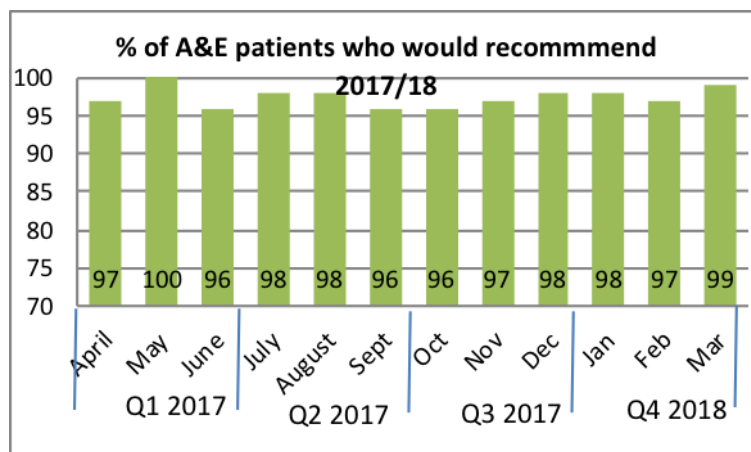


Table 4 Maternity Percentage Recommend Scores 2017/18

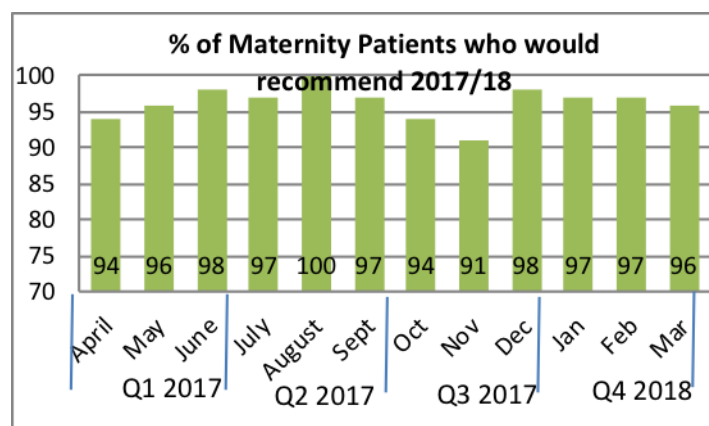
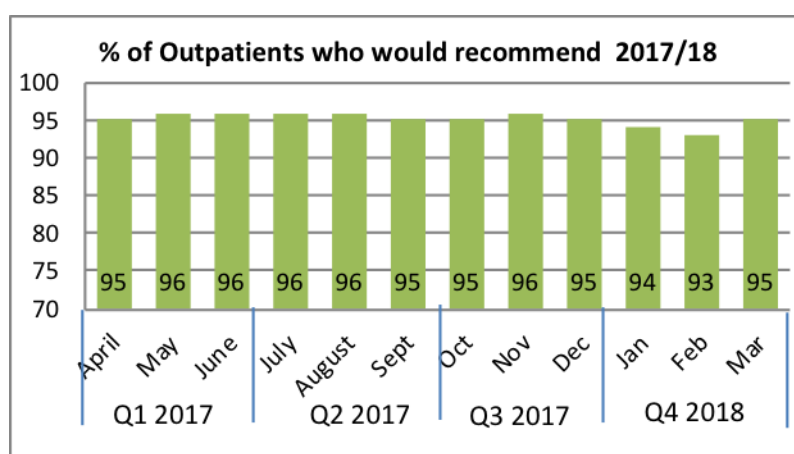




Table 4 Outpatients Percentage Recommend Scores 2017/18



## Patient Stories and Improvements following patient feedback.

### Story One

#### Multi Team Working

RN had an appointment in the fracture clinic, at a time when the Hospital Transport Service was in transition to a new provider. RN was expecting to be collected by ambulance transport and was ready from 13.00, but transport did not arrive.

RN contacted PALS for help. The team checked iPM and RN was coded as a Did Not Attend, despite the fact that he had spoken to the staff and they said get to the clinic when he could. PALS also contacted the hub, and explained the situation to the member of staff. The Team asked for advice for RN, who was waiting at home with a painful swollen leg. The PALS team contacted clinic and A&E for advice, and then called the patient back to advise him to attend A&E, if he felt it was an emergency. Unfortunately, he couldn't get to A&E, by any other means other than by hospital transport, and as he said it was not life threatening, he did not want to call 999. He was concerned that he did not want to leave it as he feared he may be getting a wound infection. The PALS Team continued to raise concerns about this patient and after a few challenges contacting administration, spoke to the consultant's secretary, who in turn spoke with the consultant. The consultant requested immediate attendance at hospital and along with the PALS Team, Patient Experience Manager and the Transport Services Manager, the gentleman was seen a few hours later in the hospital and treated successfully.

#### **Lesson Learned**

- 1) Communication from administration teams to inform staff of changes to secretarial staff to ensure people have the right contact details.
- 2) Answering patient calls and returning messages in a timely fashion is important. Changes to phone coverage by secretaries has since been implemented
- 3) Involve clinicians with discussions relating to a difficult clinical query as they can make the final judgement for urgent treatment, which cannot be made by secretary or PALS team.

**Overall Outcome:** Good communication with all teams including transport resulted in a quick solution to a patient who needed to be seen urgently and given appropriate treatment

## Story Two

### **Discharge Planning**

LH contacted PALS in April 2017 with concerns that she was not being discharged from hospital. It was prior to the Easter Bank Holiday weekend and she was deemed fit for discharge and she was desperate to go home. LH understood that her discharge was being delayed because her GP was refusing to pay for a drug she needed to take home.

Contact was made with the Hospital at Home Team but as her ongoing care was under the remit of the district nurse team, they were unable to help.

The PALS Team then contacted the Integrated Discharge Team, Team Leader who assisted. The Team Leader contacted the PALS Team back to say that the information given to PALS was incorrect and in fact LH's GP was not licensed to prescribe the drug which she needed. The drug had to be supplied from the Hospital and needed to be prescribed by a Consultant who would oversee the management of the patient. The Team Leader arranged for a consultant to write up her TTA's and arranged for district nurses to visit the patient at home that evening and 3 times a day after that until treatment finished.

The patient was discharged from the ward later that day, and she was extremely happy that she would be spending Easter at home and not in hospital.

### **Lessons Learned:**

- 1) Adequate planning is needed to enable discharge for patients particularly on bank holiday weekends
- 2) Appropriate information should be given to patients relating to their medication, and staff should check that patients understand the information given.

**Overall Outcome:** Good communication and fast team working with various hospital services gave a positive outcome for the patient, for which she was extremely grateful.

## Improvement One

### **Patient Essential Care Packs**

Patients are sometimes admitted to hospital at short notice, which means they often come ill equipped for their stay. Evidence indicates that nurses spend more than 25 minutes per day obtaining essential items, but if patients have to go without these items it may have a negative impact on their wellbeing, as well as their experience.

Patient Essential Care Packs provide patients with the key items needed to make their stay more comfortable and can be tailored to what patients feel is essential for them. Our packs were made up to contain items such as toothpaste, tooth brush, comb, shower gel, flannel, eye mask, ear plugs and essential information contained in the Welcome Booklet, Patient Advice and Liaison Service (PALS) and prevention of falls leaflets. . The following areas were included in the pilot project

- Emergency Admissions Unit 1 (EAU 1)
- Emergency Admissions Unit 2 (Ward 4)
- Surgical Admissions Unit (SAU)
- Paediatric Admissions Unit (PAU)

## Patient Feedback

*"When I was admitted unexpectedly I was desperate to brush my teeth. When I was given the pack it made me feel comfortable because I could brush my teeth. It is a really good idea"*

*"I was really surprised to receive the pack and it really helped me, especially the eye shield and ear plugs, as the ward was quite noisy"*

*"Items were sufficient enough for a short stay. Thank you"*

## Staff Feedback

*"The patients really appreciate it and were surprised it was free, some asked if they had to pay for it!"*

*"The staff found them really helpful as it saved them time running around to get all the bits and pieces together"*

*"We did not have eye pads and ear plugs on the ward and these went down really well with the patients"*

*"The packs were really helpful particularly for the patients who have been sent to the ward via their GP"*

Further packs have been ordered and long term funding options are being explored as this pilot was supported by Charitable Funds. As the feedback has been positive there is clear value in continuing with the packs.

## Improvement Two

### **Pets as Therapy (PaT) Dogs**

It has long been accepted that animals can be very therapeutic in aiding recovery and to improve wellbeing for people who have been ill. Research has shown that stroking a pet can not only reduce blood pressure but also reduce psychological responses to anxiety. The presence of pets can also promote social interaction and relaxation. It has been a project driven by Senior Nurses in the Trust to introduce the PaT Dogs programme to assist with the wellbeing of patients, in particular for those on our Medicine for the Elderly and Stroke Wards.

Two dogs were introduced into the Trust this year and are now members of the Volunteers Team. The owners (and their dogs) have to undergo special assessment and training so that they can visit people in hospitals, hospices and other organisations.

At the moment the dogs do not visit the wards, but patients who are able to can see them in the Therapies Hub. They are proving to be a great hit, not only with patients, but also with staff! We have also already witnessed some positive outcomes from the visits. One patient who had suffered a dense stroke and only spoke one word, "yes", was introduced to the dogs. One of them put their head on his leg and he attempted to lift his hand and said "paw". We know that the PaT Dogs are going to prove to be very popular with everyone in the Trust.

## National Inpatient Survey 2017

The report of the L&D inpatient survey was received on the 11/05/18 and the results detailed in the table below are published by the Care Quality Commission. Detailed management reports are shared internally and a programme of work will be developed and monitored at Clinical Outcomes, Safety and Quality meetings. Patients who were treated in July 2016 were surveyed. The Trust had a response rate of 43% against a national average of 44%.

### Results of the national in-patient survey 2016

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	8.5	Decreased	The same
Waiting lists and planned admission, answered by those referred to hospital	9.0	9.1	8.9	8.8	8.8	No change	The same
Waiting to get to a bed on a ward	7.0	6.5	7.1	7.3	6.7	Decreased	Worse
The hospital and ward	8.1	8.1	8.0	8.0	7.6	Decreased	The same
Doctors	8.2	8.4	8.4	8.3	8.3	No change	The same
Nurses	8.1	8.2	8.1	8.3	7.7	Decreased	The same
Care and treatment	7.5	7.6	7.6	7.7	7.5	Decreased	The same
Operations and procedures, answered by patients who had an operation or procedure	8.3	8.2	8.4	8.4	8.5	Increased	The same
Leaving hospital	7.0	7.1	6.8	6.8	6.8	No change	Worse
Overall views and experiences	5.5	5.5	5.5	5.3	5.2	Decreased	The same

*Note all scores out of 10*

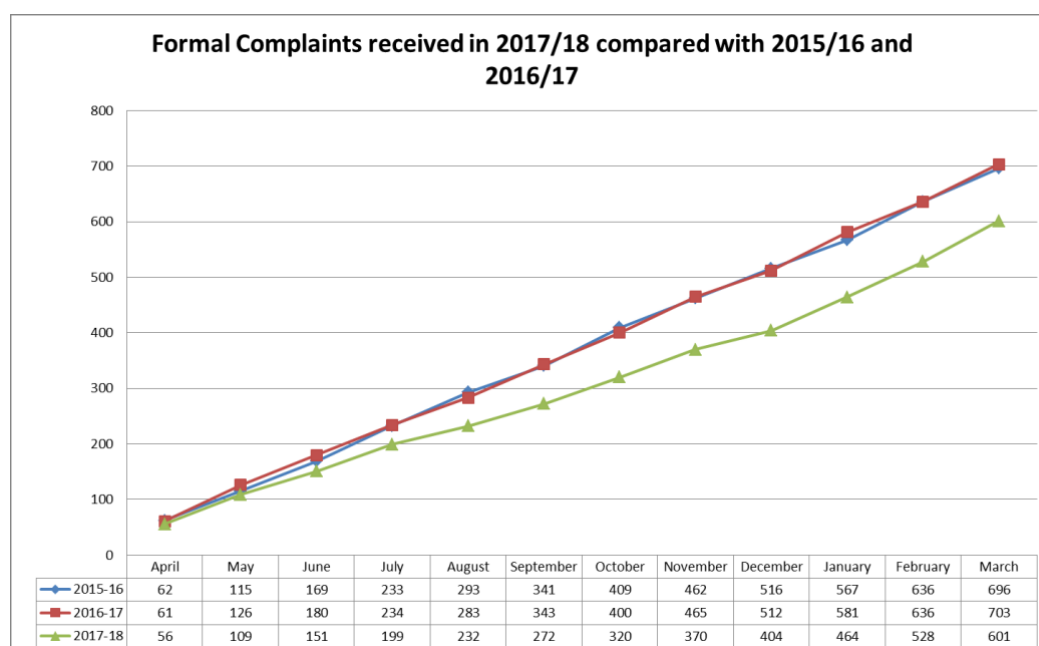
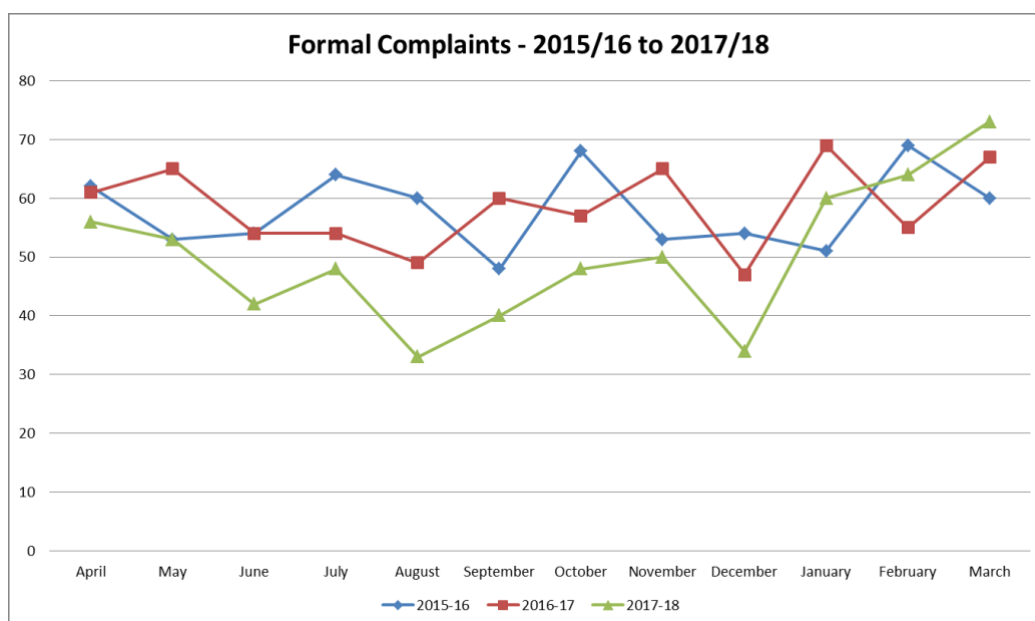
*Hospital and Ward category asks questions about cleanliness, hospital food and sleeping areas. The category Doctors and Nurses includes questions on confidence and understanding staff and Care and Treatment covers privacy, information on treatment and decisions about care.*

## 5.5 Complaints

During 2017/18 the Trust concentrated on developing processes which allow the learning from complaints to be shared with staff and we have continued to welcome patient feedback. There has been a continued focus to ensure that we are answering complaints and concerns efficiently and in a timely manner. We continually use this information to improve our services.

