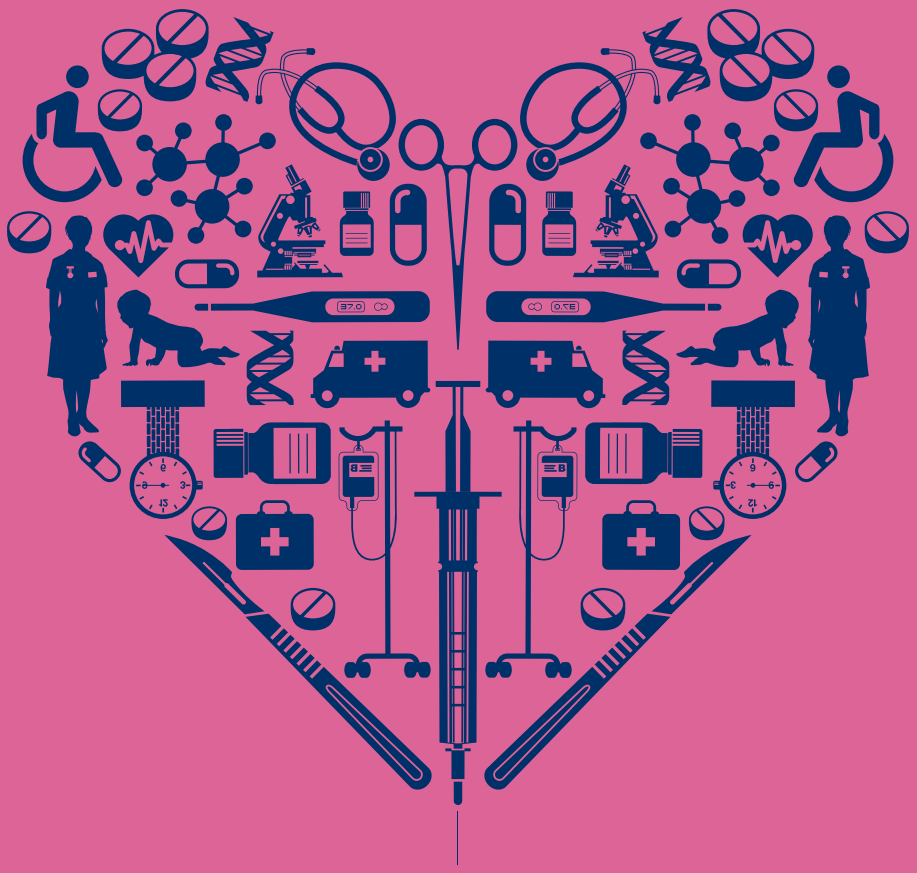
LUTON & DUNSTABLE UNIVERSITY HOSPITAL



Annual Report and Accounts

for the period April 2018 to March 2019
incorporating Quality Account

Luton and Dunstable University Hospital
NHS Foundation Trust

NHS

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

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