Our Trust has made significant efforts to resolve people's concerns quickly, via our PALS Team. Service Managers have been pro-active in contacting complainants to help resolve their complaints informally, thereby reducing the need for them to follow the formal complaints process.

During 2017/18 we received **601 formal** complaints compared to 704 in 2016/17 and 696 in 2015/16. There has been a decrease in formal complaints due to early intervention by the Service Managers, although it is recognised that there is a heightened public awareness of the option to complain.



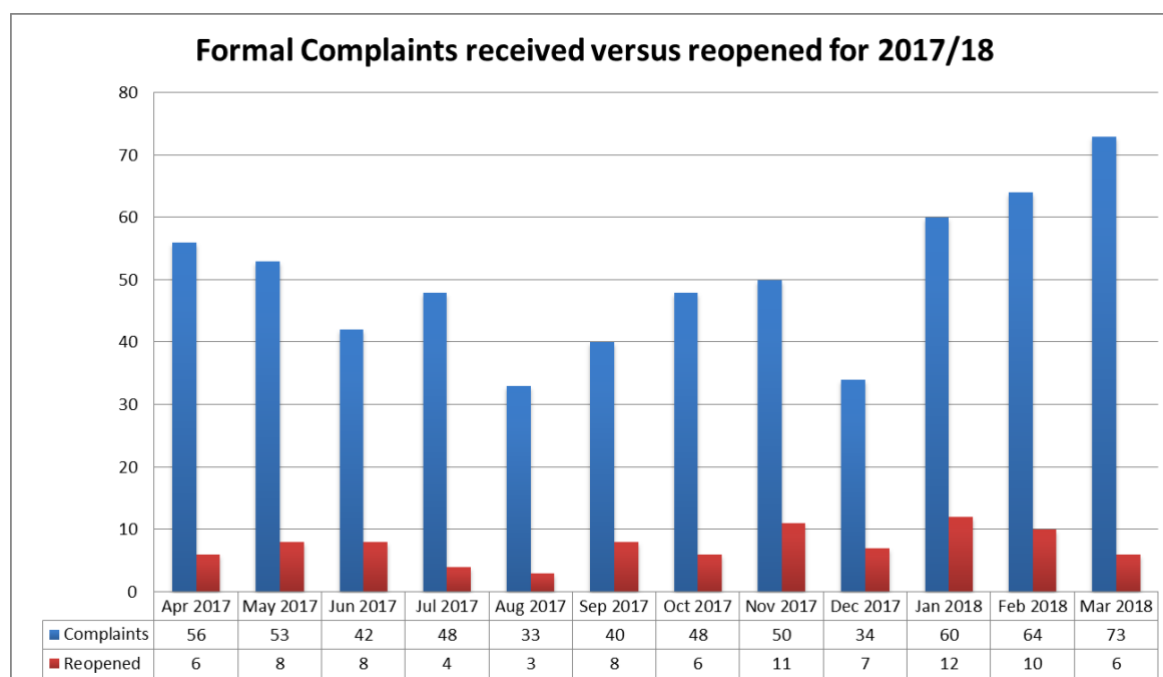
Improvements were made to the categorisations of complaints themes, to enable better learning and reporting. By implementing the use of the recommended coding from NHS Digital, investigations can be focussed around the specific themes. These changes were implemented from 1<sup>st</sup> April 2017, so we currently have 12 months of data. This will help us to better understand the nature of our complaints so that we can deal with them well in a timely way. This will also enhance our internal and external reporting, highlighting specific areas where we can improve.

We have also improved the method by which we acknowledge complaints. We endeavour to acknowledge all complaints within 3 working days and have achieved an average of 97.5% throughout this financial year with 100% acknowledged within the 3 day lead time in 7 out of the 12 months. It is not always possible to formally acknowledge a complaint within 3 days if the complaint has been raised via the hospital's website and not all relevant details are available. The information required when submitting a complaint has now been highlighted on the hospital website to reduce any unnecessary delays.

We aim to respond to complaints within 35 days but this has proven difficult to achieve in some cases, often because of reasons outside of the investigators control. The Patient Affairs Team currently sends out a weekly report of breached responses to the divisions but to help us meet the target in 2018/19 we have developed a tracking system to monitor complaints through each stage of the complaints process.

The monitoring and tracking of complaints handling is now part of the Divisional Performance Meeting monitoring agenda and the Board maintain oversight and are committed to increasing the response times.

In 2017/18 we re-opened 89 complaints. The graph below shows the number of formal complaints re-opened in comparison to the number received each month. Our aim for 2018/19 is to continue to reduce the number of re-opened complaints by ensuring 'first time right' responses.



## Learning from Complaints

This year we have strengthened our complaints process to ensure that we are learning from complaints to improve the services we provide. Complaints that are justified and partly justified and where recommendations have been made, there is an action plan that is monitored by the divisions with assurance provided to the Complaints Board. Below are examples of some of the improvements made during 2017/18:

- A few of our complaints that were made especially within the Medical Inpatients were about the PIPA boards above patient's beds – (they are the above bed boards used

in the hospital). For example, staff were not aware a patient was deaf and therefore spoke to them as if they were a hearing person. A board would have allowed the icon to be placed on it so all staff were aware. As a result of this complaint, boards are now in place on the wards with icons and more boards have been ordered.

- We received complaints about the waiting area within Surgical Short Stay Unit (SSAU). The concerns raised were that the waiting area for patients going to theatre is not ideal and challenged the need to provide a comfortable and relaxing environment. As a result of such complaints, there was a discussion with Nursing Staff managing the area and revisited options to improve the environment. The division plans to use the capital equipment budget or charitable funds to improve the chairs and facilities in the unit.
- We have introduced a red flag system in the surgical division for clinic letters to be typed urgently where a patient needs imaging prior to a scheduled appointment or procedure. This has meant that patient experience is improved; delays prevented, and avoid waste of NHS resources.

### **Listening to Patient Concerns**

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. The top themes of complaints related to clinical treatment, appointment delays and cancellations, communication and attitude of staff.

In 2017/18 all complaints were thoroughly investigated by the General Manager for the appropriate division and a full and candid response was sent to the complainant.

The majority of complaints were resolved at local resolution level, with seven complainants requesting that the Parliamentary and Health Service Ombudsman (PHSO) review their complaints. Four complaints are still under investigation by the PHSO and awaiting a draft report and for three of the complaints; we have received a draft report from the PHSO with a decision not to uphold the complaints. We are currently awaiting the final report to close them.

In 2018/19 we aim:

- To continue to promote informal and prompt resolution of concerns at a local level and involvement by Service Managers to contact complainants there by reducing the number of formal complaints and improving patient experience.
- To continue to raise the profile of complaints within the Trust via newsletters and training.
- Where investigators are having difficulty completing investigations due to circumstances outside their control they will be asked to work closely with the Patient Affairs Team and to keep complainants updated in a timely manner and negotiate extensions where appropriate.

### **Compliments**

During the reporting period over **4,840 compliments** were received about our staff and our services.

Below are some extracts taken from the compliments we received:

*Thanks to everyone in A&E*

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

*Excellent handling of my case (breast cancer)*

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

*Thank you*

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

*Thank You to the Cardiology Department*

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

*Compliments to catering department*

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

## **5.6 Implementing the Priority Clinical Standards for Seven Day Hospital Services**

The delivery of seven day services across England is a priority for NHS England (Keogh 2013)\* There are 10 Quality Standards and four priority clinical standards that Trusts must implement to have an impact on safety and mortality

The aim is to deliver standards to 90% of patients by 2020

- Clinical standard 2 - Time to first consultant review
- Clinical standard 5 - Diagnostics
- Clinical Standard 6 – interventions / key services
- Clinical standard 8 – On-going review

A Seven Day survey is carried out twice a year in April and September. The survey focuses on measuring the Trust compliance with the four priority standards and the survey reviews approximately 210-280 cases that was initially a prospective survey but is now a retrospective case note review.

The Trust is making progress and is set to achieve the standards.



## 5.6 Performance against Key National Priorities 2017/18

End of year data  
at in May 2018

		2014/15	2015/16	2016/17	2017/18	Target 17/18
Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	10	11	8	9	6
MRSA	To achieve contracted level of 0 cases per annum	3*	1	1	1	0
Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	100%	100%	99.9%	100%**	96%
Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	91%	88.4%	88.6%**	89.2%	85%
Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.5%	95.8%	96.4%**	96.3%**	93%
Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	98.9%	98.6%	100%	100%**	94%
	Anti-cancer Drugs	100%	99.8%	100%	100%**	98%
Patient Waiting Times	Referral to treatment - percentage patients waiting so far within 18 weeks - incomplete pathways	96.9%	96.3%	93.2%	91.9%	92%
Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.6%	98.6%	98.8%	98.4%	95%
Six week diagnostic test wait	% waiting over 6 weeks for a diagnostic test	N/A	N/A	0.7%	3.4%	<1%

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

\*\* currently to February 2018 – March data to be added in May 2018

## 5.7 Performance against Core Indicators 2017/18

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

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time, divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality; however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. The L&D is a provider of level 3 Neo-natal care that cares for the most premature babies and it is acknowledged that SHMI does not adequately risk adjust for a level 3 NICU provided in a District General Hospital. Other benchmarking data is used to provide assurance on performance and data is also subject to on-going review. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' rather than the numerical codes which correspond to these bandings

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
Value and banding of the SHMI indicator	Published Apr 13	As	As			2

	(Oct 11 –Sep 12)	expected	expected			
	Published Jul 13 (Jan 12 - Dec 12)	As expected	As expected			2
	Published Oct 13 (Apr 12 –Mar 13)	As expected	As expected			2
	Published Jan 14 (Jul 12 – Jun 13)	As expected	As expected			2
	Published Oct 14 (Apr 13 –Mar 14)	As expected	As expected			2
	Published Jan 15 (Jul 13 – Jun 14)	As expected	As expected			2
	Published Mar 16 (Sep 14 –Sep 15)	As expected	As expected			2
	Published Mar 17 (Sep 15 –Sep 16)	As expected	As expected			2
	Published Mar 17 (Sep 16 –Sep 17)	As expected	As expected			2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level <i>(The palliative care indicator is a contextual indicator)</i>	Published Apr 13 (Oct 11 –Sep 12)	12.4%	19.2%	0.2%	43.3%	N/A
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 –Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 – Jun 13)	12.6%	20.6%	0%	44.1%	N/A
	Published Oct 14 (Apr 13 –Mar 14)	13.7%	23.9%	0%	48.5%	N/A
	Published Jan 15 (Jul 13 – Jun 14)	14.7%	24.8%	0%	49%	N/A
	Published Mar 16 (Sep 14 –Sep 15)	13.8%	26.7%	0%	53.5%	N/A
	Published Mar 17 (Sep 15 –Sep 16)	26.2%	29.6%	0.4%	56.3%	N/A
	Published Mar 18 (Sep 16 –Sep 17)	32.8%	31.6%	11.5%	59.8%	N/A
The Luton and Dunstable University Hospital considers that this data is as described for the following reason:						
<ul style="list-style-type: none"> <li>This is based upon clinical coding and the Trust is audited annually.</li> </ul>						
The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:						
<ul style="list-style-type: none"> <li>Mortality rates remain as expected and other benchmarking, including HSMR remains one of the Trust quality priorities for 2017/18 and 18/19.</li> <li>The Mortality Board maintains ongoing oversight of any indicators that flag as an outlier including palliative care coding in which the Trust is in line with the national average.</li> </ul>						

Indicator: Readmission rates					
The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.					
	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 – 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2010/11	10.16	11.17	13.00	0.0%
	2011/12	10.64	11.26	13.50	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*

	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
<p>The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> <li>This is based upon clinical coding and the Trust is audited annually.</li> <li>The Trust does not routinely gather data on 28 day readmission rates</li> </ul>					
<p>The Luton and Dunstable University Hospital has taken the following actions to improve this percentage, and so the quality of its services, by:</p> <ul style="list-style-type: none"> <li>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</li> </ul>					
*The most recent available data on NHS Digital is 2011/12 uploaded in December 2013.					

Indicator: Patient Reported Outcome Measures (PROMs) scores					
PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.					
	Reporting period	L&D Score	National Average	Highest score (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*	0.078	0.08	0.14	0.06
Varicose vein surgery	2010/11	**	0.091	0.155	-0.007
	2011/12	**	0.095	0.167	0.049
	2012/13	**	0.093	0.175	0.023
	2013/14	**	0.093	0.15	0.023
	2014/15	**	0.1	0.142	0.054
	2015/16	**	0.1	0.13	0.037
	2016/17*	**	0.099	0.152	0.016
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14	0.369	0.436	0.545	0.342
	2014/15	**	0.442	0.51	0.35
	2015/16	**	0.45	0.52	0.36
	2016/17*	0.38	0.44	0.53	0.33
Knee replacement surgery	2010/11	0.325	0.299	0.407	0.176
	2011/12	0.313	0.302	0.385	0.181
	2012/13	0.321	0.319	0.409	0.194
	2013/14	0.297	0.323	0.416	0.215
	2014/15	**	0.328	0.394	0.249
	2015/16	**	0.334	0.412	0.207
	2016/17*	0.30	0.32	0.39	0.24
<p>The Luton and Dunstable University Hospital considers that this data is as described for the following reasons</p> <ul style="list-style-type: none"> <li>Results are monitored by the Clinical Audit and Effectiveness Group</li> <li>Results are monitored and reviewed within the surgical division</li> </ul>					
<p>The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:</p> <ul style="list-style-type: none"> <li>Reviewing these results in both high level committees and within the surgical division.</li> <li>Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings.</li> <li>This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required</li> </ul>					
* Relates to April 16 to March 2017 (most recent data published by NHS Digital)					
** Score not available due to low returns					

Indicator: Responsiveness to the personal needs of patients during the reporting period					
<p>This measure is taken from the National Inpatient Survey and is scored based on the response to five key questions:</p> <ul style="list-style-type: none"> <li>• Were you involved as much as you wanted to be in decisions about your care and treatment?</li> <li>• Did you find someone on the hospital staff to talk to about your worries and fears?</li> <li>• Were you given enough privacy when discussing your condition or treatment?</li> <li>• Did a member of staff tell you about medication side effects to watch for when you went home?</li> <li>• Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?</li> </ul>					
	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	71.6	76.7	88	70.7
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
<p>The Luton and Dunstable University Hospital considers that this data is as described for the following reasons</p> <ul style="list-style-type: none"> <li>• The source of the data is the National In-Patient Survey.</li> </ul>					
<p>The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:</p> <ul style="list-style-type: none"> <li>• Continued implementation of Electronic Prescribing system and that has improved timeliness of available medications for patients to take home</li> <li>• On-going refurbishment programme to assess the high risk environmental areas that need attention particularly toilets and bathrooms</li> <li>• On-going monitoring of patient feedback from the Patient Experience Call Centre and Friends and Family feedback</li> </ul> <p><i>*The most recent available data on NHS Digital is 2016/17 published August 2017</i></p>					

Indicator: Staff recommendation					
<p>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.</p>					
	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%
	2017/18	72%	70%	87%	60%
<p>The Luton and Dunstable University Hospital considers that this data is as described for the following reasons</p> <ul style="list-style-type: none"> <li>• The source of the data is the National Staff Survey.</li> </ul>					
<p>The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:</p> <ul style="list-style-type: none"> <li>• The hospital runs with a clinically led, operating structure.</li> <li>• 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.</li> <li>• Transforming Quality Leadership Group in place and supports areas across the Trust through a 'buddy' process.</li> <li>• Ongoing engagement with staff through bi-annual engagement events and monthly team briefing</li> </ul> <p>* Not available on NHS Digital website</p>					

Indicator: Risk assessment for venous thromboembolism (VTE)					
<p>The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.</p>					
	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%
	2017/18 – Q3	95.91%	95.3%	100%	76.08%
The Luton and Dunstable University Hospital considers that this data is as described for the following reasons					
<ul style="list-style-type: none"> <li>There is a robust process for capturing the evidence of completion</li> </ul>					
The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:					
<ul style="list-style-type: none"> <li>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.</li> <li>We have implemented an electronic solution to the risk assessment process that has had a significant impact. By March 2018 the Trust was at 99.8% compliance.</li> <li>We undertake root cause analysis on all patients who develop a VTE.</li> </ul>					

Indicator: <i>Clostridium difficile</i> infection rate					
The rate for 100,000 bed days of cases of <i>Clostridium difficile</i> 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 <i>C. difficile</i> infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	5.1	15.1	62.2	0
	2015/16	5.4	14.9	66	0
	2016/17	3.6	13.2	82.7	0
	2017/18	3.9+	Not Avail*	Not Avail*	Not Avail*
The Luton and Dunstable University Hospital considers that this data is as described for the following reasons					
<ul style="list-style-type: none"> <li>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.</li> <li>The Trust had 9 <i>C.difficile</i> for 2017/18</li> </ul>					
The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:					
<ul style="list-style-type: none"> <li>maintaining <i>C.difficile</i> high on the training agenda for all healthcare staff</li> <li>rigorously investigating all cases of <i>C.difficile</i> through the RCA mechanism and actioning all learning points identified</li> <li>assessing all patients suspected of <i>C.difficile</i> infection when alerted</li> <li>uncompromisingly isolating suspected cases of <i>C.difficile</i> when first identified</li> <li>attending the CCG Infection Control Network with its potential for shared learning</li> <li>monitoring high standards of environmental cleaning (including equipment) and exploring other mechanisms of reducing <i>C.difficile</i> contamination further</li> </ul>					
*Data not available on NHS Digital					
+ Local Data					

Indicator: Patient safety incident rate					
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.					
	Reporting period	L&D Score	National Average	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	23.3	41.1	23.1	69.0
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Total number and rate of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2010/11	0.03	0.04	0.17	0
	2011/12	0.03	0.05	0.31	0
	2012/13	0.03	0.05	0.26	0
	2013/14	0.03	0.05	0.38	0
	2014/15	0.25	0.19	1.53	0.02
	2015/16	0.09	0.16	0.97	0
	2016/17	0.06	0.2	0.53	0.01
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
<p>The Luton and Dunstable University Hospital considers that this data is as described for the following reasons</p> <ul style="list-style-type: none"> <li>The hospital reports incident data and level of harm monthly to the National Reporting and Learning System</li> <li>31 Serious Incidents were reported in 2017/18 compared with 22 in 2016/17, 32 in 2015/16 and 46 in 2014/15 (excluding pressure ulcers). Two incidents were downgraded in 2017/18 by the CCG on receipt of the investigation findings which identified that there were no acts or omissions in care that contributed to the outcome for the patient.</li> <li>The Trust reported 4 Never Events in 2017/18 under the following Department of Health criteria - a wrong implant/prosthesis, insulin overdose, a wrong site surgery, nasogastric feed into the lung</li> <li>The Trust is contractually required to notify its Commissioners of a Serious Incident within 2 working days of identification – in 2017/18 this target was met in 28 out of 29 cases (96%) compared to 18 out of 22 cases (82%) in 2016/17.</li> <li>The Trust is also contractually required to submit an investigation report for all Serious Incidents within 60 working days of the notification. During 2017/18 this target was met in 28 out of 29 cases (96%) compared to 17 out of 19 cases (89%) in 2016/17. One incident is on a “stop the clock”.</li> <li>The Trust continues to review its systems and processes to ensure it can meet the contractual requirements going forward.</li> <li>The Trust was 100% compliant with the Duty of Candour contracted requirements.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>Introduction of a step by step guide to prepare and administer insulin in every preparation area</li> <li>Review and modify the process for producing and destroying handover sheets for clinicians</li> <li>Changing the way patients with potentially difficult airway management are cared for during surgery</li> <li>Improve the reporting of potentially life changing results from imaging</li> <li>Improve the telephone triage advice recorded for patients ringing the maternity unit for advice</li> </ul> <p>*Data not available on NHS Digital  ** NRLS amended their calculation from per 100 bed days to per 1000 bed days in 2013 so no comparable historical data available</p>					

## 5.9 Embedding Quality – Workforce factors

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

### Recruitment and Resourcing

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

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

## **Registered Nurses**

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

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

## **Acorn Preceptorship Programme**

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

## **Assistant Practitioners**

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

## **Healthcare Assistants**

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

## **Needs Based Care**

The Trust has commenced recruitment to posts that enable the transition to a Needs Based Care (NBC) model of delivery that has continuity of care as its key principle. This has resulted in the introduction of a number of new consultant, specialist and other front line

posts. Recruitment to these posts will continue up to October 2018 in order to ensure our patients receive the right care, in the right place and at the right time based on their clinical need.

## **Agency Collaboration**

The Trust has continued to work collaboratively with trusts across Bedfordshire and Hertfordshire on joint tendering and common processes to ensure best value for the use of agency staff without risks to patient safety. The project continues to deliver savings to the Trust and provide consistency within the local agency market.

## **Consultant Job Planning**

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

## **Communicating and engaging with our staff**

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

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

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

Examples of staff communications and engagement include:

- Monthly staff briefings are led by our Chief Executive. We share information on key operational issues and gain feedback from staff
- Executive Team present to new staff at induction monthly.
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets quarterly with our Council of Governors, which includes nine elected staff governors
- Quarterly public Trust Board meetings



- Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust
- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

## **Staff Involvement Group**

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

## **Staff Involvement Group Newsletter**

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

## **Engagement events 2017**

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

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

## **Our Volunteers**

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

The Voluntary Services Manager is responsible for overseeing external organisations such as the RVS, Carers in Bedfordshire, Hospital Radio and also organisations or businesses wishing to offer one day volunteering. She is a member of the National Executive Committee

of NAVSM (The National Association of Voluntary Services Managers – NHS) and contributes to the Special Projects team, which has recently published and distributed their 'Good Practice Guide' to VSMs across the NHS. She also assists in organising the NAVSM annual training seminar.

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

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

Our volunteer base is made up as follows:

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

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

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

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

During 2017 / 2018:

- Our Trust volunteers gave us a total of over 23,000 hours, which is the equivalent to 12.3 full time band 2 staff.
- 74 new volunteers were recruited and there were a total of 58 Leavers.

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

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

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

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

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

## **Health and Wellbeing / Occupational Health**

We offer a full range of Occupational Health and Wellbeing Services which contribute to increasing the effectiveness of the organisation, by enhancing staff performance and morale through reducing ill-health, absence and accidents.

During 2017/18 the Trust has continued with initiatives, to promote opportunities for staff to adopt a healthier lifestyle either on site or by promoting external facilities that are conducive to good health.

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

In June 2017, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place, which proved to be very popular. Awareness raising stands and activities included: Chair based fitness exercise demonstrations by Active Luton, Chi Kung Tai Chi demonstrations, smoking cessation, smoothie bikes, Blood pressures, Heights/weights and Body Mass Index, healthy eating, a nutritionist performing health snacks

demonstrations, table tennis and a skipping challenges, and a company promoting ergonomic posture correction and active working products among other initiatives.

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

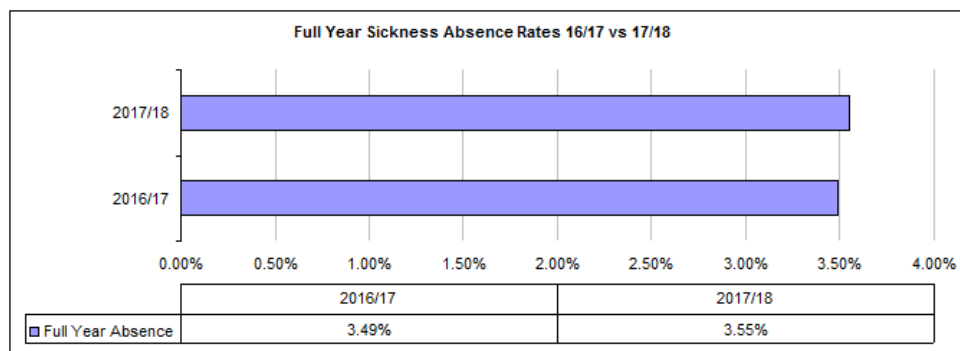
The Wednesday walking activity (30 minutes of a brisk walk) that first started in 2009 continued to take place every Wednesday lunchtime.

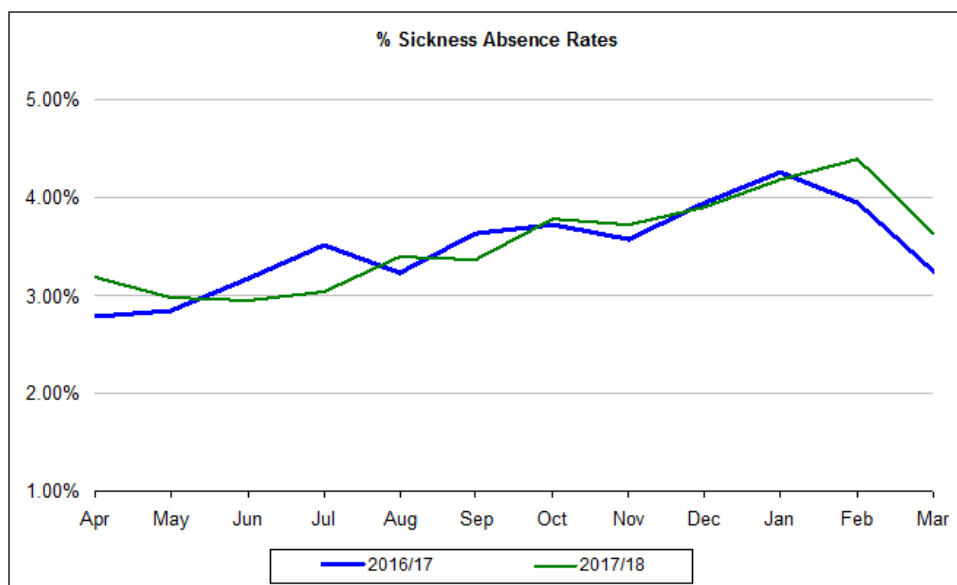
The Occupational Health team were successful in retaining their accreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf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

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

### Health Checks for staff

The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. A company commissioned by Luton Borough Council provides free health checks to those over the age of 40 and up to the age of 74. Whilst this is national scheme we have been able to continue to secure dates for this service to be brought on site to our staff. Since October 2013 sessions have been available on a monthly basis with over 520 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary referrals made.





## Fruit and Vegetable Market Stall

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

Since September 2015, the stall has been on site one day a week. In April 2016 we introduced a new activity entitled 'Apples and Pears to take the stairs'. This activity takes place on a monthly basis to encourage staff to use the stairs more, increase levels of fitness and also to raise awareness of the fruit and veg stall.

## 2017 NATIONAL STAFF SURVEY SUMMARY OF RESULTS

### 1. Introduction

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

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

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

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

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

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

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

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

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

- Percentage scores, i.e., percentage of staff giving a particular response to one, or a series of survey questions.
- Scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these summary scores, the minimum score is always 1 (Strongly disagree) and the maximum score is 5 (Strongly agree)

## 2. Response Rates

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

\* Acute Trusts

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

## 3. Staff Engagement

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

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

KF 7 Staff ability to contribute towards improvements at work	72%	70%	75%	70%	No significant change	Above (better than) average
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#### 4. Key Findings

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

##### 4.1 Top Ranking Scores

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

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

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

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

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

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

### **4.2 Bottom Ranking Scores**

Bottom 5 Ranking Scores	2017 National NHS Staff Survey		2016 National NHS Staff Survey		Change since 2016 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 16 % of staff working extra hours***	75%	72%	79%	72%	No significant change	Highest (worst) 20%
KF 20 % of staff experiencing discrimination at work in the last 12 months	17%	12%	15%	11%	No significant change	Highest (worst) 20%
KF 22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	15%	18%	15%	No significant change	Highest (worst) 20%



KF 25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	31%	28%	33%	27%	No significant change	Highest (worst) 20%
KF 15 % of staff satisfied with the opportunities for flexible working plan	48%	51%	50%	51%	No significant change	Lower than average

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

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

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

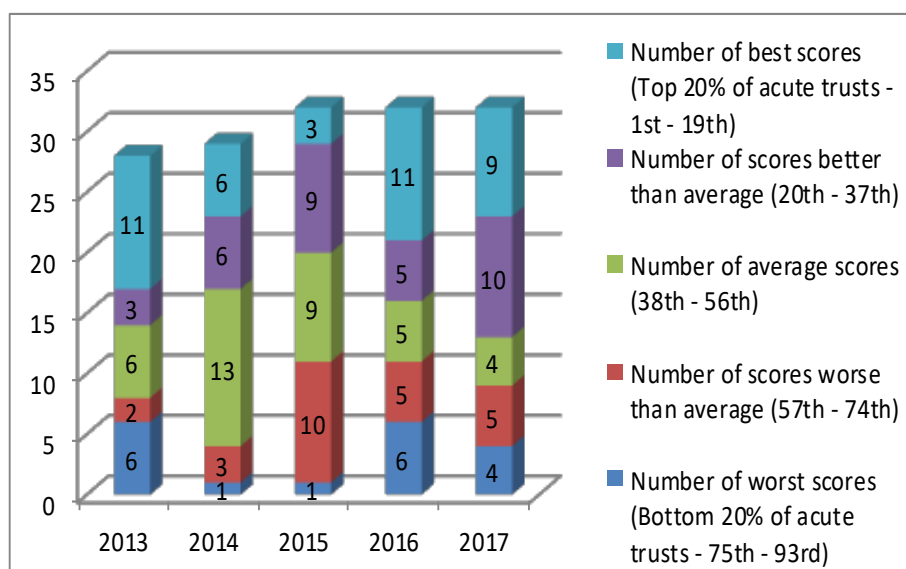
- % appraised in the last 12 months
- Effective use of patient/service users feedback
- % witnessing potentially harmful errors, near misses or incidents in the last month
- % experiencing physical violence from staff in last 12 months

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

#### **Key findings over the past five years**

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

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



## Next Steps

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

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

## Action

### Violence and Harassment

- The Trust reviewed the data and other intelligence that identified there was an issue related to reported incidents involving confused patients on the ward. As a result new training was put in place to support staff dealing patients with cognitive impairment.
- The Trust implemented 'Baywatch' which ensures that the nurses who are observing patients, such as those with dementia, are clearly identified and that patients and visitors are aware that those nurses cannot leave the bay.
- The Managing Conflict Policy has been reviewed and a new scheme including exclusion letters and Action Against Abuse signage is being rolled out and awareness training planned.

#### Staff working extra hours

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

#### Flexible Working

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

#### Discrimination

- The Trust has an Equality, Diversity and Human Rights Committee and have set up a task and finish group specifically looking at these issues. During Equality and Diversity Week (14-18<sup>th</sup> May) the Trust will be having a weeklong series of activities to raise awareness about the issue.
- The Trust began a process in July 2017 using the Engagement Events, to establish a new set of values.

### **5.10 Improving the quality of our environment**

The Trust actively engages with patients through the Patient Led Assessment of the Care Environment (PLACE) initiative.

An annual inspection, led by a nominated patient representative, is undertaken as directed by the Department of Health. In addition to the annual inspection, monthly inspections are undertaken, again led by a patient representative and supported by Non-Executive Directors of the Trust. Information received from inspections is used to improve the patient environment and patient experience.

In the year, a number of schemes of work have been undertaken to improve facilities for our patients, this includes:-

- Updating outpatient areas
- Refurbished and extended the Oral and Maxillo Facial department
- Improvement to the neo-natal accommodation
- Expanded endoscopy

Looking forward into 2018/19, the Trust already has advanced plans to make further improvements to the hospital estate with the:-

- Installation of new MRI scanners
- Construction of a new Endoscope Decontamination
- Refurnished accommodation offsite to provide services in the centre of Luton
- Upgraded electrical infrastructure

In the coming year, a number of schemes of work for the hospital estate are planned to take place. The works underpin our commitment to keep patients safe at all times; these works include the replacement of the automatic fire detection system, reinforcement works to power supplies and replacement of old heating systems.

## **5.11 Quality and Business Strategy**

One of our key approaches to delivering high quality sustainable is to ensure all of our projects are subject to a Quality Impact Assessment. These formal assessments are made at Executive and Divisional level and assurance is provided to the Finance, Investment and Performance Committee and where appropriate, the Clinical Outcome, Safety and Quality Committee.

We have also continued to market its services to GP's and held a range of events to promote our services, where expert speakers have drawn good attendances. We continue to ensure we have clear processes in place to refer to clinically, the quickest place to see patients, and can clearly evidence and promote the quality of our services. We continue to inform GPs of key service developments and engage with them regarding any concerns and issues to ensure we continually improve.

## **5.12 Review of Quality Performance - how the Trust identifies local improvement priorities**

The hospital agreed the Corporate Objectives, and these include the quality objectives. The Trust Governors, that include staff and public representatives, were engaged with the development of these objectives. This is through the Council of Governors meetings and their selection of the indicator to review annually. The Quality Priorities for 2018/19 were agreed through a stakeholder engagement process to develop the Quality Strategy that was launched at our Staff Engagement Event in December 2017 where over 2000 staff attended and received the information.

The list of clinical indicators which were developed and added to in previous years remain included. People identified those indicators most important to them and also stated the elements of care that they would want the Trust to concentrate on improving.

Amendments to the quality priorities have been considered by staff in management executive based on performance and improvement needs. Where there has not been progress made, these have remained a quality priority for 2018/19.

Quality is discussed and monitored at quarterly monitoring meetings with our local Clinical Commissioning Groups. There remains a high level of agreement among the various groups of people that have contributed to determining priorities.

## 6. Statement of Directors' responsibilities in respect of the Quality Report

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to March 2018
  - papers relating to Quality reported to the board over the period April 2017 to May 2018
  - feedback from commissioners dated TBC
  - feedback from governors dated 28/3/2018
  - feedback from Healthwatch Luton received TBC
  - feedback from Luton Overview and Scrutiny Committee – TBC
  - feedback from Central Bedfordshire Social Care Health and Housing Overview and Scrutiny Committee received TBC
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated TBC
  - the 2017 national patient survey [not received at time of signing]
  - the 2017 national staff survey 8/3/2018
  - the Head of Internal Audit's annual opinion over the trust's control environment dated TBC
  - CQC Inspection Report dates 03/06/2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

23<sup>rd</sup> May 2018  
.....Date.....Chairman

23<sup>rd</sup> May 2018  
.....Date.....Chief Executive

Note: An Equality Analysis has been undertaken in relation to this Quality Account.

## **7. Comments from stakeholders:**







**Central Bedfordshire comment on the Luton and Dunstable  
University Hospital NHS Trust**

**Comments from Luton Borough Council Health and Social Care Review Group  
L&D Hospital NHS Foundation Trust Quality Accounts 2016-17**





## Comments received from the Trust Stakeholders

Comment	Response

## **8. Independent Auditor's Assurance Report**

## 9. Glossary of Terms

Term	Description
<b>Acute Kidney Infection (AKI)</b>	A painful and unpleasant illness caused by bacteria travelling from your bladder into one or both of your kidneys
<b>Anticoagulation</b>	A substance that prevents/stops blood from clotting
<b>Antimicrobial</b>	An agent that kills microorganisms or stop their growth
<b>Arrhythmia</b>	Irregular Heartbeat
<b>Aseptic Technique</b>	Procedure performed under sterile conditions
<b>Cardiac Arrest</b>	Where normal circulation of the blood stops due to the heart not pumping effectively.
<b>CAUTI</b>	Catheter Acquired Urinary Tract Infection – this is where the patient develops an infection through the use of a catheter
<b>CCG</b>	Clinical Commissioning Group.
<b>Chronic Obstructive Pulmonary Disease (COPD)</b>	A disease of the lungs where the airways become narrowed
<b>Clinical Audit</b>	A <u>quality improvement</u> process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
<b>Continence</b>	Ability to control the bladder and/or bowels
<b>Critical Care</b>	The provision of intensive (sometimes as an emergency) treatment and management
<b>CT</b>	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.
<b>CT Coronary Angiography (CTCA)</b>	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.
<b>CQUIN</b>	Commissioning for Quality and Innovation – these are targets set by the CCG where the Trust receives a financial incentive if it achieves these quality targets.
<b>DME</b>	Division of Medicine for the Elderly

<b>Term</b>	<b>Description</b>
<b>Elective</b>	Scheduled in advance (Planned)
<b>EOL</b>	End of Life
<b>Epilepsy</b>	Recurrent disorder characterised by seizures.
<b>EPMA</b>	Electronic Prescribing and Monitoring Administration system in place.
<b>Grand Round</b>	A lunch time weekly meeting with consultants and junior medical staff to communication key issues and learning.
<b>HAI</b>	Hospital Acquired Infection
<b>Heart Failure</b>	The inability of the heart to provide sufficient blood flow.
<b>Hypercalcaemia</b>	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
<b>HSMR</b>	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.
<b>Laparoscopic</b>	Key hole surgery
<b>Learning Disability</b>	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
<b>LIG</b>	Local Implementation Group
<b>Meningococcal</b>	Infection caused by the meningococcus bacterium
<b>Magnetic Resonance Imaging (MRI)</b>	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
<b>MUST</b>	Malnutrition Universal Screening Tool is a nutritional assessment that is carried out on inpatients to ensure that they are maintaining their body weight
<b>Myocardial Infarction</b>	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
<b>Myringotomy</b>	A surgical procedure of the eardrum which alleviates pressure caused by the build up of fluid
<b>Needs Based Care</b>	Inpatient adult wards are organised by patient need rather than age for example a cardiac ward, respiratory ward.
<b>Neonatal</b>	Newborn – includes the first six weeks after birth
<b>Non Invasive Ventilation (NIV)</b>	The administration of ventilatory support for patients having difficulty in breathing

Term	Description
<b>Orthognathic</b>	Treatment/surgery to correct conditions of the jaw and face
<b>Parkinson's Disease</b>	Degenerative disorder of the central nervous system
<b>Partial Booking</b>	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
<b>Perinatal</b>	Period immediately before and after birth
<b>Pleural</b>	Relating to the membrane that enfolds the lungs
<b>Prevalence</b>	The proportion of patients who have a specific characteristic in a given time period
<b>Red and Green</b>	The Red:Green Bed day is a visual management system to assist in the identification of wasted time in a patients journey. If it is red, the patient has not progressed, green they have.
<b>QSIR</b>	Quality, Service Improvement and Redesign The QSIR programmes are delivered in a variety of formats to suit different levels of improvement experience and are supported by publications that guide participants in the use of tried and tested improvement tools, and featured approaches, as well as encouraging reflective learning.
<b>Safety Thermometer/Harm Free Care</b>	Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism
<b>Seizure</b>	Fit, convulsion
<b>Sepsis</b>	The presence of micro-organisms or their poisons in the blood stream.
<b>SEPT</b>	South Essex Partnership University NHS Foundation Trust
<b>SHMI</b>	Summary Hospital-level Mortality Indicator ( <b>SHMI</b> ) is an indicator which reports on mortality at trust level across the NHS in England using a standard
<b>SSNAP</b>	The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit.
<b>Stroke</b>	Rapid loss of brain function due to disturbance within the brain's blood supply



Term	Description
<b>Syncope</b>	Medical term for fainting and transient loss of consciousness
<b>Two week wait</b>	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
<b>Transfusion</b>	Describes the process of receiving blood intravenously
<b>Trauma</b>	Physical injury to the body/body part
<b>UTI</b>	Urinary Tract Infection
<b>Venous Thromboembolism (VTE)</b>	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 2017 – March 2018 (Projects managed by the Clinical Quality Department)

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
<b>GENERAL PAEDIATRICS INTERNAL HEALTH RECORD KEEPING AUDIT 2016/2017</b>  <b>N = 20</b>	Paediatrics	Audit	April 2017	<b>Main Aims:</b> <ul style="list-style-type: none"> <li>• Measure compliance with standards set out by NHSLA, CQC and local guidelines</li> </ul> <b>Findings:</b> <ul style="list-style-type: none"> <li>• 54% of standards fully compliant</li> <li>• 8% of standards with high compliance</li> <li>• 14% of standards with moderate compliance</li> <li>• 24% of standards with low compliance</li> </ul> <b>Key Recommendations/Actions:</b> <ul style="list-style-type: none"> <li>• Disseminate results at induction of junior doctors.</li> <li>• Get all documents printed with relevant details (areas of poor compliance) on BOTH SIDES</li> <li>• Integrate name of admitting Consultant into printed sheet.</li> <li>• Arrange for automatic importing of all results or importing with one mouse click.</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
<b>RE - AUDIT OF FAMILIAL HYPERCHOLESTE ROLAEMIA</b>  <b>N = 9</b>	<b>Biochemistry</b>	<b>Audit</b>	<b>May 2017</b>	<p><b>Main Aims:</b></p> <ul style="list-style-type: none"> <li>The aim of the re-audit was to provide evidence against the following quality standards from QS41:</li> </ul> <ol style="list-style-type: none"> <li>Adults with a total cholesterol above 7.5 mmol/l before treatment have an assessment for familial hypercholesterolaemia.</li> <li>People who are given a clinical diagnosis of familial hypercholesterolaemia because they have high cholesterol and family history or other signs are offered DNA testing as part of a specialist assessment.</li> <li>Adults with familial hypercholesterolaemia are offered drugs to reduce the low-density cholesterol (bad cholesterol) in their blood to less than a half of the level before treatment</li> <li>People with familial hypercholesterolaemia are offered a detailed review of their condition at least once a year.</li> </ol> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>The findings from this re-audit provide evidence of compliance with the Quality statements in QS41 – Familial Hypercholesterolaemia, including statements 1, 3, 5, 6 and 8</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>No findings to action</li> </ul>
<b>HEALTH RECORDS KEEPING AUDIT 2016/ 2017 MEDICAL MULTIDISCIPLINAR Y</b>  <b>N=40</b>	<b>Medicine Multidisciplin ary</b>	<b>Audit</b>	<b>July 2017</b>	<p><b>Main Aims:</b></p> <ul style="list-style-type: none"> <li>To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings.</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>Overall the Audit for Health records shows a high compliance rate with the majority of clinical standards. 49/56 (87%) of the total number of standards were recorded as highly or fully compliant, whilst only 6/56</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<p>(11%) were amber with moderate compliance and 1/56 (2%) were red of low compliance.</p> <ul style="list-style-type: none"> <li>• The health records audit conducted for the period of February 2015 showed only 48/66 (72%) of the total number of standards as being fully or highly compliant. Whilst 9/66 (14%) were of moderate compliance and a further 9/66 (14%) were of low compliance. In comparison our results show a vast improvement in compliance with the standards. However despite these improvements there are still a few areas which have been highlighted that require intervention and improvement.</li> <li>• For optimal continuity of care all aspects of patient's records need to be identifiable by staff with the patient's name, hospital number, date of birth, and NHS number. The implications of unlabelled patient records can lead to delays in providing patient care. Our records show that these standards (Q 5, 6, 7) are of moderate compliance.</li> <li>• One of the areas of poor performance identified is the notable lack of height measurement in all the health records reviewed (Q 10.1). Height in addition to weight is an important parameter when it comes to calculating body surface area for drug administration. It is understandable that there may be difficulties in calculating height for patients due to risk of falls or immobility. Nonetheless various alternate methods can be implemented to accurately estimate height which can be done through education and training.</li> <li>• All patients must have their drug allergy status filled in on EPMA to prevent drug errors. Our audit shows this standard (Q30.6) to be of moderate compliance. Similarly, discharge letters should contain accurate documentation and reasoning of regular patient medications which have been amended during their hospital stay. Many patients on discharge are followed up in the community by various health care teams</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<p>and this information can often only be conveyed through discharge summaries. Our audit shows this standard to be of moderate compliance (Q 37.2)</p> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• To regularly review patients notes and ensure they are correctly labelled</li> <li>• Education and training of staff members on how to estimate height using arm span and ulna length. Review notes to ensure these parameters are documented</li> <li>• Review previous patient notes, check admission clerking, contact patient's regular GP</li> <li>• Education and training of junior doctor of the importance in continuity of care in mentioning medication amendments on discharge letters. Liaise with pharmacists when discharging patients.</li> </ul>
<p><b>ENT INTERNAL HEALTH RECORD KEEPING AUDIT 2016/2017</b></p> <p><b>N = 20</b></p>	<p><b>ENT</b></p>	<p><b>Audit</b></p>	<p><b>August 2017</b></p>	<p><b>Main Aims:</b></p> <ul style="list-style-type: none"> <li>• Measure compliance with standards set out by NHSLA, CQC and local guidelines</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>• 35% of standards fully compliant</li> <li>• 42% of standards with high compliance</li> <li>• 15% of standards with moderate compliance</li> <li>• 8% of standards with low compliance</li> </ul> <p><b>Key Recommendations/Actions:</b></p>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>• On-call SHO to ensure all patients seen in A&amp;E have a completed A&amp;E proforma before they move to the ward, or to clerk directly into specialities page of the A&amp;E proforma and inform A&amp;E doctor.</li> <li>• For more stable patient's referred from, but not seen in A&amp;E, when discussing with the referrer doctor, ensure they have clerked the patient before transfer to SAU.</li> <li>• Patient height and weight usually done by A&amp;E in stable patients. But when not possible, this should be done when the patient is stable. Records for height and weight must be checked routinely by nursing staff when patient arrives on the ward, and any missing data should be highlighted for collection.</li> <li>• Poor compliance with entries showing evidence of involvement of the patient/carers in the care plan/actions (where applicable). Document patient agreement/disagreement; Document carer details if seen with carer; Allow opportunity to ask questions and discuss management plan.</li> <li>• Poor compliance with name of the healthcare professional clearly documented and their job title clearly documented. This will be emphasised at induction before new SHO's start the post.</li> <li>• All relevant clinical investigation reports should be copied into discharge letters, as opposed to "See ICE" or "As per ICE".</li> </ul>
<b>RE-AUDIT OF THE ADMINISTRATION OF IVT INJECTIONS IN OPHTHALMOLOGY</b>  <b>N = 15</b>	Ophthalmology	Re-Audit	August 2017	<b>Mains Aims:</b>  Re-measure compliance with the revised protocol of administration of intravitreal injections. Specifically to: <ul style="list-style-type: none"> <li>• Identify whether the Ophthalmology Department are adhering to the revised protocol</li> <li>• Identify areas where compliance with the protocol need to be improved</li> <li>• Identify areas of good practice</li> </ul> <b>Findings:</b>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>• Full compliance (100%) with 80% of standards</li> <li>• Moderate compliance (87%) with 10% of standards</li> <li>• Poor compliance with 10% of standards</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <p>Re training of staff and sharing during:</p> <ul style="list-style-type: none"> <li>• Ophthalmology Service Line Meeting: 10/07/17</li> <li>• Medical Retina meeting: 09/06/17</li> <li>• Clinical Governance Meeting Ophthalmology: 21/07/17</li> <li>• Ophthalmology Nursing team meeting daily team briefs</li> <li>• Quarterly audits next due on 18/09/2017</li> </ul>
<p><b>SAFE EFFECTIVE DISCHARGE AUDIT</b></p> <p><b>N=40</b></p>	Corporate	Audit	August 2017	<p><b>Mains Aims:</b></p> <ul style="list-style-type: none"> <li>• To measure compliance with standards set out within the local Discharge Policy and to review completion of the Discharge Checklist.</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>• 25% of standards fully compliant</li> <li>• 18% of standards with high compliance</li> <li>• 15% of standards with moderate compliance</li> <li>• 42% of standards with low compliance</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• Improve the quality of discharge plans being clearly documented within the clinical records to include conversations had with patients and/or their advocates .Action: Correspondence to be sent to nursing staff, discharge planning staff and nursing staff to remind them of the importance of clear documentation of discharge plans made.</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>• Improve documentation to evidence medications have been explained including pain management to the patients or patients advocate prior to discharge taking place. Action: Copy of Audit findings to be disseminated to Matrons and Ward Managers and findings of discharge audit to be discussed at safety briefings on all wards. Presentations to be given at ward sisters and Matrons meetings.</li> <li>• Improve documentation to evidence that wound care is explained to patient prior to discharge. Action: Tissue Viability Service to discuss findings of Audit at training sessions given and relay the importance</li> <li>• Improve the number of referrals being made to the continence service on discharge and evidence products are given on discharge. Action: Presentation to be given at Ward sisters meeting to discuss increasing the number of referrals made to the continence service.</li> <li>• Information regarding dietary advice given prior to discharge. Action: Presentation to be given at Ward sisters meeting to discuss increasing the number of referrals made to the continence service.</li> <li>• Easy read versions of information leaflets about discharge to be given were necessary on discharge. Action: To review current easy read leaflet and update accordingly.</li> <li>• Improve the quality of referrals being sent out to community teams. Action: Community referral for care homes to be devised and uploaded onto evolve for staff to access.</li> <li>• Improve the use of the discharge checklist on discharge. Action: Discharge Checklist at the time of audit was being reviewed and a new version was implemented. Alongside this the Adult Safeguarding Lead will discuss the importance of using these at all training sessions given.</li> <li>• Update nursing and medical staff on the findings from this audit. Action: Presentation to be given at Ward sisters meeting and Grand round.</li> <li>• Update L&amp;D staff and partners on the results of this Audit. Action: Complete a presentation at a learning event where representations from all partners are present.</li> </ul>



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<b>GYNAECOLOGY RECORD KEEPING AUDIT 2017</b>  <b>N = 20</b>	O&G	Audit	August 2017	<b>Main Aims:</b> <ul style="list-style-type: none"> <li>Measure compliance with standards set out by NHSLA, CQC and local guidelines</li> </ul> <b>Findings:</b> <ul style="list-style-type: none"> <li>53% of standards fully compliant</li> <li>5% of standards with high compliance</li> <li>9% of standards with moderate compliance</li> <li>33% of standards with low compliance</li> </ul> <b>Key Recommendations/Actions:</b> <ul style="list-style-type: none"> <li>Improve standard of discharge letters, missing test results, documentation of medication, clinical narrative and patient information. Action: Support for junior doctors to complete discharge letters in a timely way to ensure important information is not omitted. Post op patient letters to be written by the person performing the op or senior to ensure accuracy is improved</li> <li>Legibility of handwriting to be improved, printing of names or use of stamps requires to be more widespread, especially amongst medical staff. Action: Staff need to be made aware of the difficulties of interpreting handwriting and importance of clear legible documentation</li> <li>Missing patient information on parts of records, i.e. no name, hospital number. Action: All staff entering information in records to be made aware o importance of documentation. Use of Evolve to print off the continuation sheets</li> </ul>
<b>TRUSTWIDE PAIN SURVEY 2017</b>  <b>N = 133</b>	Anaesthetics	Survey	August 2017	<b>Main Aims:</b> <ul style="list-style-type: none"> <li>Measure the efficacy of the action plans formulated within previous surveys.</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>Inform the ongoing development of pain management care for all in-patients at the Luton and Dunstable Hospital NHS Foundation Trust.</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>Pain scores were recorded with every observation in 92% of cases. This continues to be the case within this audit. However we have examined this further and looked at the Women's and Children's directorate in more detail. We have shown that the maternity department have the least amount of pain scores completed. With the rest of the hospital completing pain assessment 100%.</li> <li>It is clear that the introduction of Ward Ware into the hospital has had a big impact on pain assessment documentation. However, the women's and children's directorate (specifically Maternity Dept.) do not have Ward Ware due to specific needs for documentation in these areas. Karlsten (2005) and Gordon (2008) found that regular documentation enforces some kind of action, and this subsequent management was found to lead to improvements in patient satisfaction. However, simply having a pain score documented is not sufficient; patients' and nurses' pain reports have been found to be incongruent (Chang 2010).</li> <li>I think we need to be mindful of this research. It is important for health care professionals to understand the subjective nature of pain. They also have to understand, reflect on and challenge their own inherent attitudes and beliefs regarding a person in pain. This is reflected regularly in our pain teaching. This is an area which would benefit from further audit, to investigate and demonstrate improvements in nurses and patients pain reports. The hypothesis being that the more congruent nurses and patients are in the pain assessment, the better the outcomes and management of pain will be. This will have an impact and improve patient</li> </ul>

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				<p>satisfaction and develop the therapeutic relationship.</p> <ul style="list-style-type: none"> <li>• Sixty nine percent of patients surveyed reported they experienced pain during their admission. This is a reduction from previous surveys; however this does not show any particular relevance as patient's main complaint and reason for admissions to hospitals can be pain. It is how we manage it that is the important indicator.</li> <li>• Fifty three percent experiencing pain described it as unbearable in the 2015 survey. We have shown a 17% improvement in the amount of unbearable pain. Overall 69% in 2017 experienced pain compared to 75% in 2015.</li> <li>• A question we believed was important to add within this audit was to find out if the patient's pain is acute or chronic. We inputted this data as patients often do not understand the terminology. This is important. The management of acute and chronic pain are very different. We may not offer traditional methods of analgesia and would opt to provide information and support for services within the community. We can see that chronic pain 21% of patients surveyed had a chronic pain condition. 15% reported it as unbearable pain and 70% medium pain. We will consider in the next audit asking this group of patient's different questions regarding their pain management experience in the hospital setting.</li> <li>• We know acute pain is usually associated with an underlying physiological (labour pain) or pathological (postoperative pain) process. Therefore it is understandable that many of our patients are admitted with a painful problem. It may be recurrent, with or without a background of ongoing chronic pain, (e.g. sickle cell disease, rheumatoid arthritis). Particularly after surgery, patients will be subjected to degrees of pain and we need to be able to assess this pain, commence pain strategies</li> </ul>

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				<p>preoperatively if possible and implement strategies to minimise the pain so that the patient is able to deep breath, cough and mobilise comfortably postoperatively. The RCoA pain management audit recipes (2012) states, effective pain control relies on recognition of an analgesic need by regular assessment and appropriate treatment. Regular assessment can be tied in with routine physiological observations. In most patients pain control plans should result in good pain control. Identifying patients in whom that plan has not been entirely effective should lead to improved methods. Patients identified as having moderate or severe pain should have this managed and dealt with. Where this does not occur further investigation is indicated. This audit would be a useful aid to check compliance with regular pain assessment, quantifies the prevalence of significant pain, and identifies patients in whom subsequent assessment indicates that the pain was not effectively brought under control.</p> <ul style="list-style-type: none"> <li>• Ninety two percent of patients reported that staff asked if they were in pain compared to 90% in the previous survey. However, it is interesting as this differs as 100% of patients had a pain score documented on Ward Ware. This shows a small difference in patients self-report and what is documented.</li> <li>• Ninety five percent of patients felt that staffs were understanding and sympathetic about their pain, compared to seventy five percent on the last survey. The action plan from the previous survey was to increase education in surgical and medical wards in the form of workshops to improve assessment skills. On pain ward rounds we worked with the nurses on an informal basis to help improve communication with patient around pain assessment.</li> <li>• The audit still shows a lesser amount of sympathy and understanding was offered within the medical directorate compared to surgery however a significant overall improvement has been achieved compared to last</li> </ul>

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				<p>year's results.</p> <ul style="list-style-type: none"> <li>• Suggestions were made by staff to reduce pain in 97% of cases, of which, painkillers was suggested in the majority (78%). The previous survey identified suggestions were made by staff to reduce pain in 89% of cases. Pain killers were suggested in 72% of cases. 3% of patients felt nothing was suggested compared to 11% from the previous survey. This is a decrease from the last audit. An overall improvement of 8% compared to previous survey in staff making suggestions to improve pain.</li> <li>• Fifty one percent of patients reported that they received pain medication immediately after it was requested compared to 62% in the previous survey. Thirty seven percent of patients reported they waited for an acceptable amount of time compared to 19% from the previous survey. Overall the survey shows an improvement as 88% of patient waited an acceptable time period to get their analgesia compared to 81% on the last survey. A reason for this improvement could be due to the EPMA system being fully implemented across the trust. 10% felt they had to wait a long time to receive pain medication compared to 19% on the last survey. Since the last survey we have worked hard to improve education for staff regarding timely administration of analgesics.</li> <li>• There has been improvement (from 66% to 73%) in the percentage of patients reporting that a nurse/doctor returned to check on their pain following pain relief. The worst performing area continues to be the medical directorate. 76% of patients reported that the nurse or doctor re-evaluated the pain after an intervention was made. 24% said the nurse/doctor did not evaluate. Although comparing to the other directorates they are still the worst performing area they are showing a significant improvement. Again we have worked hard at our training programmes especially across the medical directorate with informal ward</li> </ul>

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				<p>based education.</p> <ul style="list-style-type: none"> <li>Ninety six percent of patients felt nursing staff helped manage their pain compared to 89% in the previous survey. This is an improvement from the last survey having only 4% patients not feeling that nurses have done all they can to manage their pain.</li> <li>Fifty percent of patients experienced pain during the night, of which 84% felt it was managed appropriately. The previous survey identified 61% of patients experienced pain during the night, of which, 70% felt it was managed appropriately and 30% felt it was not managed appropriately. Patients do tend to experience more pain at night time. This is a common problem for anyone suffering with pain, this may be due to environment factors for example: sleeping in a different bed, noise levels, no distraction. However it is important we ensure the patient is listened to and treated appropriately. We can see there has been a significant improvement in pain management at night compared to the last survey.</li> <li>Sixty one percent of patients felt overall their pain was managed very well, 30% felt it was managed reasonably well, 8% felt it could have been managed better and 1% felt it was not managed well at all. So overall 91% patients felt their pain management was treated appropriately compared to 74% on the previous survey. We have seen a significant improvement and patients are reporting that they are satisfied with their pain management overall.</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <p>Pain score in Maternity department not always documented.</p> <ul style="list-style-type: none"> <li>Differing documentation in Maternity than the rest of the Trust – discuss with senior management within directorate to improve documentation.</li> </ul>

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				<ul style="list-style-type: none"> <li>• Discuss findings of audit at matrons meeting to enable feedback.</li> <li>• Identify dedicated pain link nurses for maternity wards</li> </ul> <ul style="list-style-type: none"> <li>• Continue training in importance of pain assessment and management.</li> </ul> <p><u>Re-assessment of pain management intervention in medical directorate.</u>  24% said the nurse/doctor did not evaluate their pain management in medical directorate. Although improvement has been seen compared to last survey.  b) 5% of patients felt the hospital staff were not understanding and sympathetic about pain. A lesser amount of sympathy and understanding was offered within the medical directorate. Although improvement has been seen compared to last survey.</p> <ul style="list-style-type: none"> <li>• Discuss findings of audit at matrons meeting to enable feedback.</li> <li>• Re-confirmation of pain links on medical wards and encourage attendance to pain update meetings.</li> <li>• To implement PIPPA signs for patient bedside to remind/encourage staff to assess, treat and re-assess pain.</li> <li>• Continue to deliver training across medical directorate including informal sessions.</li> </ul> <p>85% of patients with chronic pain reported moderate to unbearable pain.  Add into Stat training and other pain teachings a reminder to fill in nursing assessment and care plans – section 2. Pain assessment. Allowing staff to understand patients pain in more detail, does the patient already take pain killers before admission? What is their normal pain score? etc.</p> <ul style="list-style-type: none"> <li>• Snap shot audits to monitor the use of the nursing assessment booklet and whether staff are filling the pain section out.</li> <li>• Re-consider the questions for the following audit for patients with chronic pain</li> </ul>

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<b>PAEDIATRIC ENDOCRINE PATIENT SATISFACTION SURVEY</b>  <b>N = 7</b>	<b>Paediatrics</b>	<b>Survey</b>	<b>August 2017</b>	<p><b>Mains Aims:</b> The main aims of the survey are:</p> <ul style="list-style-type: none"> <li>• To identify levels of patient satisfaction amongst paediatric endocrine patients</li> <li>• To ensure the service provided at the L&amp;D meets the needs of families and to ensure problems are kept to a minimum</li> <li>• To identify further specific areas for improving patient experience and services to meet current demand</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>• Forty three percent of parents stated they are seen on their appointment time 'all of the time'. Forty three percent stated 'most of the time', the remaining 14% (1 patient) stated they are 'never' seen on their appointment time</li> <li>• Seventy two percent of parents were happy with their child's appointment arrangements 'all the time'. Fourteen percent were happy with arrangements 'most of the time', and 14% were happy 'sometimes'</li> <li>• All parents felt Endocrine doctors are friendly 'all the time'</li> <li>• All parents felt able to ask questions 'all the time'</li> <li>• All parents felt Doctors explained the treatment plan in a way that could be understood 'all the time'</li> <li>• Eighty six percent of parents felt there is good communication regarding their child's latest treatment plan between the Doctors at their London hospital and the Doctors here 'all the time'. Fourteen percent felt this was the case 'most of the time'</li> <li>• All parents felt clinic staff are approachable and friendly 'all the time'</li> <li>• All parents received their child's appointment for investigation within an appropriate time following their clinic appointment</li> <li>• All parents received a letter and information regarding their appointment</li> <li>• All parents felt information they had received regarding the investigation was understandable and easy to read</li> </ul>



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				<ul style="list-style-type: none"> <li>• All parents felt that on admission staff talked to them and their child regarding what was involved in the Cortisol profile test</li> <li>• All parents stated their child's Cortisol investigation started soon after their arrival to the ward</li> <li>• Most parents (86%) felt their child's cannula or the investigation was inserted skilfully 'all the time'. The remaining 14% felt this was the case 'most of the time'</li> <li>• Sixty percent of parents stated the play therapist was available for their child's cannula procedure 'all the time'. Twenty percent stated this was the case 'sometimes' and the remaining 20% felt this was the case 'never'</li> <li>• Twenty nine percent of parents found their child's cannulation procedure frightening 'all the time'; 14% found it frightening 'most of the time'; 29% found it frightening 'sometimes'; and 29% 'never' found the procedure frightening</li> <li>• Most parents (67%) felt there was enough play and distraction for their child 'all the time', and 33% felt this was the case 'most of the time'</li> <li>• Most parents felt the nurse looking after their child was friendly throughout their stay 'all the time'; 17% felt this was the case 'most of the time'</li> <li>• Eighty three percent of parents felt the service is flexible to allow for holidays 'all the time'; 17% felt this was the case 'most of the time'</li> <li>• All parents felt they understood their child's emergency regime</li> <li>• Most parents (72%) felt they were able to administer their child's emergency hydrocortisone injection; 14% felt they were unable to and the remaining 14% were not sure if they were able to administer the injection</li> <li>• All parents felt they have received adequate training on the emergency regime</li> <li>• Most parents (86%) felt confident to administer the emergency injection; 14% (1parent) did not feel confident</li> </ul>

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				<ul style="list-style-type: none"> <li>• Thirty three percent of parents felt they have adequate support in the community ;most of the time'; the remaining 67% felt this was the case 'sometimes'</li> <li>• Eighty six percent of parents stated their child has a School Care Plan</li> <li>• Half of parents felt their child's school understood their condition, whilst the other half felt their child's school did not understand</li> <li>• Forty three percent of parents felt they are given enough verbal and written information regarding their child's condition 'all the time'. Forty three percent felt this is the case 'most of the time', and 14% felt this is the case 'sometimes'</li> <li>• Just over half of parents (57%) are aware of all the charities offering support, with the other half not aware</li> <li>• Twenty nine percent of parents were aware of patient information days run by charities, whilst 71% were not aware of these</li> <li>• Forty three percent of parents felt they would like more psychological help in dealing with their child's condition</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• To incorporate school visits into job description for newly diagnosed children or those with issues at school regarding their condition</li> <li>• Increase parents awareness of charities and organisations they can choose for further support</li> <li>• Need for more psychological support for families affected</li> </ul>
<b>SURVEY OF PARENTAL PERCEPTION OF THEIR CHILD'S ENDOCRINE CONDITION &amp; TREATMENT</b>	<b>Paediatrics</b>	<b>Survey</b>	<b>August 2017</b>	<p><b>Mains Aims:</b></p> <p>The main aims of the survey are:</p> <ul style="list-style-type: none"> <li>• To identify parents perception of their child's endocrine condition and treatment</li> <li>• To improve our understanding on how families in our region cope with childhood endocrine conditions</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
N = 10				<ul style="list-style-type: none"> <li>To identify specific areas for improving the service through better understanding</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>Ninety percent of parents stated they were given verbal information at the time of diagnosis. Seventy percent felt they were given written information. Ten percent felt they were told about a website for more information, and 20% felt they were given a leaflet AND a website or more information. None of the parents felt they weren't given any information at the time of diagnosis</li> <li>Ninety percent of parents felt the information they received when their child was diagnosed was adequate</li> <li>Most parents would have preferred the information given in English (70%). The remaining would have preferred it in Bengali/Urdu.</li> <li>All parents felt they fully understood their child's diagnosis</li> <li>None of the parents felt their language was a barrier to understanding their child's condition</li> <li>All parents understood why their child takes prescribed medication</li> <li>Most parents (90%) had an Endocrine Nurse Specialist for their child. The remaining 10% (1 parent) was not sure</li> <li>All parents were aware of whom to call in case of an emergency</li> <li>Eighty nine percent of parents stated they call the Doctor/Endocrine Nurse Specialist for advice. Of these, most (87.5%) contacted them occasionally and the remaining contacted them regularly</li> <li>Forty four percent of parents stated they/their child has seen a psychologist/family therapist because of the Endocrine condition. The remaining 56% had not been seen by psychologist/family therapist</li> <li>Thirty three percent of parents felt they would have liked more psychological support when their child was diagnosed</li> <li>Forty percent of parents stated other members in their family have the same condition</li> </ul>

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				<ul style="list-style-type: none"> <li>• Thirty percent of parents stated they were related by blood to their spouse/partner</li> <li>• Eighty percent of parents felt people in their family/community think that this is only a medical condition; 20% felt their family/community thought that the endocrine condition can spread between people; 30% of parents felt their family/community thought that this is because of fate/destiny</li> <li>• Eleven percent of parents stated they felt isolated all the time; 56% stated they felt isolated some of the time; 33% did not feel isolated at all</li> <li>• Forty five percent of parents felt they received support from their extended family/relatives regarding their child's condition; 11% received support from their friends; 33% received support from both family and friends and 11% stated they received no support</li> <li>• Seventy five percent of parents would have liked to have been introduced to other parents with a child with the same condition</li> <li>• Eighty percent of parents felt the medical information given to them may affect the way they treat and manage their child with the condition; 20% of parents felt their child's age may have an affect</li> <li>• Only 1 parent (10%) stated they use other therapies or their child and this was 'special prayers'. This was used 'before their child saw a doctor'</li> <li>• No parents were using other treatments other than NHS-prescribed treatments</li> <li>• Thirty three percent of parents felt it would help if health professionals had a better understanding of their cultural, religious and health beliefs whilst managing their child's endocrine condition</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• Set up parent and teenage support group sessions</li> <li>• The need for a psychologist - To be considered by service providers for future</li> <li>• Ensure written information is provided and parents are aware of support from charities</li> </ul>

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<b>TRAUMA &amp; ORTHOPAEDIC INTERNAL HEALTH RECORD KEEPING AUDIT 2017</b>  <b>N = 20</b>	<b>T&amp;O</b>	<b>Audit</b>	<b>September 2017</b>	<b>Main Aims:</b> <ul style="list-style-type: none"> <li>Measure compliance with standards set out by NHSLA, CQC and local guidelines</li> </ul> <b>Findings:</b> <ul style="list-style-type: none"> <li>10% of standards fully compliant</li> <li>46% of standards with high compliance</li> <li>25% of standards with moderate compliance</li> <li>19% of standards with low compliance</li> </ul> <b>Key Recommendations/Actions:</b> <ul style="list-style-type: none"> <li>A high number of failed standards were due to a mix o hand written notes and electronic records (which proved most accurate). Action: to complete the transition to fully electronic notes and eliminate written notes</li> </ul>
<b>ESSENCE OF CARE RESPECT &amp; DIGNITY TRUSTWIDE AUDIT 2016/2017</b>  <b>118 Patient Questionnaires</b>  <b>16 Data Collector Questionnaires</b>	<b>Corporate</b>	<b>Survey</b>	<b>November 2017</b>	<b>Mains Aims:</b> <ul style="list-style-type: none"> <li>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</li> </ul> <b>Findings:</b> <ul style="list-style-type: none"> <li>94% of patients felt they had enough privacy when being examined and treated always, 5% felt this was the case sometimes and 1% felt they were not given any privacy</li> <li>98% of patients felt curtains were well fitting and long enough to provide adequate privacy.</li> <li>73% of patients stated staff always knock/ask before entering their bed</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<p>area/room. A further 22% stated staff sometimes knock/ask before entering. 5% stated staff do not knock or ask before entering</p> <ul style="list-style-type: none"> <li>• 93% of patients felt they always had enough privacy when using the commode or toilet. Eighty nine percent of patients felt they always had enough privacy when washing by their bed.</li> <li>• 89% of patients always felt their personal space/bed area was respected and protected.</li> <li>• Only 73% of patients stated that staff always introduced themselves on initial contact, and 81% stated that staff discussed what name they would like to be called by.</li> <li>• 89% of patients felt they were always given enough privacy when discussing their condition or treatment. A further 9% felt this was the case sometimes</li> <li>• 29% of patients felt that information about them was shared inappropriately, i.e. in a way that could be overheard or overseen.</li> <li>• Most patients were either always (92%) or sometimes (8%) happy with the way in which staff communicated with them.</li> <li>• 99% of patients felt they have been supported by staff to maintain confidence and a positive self esteem.</li> <li>• 97% of patients felt they have been listened to and have been supported to express their wants and needs.</li> <li>• Most patients (99%) felt their modesty was maintained when moving between wards/departments.</li> <li>• 99% of patients felt they have been treated with dignity and respect throughout their time in hospital, and 100% of patients were overall satisfied with their experience with regards to respect and dignity.</li> <li>• 55% of wards/areas were divided into male/female sides/ends.</li> <li>• 83% of areas stated their patients were in single sex bays</li> <li>• 86% of areas stated their toilets/washrooms were single sex</li> <li>• Most toilets/bathrooms were lockable.</li> <li>• 94% of areas had a nurse call bell in place in toilets/washrooms which patients could access in case of an emergency.</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>• 94% of areas felt their toilets/washrooms were well maintained and cleaned regularly.</li> <li>• Only 88% of areas had a room for patients and relatives where discussions could be carried out in private.</li> <li>• 46% of areas do not have privacy signs on bed curtains.</li> <li>• 20% of areas stated they do not have sufficient supplies of night clothes on their ward</li> <li>• In 81% of areas all staff were aware of respect and dignity guidelines and in 19% some staff were aware of the guidelines.</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• Reinvigorate the 'hello my name is' campaign</li> <li>• Include in daily safety briefing for 2 weeks (preferred name to be documented in handover and on the patients board above the bed/chair)</li> <li>• 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</li> <li>• Ensure use of 'Dignity Curtains'</li> <li>• Remind staff and board round / safety brief</li> <li>• Ensure domestic / housekeeping staff are aware</li> <li>• Remind all ward visitors (therapists, volunteers) to ask permission before entering</li> <li>• Obtain patients permission for medical students to attend ward round</li> <li>• Procurement to source products such as 'modesty pants'. These are to be available in a variety of sizes</li> <li>• Patients relatives / visitors are to be encouraged to provide the patient with their own clothes</li> </ul>
<b>AUDIT OF EMERGENCY THEATRE UTILISATION</b>	<b>Anaesthetics</b>	<b>Audit</b>	<b>December 2017</b>	<p><b>Main Aims:</b></p> <ul style="list-style-type: none"> <li>• To assess the utilisation of emergency theatre.</li> <li>• To establish whether there is effective use of the emergency space on a</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
<b>2017/2018</b>  <b>N= 114</b>				<p>daily basis .</p> <ul style="list-style-type: none"> <li>• To establish the interval between the time of booking and time patient arrived into theatre (anaesthetic room)</li> <li>• Identify the number of patients booked per day .</li> <li>• Identify the number of patients booked per speciality .</li> <li>• Identify the reasons why surgery was not performed/cancelled .</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>• During the three week audit period, the overall number of recorded emergency bookings was 114.</li> <li>• Out of these, 104 (91%) patients had their surgery performed and 10 (9%) patients were recorded cancelled.</li> <li>• General Surgery had the highest number of cases booked (53/114) 47 %.</li> <li>• Both Max Fax and Gynaecology Unit booked (21/114) 18 %.</li> <li>• The lowest number was Trauma (2/114) 2% .</li> <li>• There is a dedicated theatre for trauma patients on a daily basis. However, the 2 trauma cases identified were undertaken during out of hours and the other during the day due to less activity in emergency theatre.</li> <li>• Findings show that almost 53% of the cases were performed within 0-14 hours.</li> <li>• Of a total of 104 cases performed, the highest number 17/104 (16%) cases were operated upon between 0-2 hours and majority of them are general surgery.</li> <li>• 11/104 (11%) patients waited in excess of 18 hours which was significantly high.</li> <li>• Reasons for delay were not available on booking forms thus, limited the project lead to analyse the findings of this project.</li> <li>• Reasons why surgery was cancelled were due to a combination of factors. "Patient opened his bowels" (1/10), "Patient operation no longer</li> </ul>



Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<p>needed" (1/10) "Rescheduled for elective list, "Patient case is difficult" (2/10), "no surgeon available" (1/10), "Procedure done in the ward" (2/10), (3/10) reason for cancellation were not documented.</p> <ul style="list-style-type: none"> <li>Maximising theatre utilisation is obviously desirable in our emergency department. Our emergency theatre was utilised appropriately during the audit period in spite of the unpredictable nature of emergency cases .However potential improvements can be made, including accurate documentation of delays. Once delays are identified, further changes can be implemented to counter these. Another audit should be performed to measure other factors that were not covered by this exercise. Using a proforma for each case booked will be useful for future audit to ensure accurate data collection and analysis.</li> </ul> <p><b>Key Recommendations/Actions:</b> The audit identified there were few delays in utilisation of the emergency theatre. However, there was no documentation regarding the reason for the delays. Actions include:</p> <ul style="list-style-type: none"> <li>Re- design the booking form to include a section for other necessary information" for future references.</li> <li>Re-audit and focus on the reasons for delay.</li> <li>Present the audit findings at the Clinical Governance Meeting.</li> </ul>
<p><b>QUALITY OF ADULT SAFEGUARDING REFERRAL FORMS</b></p> <p><b>N = 20</b></p>	Corporate	Audit	January 2018	<p><b>Mains Aims:</b></p> <ul style="list-style-type: none"> <li>Review the quality of referrals into the Trusts Adult Safeguarding Team and if the information given identified that staff had fulfilled their duties and worked effectively to ensure that adults at risk of abuse or harm attending the Luton and Dunstable University Hospital were identified and that an appropriate referral was completed to the Adult safeguarding Team.</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>33% of standards fully compliant</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>• 17% of standards with high compliance</li> <li>• 17% of standards with moderate compliance</li> <li>• 33% of standards with low compliance</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• Timely referrals to the Adult Safeguarding Team. <b>Action:</b> Add additional training on the quality of referrals and the timeliness of these into the ongoing Level 3 Adult Safeguarding Training Programme.</li> <li>• Lack of contact details for the individual at risk and no documented evidence that the individual was consulted prior to referral being submitted. <b>Action:</b> Review of the current Datix referral process for Adult Safeguarding.</li> <li>• <b>Update:</b> referral process has now been adapted and changed to ensure contact details, capacity/consent are mandatory fields.</li> <li>• Documentation of the immediate actions taken by staff to safeguard the individual at risk. MSP compliance. <b>Action:</b> Add additional training on the quality of referrals, MSP and the documentation of staff responses to safeguard the individual at risk into the ongoing Level 1,2 &amp; 3 Adult Safeguarding Training Programme.</li> <li>• Perpetrators details to be logged where possible although it is noted staff may not always be able to access this information. <b>Action:</b> Adult Safeguarding Team to continue to review all Datix referrals and identify any details that are available prior to sending to the Local Authority to ensure correct information is given at the initial referral stage.</li> </ul>
<b>GENERAL SURGERY/UROLOGY INTERNAL HEALTH RECORD KEEPING AUDIT 2017/2018</b>  <b>N = 20</b>	<b>General Surgery/Urology</b>	<b>Audit</b>	<b>January 2018</b>	<p><b>Main Aims:</b></p> <ul style="list-style-type: none"> <li>• Measure compliance with standards set out by NHSLA, CQC and local guidelines</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>• 59% of standards fully compliant</li> <li>• 16% of standards with high compliance</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>10% of standards with moderate compliance</li> <li>15% of standards with low compliance</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>Inclusion of correspondence/referral details from referrers in the health record has dropped from 85% to 50%. <b>Action: For presentation at General Surgery CGM and induction for junior doctors</b></li> <li>Electronic discharge letters show low compliance with record keeping in 4 areas. <b>Action: For presentation at General Surgery CGM and induction for junior doctors</b></li> </ul>
<b>RE-AUDIT OF THE ADMINISTRATION OF INTRAVITREAL INJECTIONS IN OPHTHALMOLOGY</b>  <b>N = 95</b>	Ophthalmology	Re-Audit	January 2018	<p><b>Mains Aims:</b> Re-measure compliance with the revised protocol of administration of intravitreal injections. Specifically to:</p> <ul style="list-style-type: none"> <li>Identify whether the Ophthalmology Department are adhering to the revised protocol</li> <li>Identify areas where compliance with the protocol need to be improved</li> <li>Identify areas of good practice</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>Full compliance with all of the standards</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>No risks identified – fully compliant with all standards</li> </ul>
<b>OMFS INTERNAL HEALTH RECORD KEEPING AUDIT 2017/2018</b>  <b>N = 20</b>	OMFS	Audit	January 2018	<p><b>Main Aims:</b></p> <ul style="list-style-type: none"> <li>Measure compliance with standards set out by NHSLA, CQC and local guidelines</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>80% of standards fully compliant</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<ul style="list-style-type: none"> <li>• 7% of standards with high compliance</li> <li>• 3% of standards with moderate compliance</li> <li>• 10% of standards with low compliance</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• All notes written for inpatients must have a recorded time with date of note entry</li> <li>• For all cases the type of anaesthesia must be recorded. If Consent 3 forms are being used then clinicians must specify if local anaesthesia is being used by crossing out or marking the relevant notation. If Consent form 1 is to be used the appropriate box regarding anaesthesia must be ticked.</li> <li>• Record a reason for admittance where relevant e.g. emergency setting or inpatient procedure if relevant to the GP.</li> <li>• Record 'No drugs on admittance' if there are no drugs on admittance for inpatients.</li> <li>• Include any investigations and results carried out that may be of beneficial use to the GP or for further monitoring.</li> <li>• Include the discharge destination as home for inpatient cases.</li> <li>• Include arrangements for follow up if required.</li> <li>• Mention drugs on discharge on the discharge letter for inpatients and if writing an external prescription. Write 'No drugs on discharge' if no drugs were required.</li> </ul>
<b>TRAUMA EMERGENCY THEATRE UTILISATION AUDIT</b>  <b>N = 26</b>	<b>T&amp;O</b>	<b>Audit</b>	<b>January 2018</b>	<p><b>Main Aims:</b></p> <ul style="list-style-type: none"> <li>• To establish whether there is a delay in starting the first trauma case of the day over a 2 week period (prospectively). Reasons for delays were also assessed.</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>• 46% of patients had an overall journey time of more than an hour to 1.5 hours</li> </ul>

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				<ul style="list-style-type: none"> <li>Reasons for delay included incomplete paperwork on the ward, patients not ready (gown etc.), delays in assessment of patients and huddle starting on time</li> <li>Patients not always optimised overnight and a 'golden patient' was not identified</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>Send for patient at 8 am (senior anaesthetist can see patient in theatres if not seen)</li> <li><u>Golden patient</u> identified by night orthopaedic team and handed over to ward staff to ensure patient ready (handover sheet with specific instructions designed)</li> <li>Night anaesthetic SpR sees golden patient – if anaesthetic issues noted, another patient then optimised</li> </ul>
<b>INTRAVENOUS FLUID THERAPY IN CHILDREN &amp; YOUNG PEOPLE IN HOSPITAL (NICE NG29)</b>  <b>N = 42</b>	<b>Paediatrics</b>	<b>Audit</b>	<b>February 2018</b>	<p><b>Main Aims:</b> The main aims of the audit are to improve IV fluid management in children. Specifically to:</p> <ul style="list-style-type: none"> <li>Identify local compliance with NICE recommendations (NICE Guideline 29)</li> <li>Identify areas where practice needs to be improved</li> </ul> <p><b>Findings:</b></p> <ul style="list-style-type: none"> <li>IV Fluids are used across the whole range of ages of children who present to the Paediatric Department</li> <li>In general, patient's weights are used to calculate fluid requirements, and the Holliday-Segar formula was used in all but one case (98%)</li> <li>However, the way this was calculated was only documented in 14/42 (33%) cases</li> <li>In 4/12 and 5/42 cases, hypotonic saline was used for fluid resuscitation and maintenance respectively. This is not in line with guidance to use</li> </ul>

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				<p>isotonic crystalloid preparations for both purposes</p> <ul style="list-style-type: none"> <li>• In only 20/41 (49%) cases were U&amp;Es measured when starting fluids AND after 24 hours. The majority of failures were when the U&amp;Es were not repeated after 24 hours which, in some cases, was because fluids were stopped soon afterwards</li> <li>• There were slightly more who had a blood glucose measured (22/42 = 52%) which is surprising given we so often perform blood gases.</li> <li>• Fluid balance was only recorded in 60% (25/42) patients at 24 hours, and 34% (14/41) at 12 hours. 11/42 (26%) cases did not have hourly I/O recordings on the charts.</li> <li>• When it comes to the main notes, on commencing fluids, more could be documented in the notes including assessment of fluid status (19/41 or 46% not recorded) and blood results (over 50% not recorded). As time progresses, there was a 12 hourly reassessment of the fluid prescription in 71% cases, hydration levels in 61% cases and a decision of whether oral fluids can be started in 91% cases. Documentation is important to explain the rationale behind our decision-making.</li> </ul> <p><b>Key Recommendations/Actions:</b></p> <ul style="list-style-type: none"> <li>• Hypotonic saline being used for resuscitation and maintenance. <b>Action:</b> Reminder posters, teaching session</li> <li>• U&amp;Es and glucose not consistently being taken or recorded at start of therapy or every 24 hours. <b>Action:</b> Reminder posters, teaching session</li> <li>• Fluid balance at 12 and 24 hours must be accurately recorded. <b>Action:</b> Nursing staff involvement</li> </ul>
<p><b>Protected Mealtime Audit 2017</b></p> <p><b>N=20 wards</b></p>	<p><b>Corporate</b></p>	<p><b>Re-audit</b></p>	<p><b>October 2017</b></p>	<p>The objective of this audit is to:</p> <ol style="list-style-type: none"> <li>1) Repeat audit the current practice of Protected Mealtimes during a lunchtime period</li> </ol> <p>This audit aims to highlight specific areas such as:</p> <ol style="list-style-type: none"> <li>1) Visible or audible evidence of Protected Mealtimes being in progress with</li> </ol>

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				<p>outside ward stands, posters or patient and relative information or Bell ringing inside the ward to alert the beginning of PM.</p> <p>2) Preparation of the patient and their surroundings taking place before the mealtime</p> <p>3) The timings of the meal service and the number of staff involved</p> <p>4) Activity and personnel on the ward during Protected Mealtime</p> <p>5) If relatives or Ward Volunteers were present (and if helping) at mealtime</p> <p>6) If there was sufficient knowledge and understanding about Protected Mealtimes</p> <p>7) For this audit five patients were asked their views about the standard of the meals and drinks provided during their stay in hospital, and if they had received assistance when meals and drinks were provided (if needed)</p> <p>8) Any areas of positive and negative care seen during the audit period</p> <p><b><u>Main Findings and actions to be taken</u></b></p> <ul style="list-style-type: none"> <li>• 75% of all meal services started at the time stated on the trust meal schedule (NEW question)</li> <li>• 75% of the meal times corresponded to the time stated on the board outside the ward (NEW question)</li> </ul> <p><b><u>Improvements seen in this audit</u></b></p> <ul style="list-style-type: none"> <li>• Number of visible Protected Mealtimes signs outside wards (55% instead of 26% in 2016) <b>Ward managers/ward staff</b></li> <li>• Number of wards with closed doors during Protected Mealtimes (previously 74% now 80%) <b>Ward managers/ward staff</b></li> <li>• Number of patients who are now given the opportunity to wash their hands/use wipes prior to their meals (90% instead of 79%) <b>Engie Ward Housekeepers</b></li> <li>• Assistance given to re-position or assist patients in sitting up or out for meal times (85% instead of 74%)</li> </ul>

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<p><b>Ward staff</b></p> <ul style="list-style-type: none"> <li>The wards using a bell to signify the start of Protected mealtimes (60% instead of 37%)</li> </ul> <p><b>Ward staff /Engie Ward Housekeepers</b></p> <ul style="list-style-type: none"> <li>The number of wards where <b>all</b> or <b>some</b> staff were involved in the meal service has improved from 47% in 2016 to 70% in 2017</li> </ul> <p><b>Ward staff</b></p> <ul style="list-style-type: none"> <li>Number of staff and visitors alerted to the PM as they arrived on a ward has increased 10% to 60%</li> </ul> <p><b>Ward staff</b></p> <ul style="list-style-type: none"> <li>A reduction in the cleaning being observed during meal service 25% instead of 32% in 2016 –</li> </ul> <p><b>Engie – Domestic staff</b></p> <ul style="list-style-type: none"> <li>Thirty five per cent of wards in the audit benefit from a volunteer meal time assistant in their area.</li> </ul> <p><b>Voluntary Services</b></p> <ul style="list-style-type: none"> <li>Sixty five per cent of areas staff were aware and knew about PMI. This was an improvement from the 2016 audit.</li> </ul> <p><b><u>Areas unchanged from the previous audit in 2016</u></b></p> <ul style="list-style-type: none"> <li>Clinical Activity taking place during the meal service remains high and unchanged at 70%</li> </ul> <p><b><u>Areas needing improvement &amp; those who can support the improvements:</u></b></p> <ul style="list-style-type: none"> <li>Increase the number of PM floor stands outside ward areas.</li> </ul> <p><b>Ward managers / Matrons &amp; staff</b></p> <ul style="list-style-type: none"> <li>Patients table areas needing clearing before meal services (84% down to 60%)</li> </ul> <p><b>Ward managers/staff</b></p> <ul style="list-style-type: none"> <li>The number of areas where <b>all</b> staff were involved in the meal service has declined from 47% in 2016 to 5% in 2017</li> </ul> <p><b>Ward managers / staff</b></p> <ul style="list-style-type: none"> <li>The number of patients being offered support and encouragement with</li> </ul>



Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<p>eating has reduced to 85% from 94%. More Volunteer Meal time assistants available?</p> <p><b>Ward managers / staff / Voluntary services</b></p> <ul style="list-style-type: none"> <li>• More staff and visitors are to be alerted to the fact that it is PM in order to minimise disruption to the ward during mealtimes –</li> </ul> <p><b>Ward managers / Staff</b></p> <ul style="list-style-type: none"> <li>• Cleaning of ward areas not to take place during meal service –</li> </ul> <p><b>Engie / Estates</b></p> <ul style="list-style-type: none"> <li>• Continued audit of compliance with meal times against trust schedule -</li> </ul> <p><b>Engie / Estates</b></p> <ul style="list-style-type: none"> <li>• Meridian set up to be amended to show result in Red, amber or green (RAG) rating an some questions have been set up incorrectly on the system.</li> </ul> <p><b>Jacqui A-J and Patient Experience to work together to amend</b></p> <p><b><u>Conclusion</u></b></p> <p>Many areas of Protected mealtimes philosophy had improved in this audit since the earlier audit in January 2016 which is to be commended to all those making that possible. Those include all areas mentioned on page 21.</p> <p>Since the earlier audit in January 2016 there have been changes in the distribution of the catering and drinks service from in house to contract catering. The distribution of drinks and meals are now performed by the ward Housekeepers provided by Engie.</p> <p>This may have had an impact on the engagement of the nursing staff (RN's and in particular Health Care Assistants) in the distribution of the meals and an unfortunate reduction in the number of patients being offered helped with their meals. We should however be mindful that 85% of patients were either offered help with meals or didn't require assistance which is the principle reason for the protected mealtime philosophy. The patient satisfaction survey demonstrated that 9% of patients felt that they would have like or needed assistance.</p>

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				<p>Protected meal times is a time for focusing on meal distribution and assistance for the patients but this audit demonstrates that clinical activity continues in 70% of all areas at lunch time.</p> <p>The principle reason for PM is to increase nutrient intake of hospitalised patients and a recent systematic review and meta-analyses of Protected Mealtimes in hospital and nutritional intake Porter <i>et al</i> (2017) concluded that due to the small number of observational studies and the quality of evidence of the effect of the intervention on nutritional intake there was insufficient evidence for widespread implementation in hospitals.</p> <p>However they did acknowledge a meta-analysis of mealtime assistance in hospitals which concluded a statistically significant improvement in daily energy and protein intake in favour of those receiving mealtime assistance (Tassone <i>et al</i> 2015). With this in mind proving adequate support to our patients is essential.</p> <p>One finding in this audit is that more wards are requesting assistance from Mealtime volunteers to support the wards and the patients. However in conversation with the Voluntary Services manager this has been proving difficult in recent months to attract volunteers to this specific role within the trust.</p> <p>The NMC (2015) make it quite clear that the “fundamentals of care such as nutrition and hydration” are a priority in everyday care of our patients. Food and hydration are an essential treatment for patients and should form an important part of the day with support for those requiring assistance.</p> <p>Whilst it isn’t a registered nurses responsibility to feed all their patients at every mealtime it is important that they identify those who are “nutritionally at risk patients” under their care and co-ordinate nutritional care at mealtimes particularly if they are busy with medication rounds or other clinical work at this time.</p>

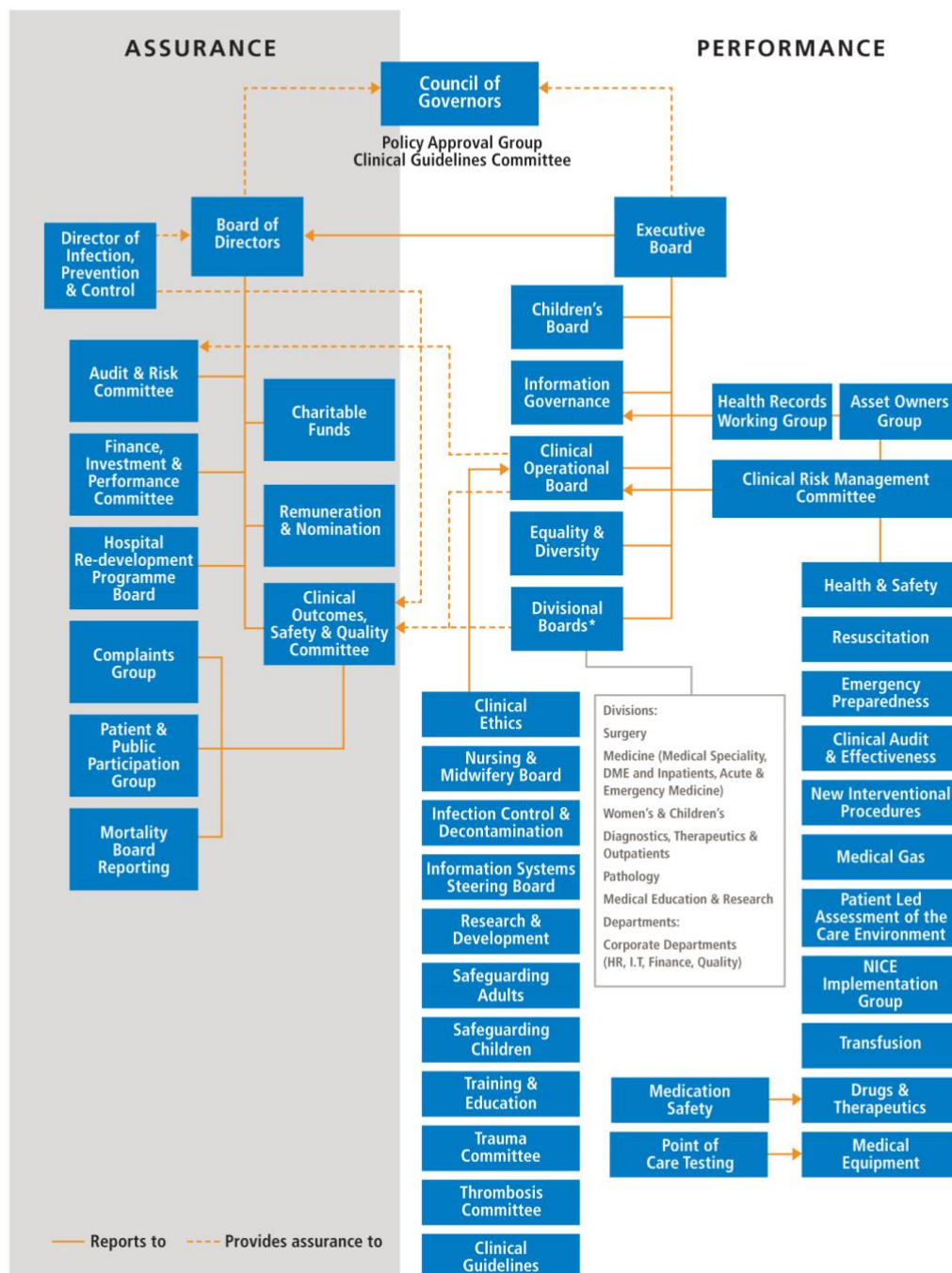
Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Findings, Key Recommendations/Actions
				<p>That said this audit demonstrates that not only does the legacy of the Protected Mealtimes philosophy remain in the trust but improvements have been demonstrated in many areas. The patient side of mealtime assistance is good (85%) but this has been one of the areas which has seen a decrease since the previous audit in 2016. In order to improve outcomes and to provide a quality service for our patients' good nutritional care must remain a priority for all patients (BAPEN 2010).</p>
<p>PLANNED CAESAREAN SECTION AUDIT (Registered title "LSCS Audit- RCOG Maternity Indicators") (n=1351)</p>	<p><b>O&amp;G</b></p>	<p><b>Audit</b></p>	<p><b>February 2018</b></p>	<p>Main aims: To understand how many Elective Caesarean Sections are performed for maternal request including those women who have had 1 previous caesarean where the clinical picture does not indicate medical need.</p> <ul style="list-style-type: none"> <li>• To identify High risk groups for caesarean section and to explore the reasons for the decisions leading to caesarean section in order to focus the appropriate changes to reduce the rate where it is most relevant.</li> <li>• To establish if there are significant factors or groups including indication for caesarean that increase risk.</li> </ul> <p><b>Findings:</b></p> <p>1) 32% of all Deliveries in the 3 month audit were caesarean section</p> <ul style="list-style-type: none"> <li>• 14.2% of total deliveries were Elective Caesarean Sections</li> <li>• 4.5% of total deliveries were Emergency Caesarean Sections</li> <li>• 11% of total Deliveries were Urgent Caesarean Sections</li> <li>• 2.5% of total Deliveries were scheduled Caesarean sections.</li> </ul> <p>2) From the total Elective Caesarean Sections performed, the greatest percentage – 60% - were performed due to previous LSCS</p> <p>3) Only 12% of those women having an Elective Caesarean for previous had been seen in a VBAC clinic, however, 62% of records did not have the information available.</p> <p>4) Of the 6 indications for Elective caesarean advised by the NICE guidelines, we were performing 93% of elective caesarean within guidelines. However, 57%</p>

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				<p>of women with at least 1 previous caesarean section had a repeat caesarean. This needs to be reviewed as we should be looking at why these women were choosing not to have a VBAC.</p> <p>Key Recommendations/actions:</p> <ul style="list-style-type: none"> <li>• To launch and raise awareness of the newly implemented guideline for elective caesarean section for maternal request to ensure the community Midwifery Teams are aware of the pathway of referral as they are the first point of contact and information for pregnant women.</li> <li>• All cases of caesarean section for maternal request would benefit from attending the dedicated clinic to explore 'birth options' and reasons behind choice as well as provide appropriate information and counselling.</li> <li>• To implement an Elective Caesarean pro-forma to collect data on why women are specifically choosing caesarean for any reason other than a medically advised reason ie placenta praevia</li> <li>• To audit the use of the VBAC pro-forma to ensure this is being utilised for every woman who has had up to 3 previous caesarean sections as per NICE guidelines.</li> <li>• Ensure that all women who meet the agreed criteria are referred to the VBAC clinic</li> <li>• All these appropriate cases for VBAC at the VBAC clinic will receive appropriate counselling and support with use of standardised proforma.</li> <li>• For the high number of women choosing a repeat Elective Caesarean Section after only 1 previous caesarean, looking at how we can appropriately counsel women to make an informed choice (these women would be suitable VBAC).</li> <li>• Audit the number of women who choose to come to Luton and Dunstable University Hospital for Elective Caesarean Sections for maternal request having been declined this at their booking hospitals</li> </ul>

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Birth options audit N=19	O&G	Audit	February 2018	<p><b>Aims &amp; objectives</b></p> <ul style="list-style-type: none"> <li>• To establish why a woman had been referred to the clinic and whether or not a debriefing post-delivery had taken place.</li> <li>• To establish whether or not a plan had been put in place following the clinic appointment.</li> <li>• To establish final mode of delivery.</li> </ul> <p><b>Findings &amp; discussion</b></p> <ul style="list-style-type: none"> <li>• 47% of the cases had a referral form and just 53% had a reason documented for that referral.</li> <li>• 68% of referrals were made by obstetricians, whilst only 11% were made by midwives.</li> <li>• 89% of cases didn't have a debrief following their caesarean/traumatic experience.</li> <li>• 53% of women who attended clinic had a plan agreed for birth.</li> <li>• 68% of women referred to the clinic delivered on delivery suite with 16% on MLBU and 5% in theatre.</li> <li>• 37% had an SVD, 11% had an instrumental, 16% had a LSCS and 26% had an ELSCS.</li> </ul> <p>Documentation needs to improved, in order for staff to understand rationale for referrals to the clinic. Midwives need to know how to make referrals and if possible offer it where appropriate.</p> <p>The option to debrief post birth needs to be offered routinely to help women understand what happened at their delivery, and to reduce the anxiety that may accompany this and their decision making for future births. Women need to be invited back if appropriate plans hadn't been put in place at the first appointment to reassure women and try to prevent another traumatic experience.</p>

## Committees of the Board of Directors

### Luton and Dunstable University Hospital Governance and Committee Structure



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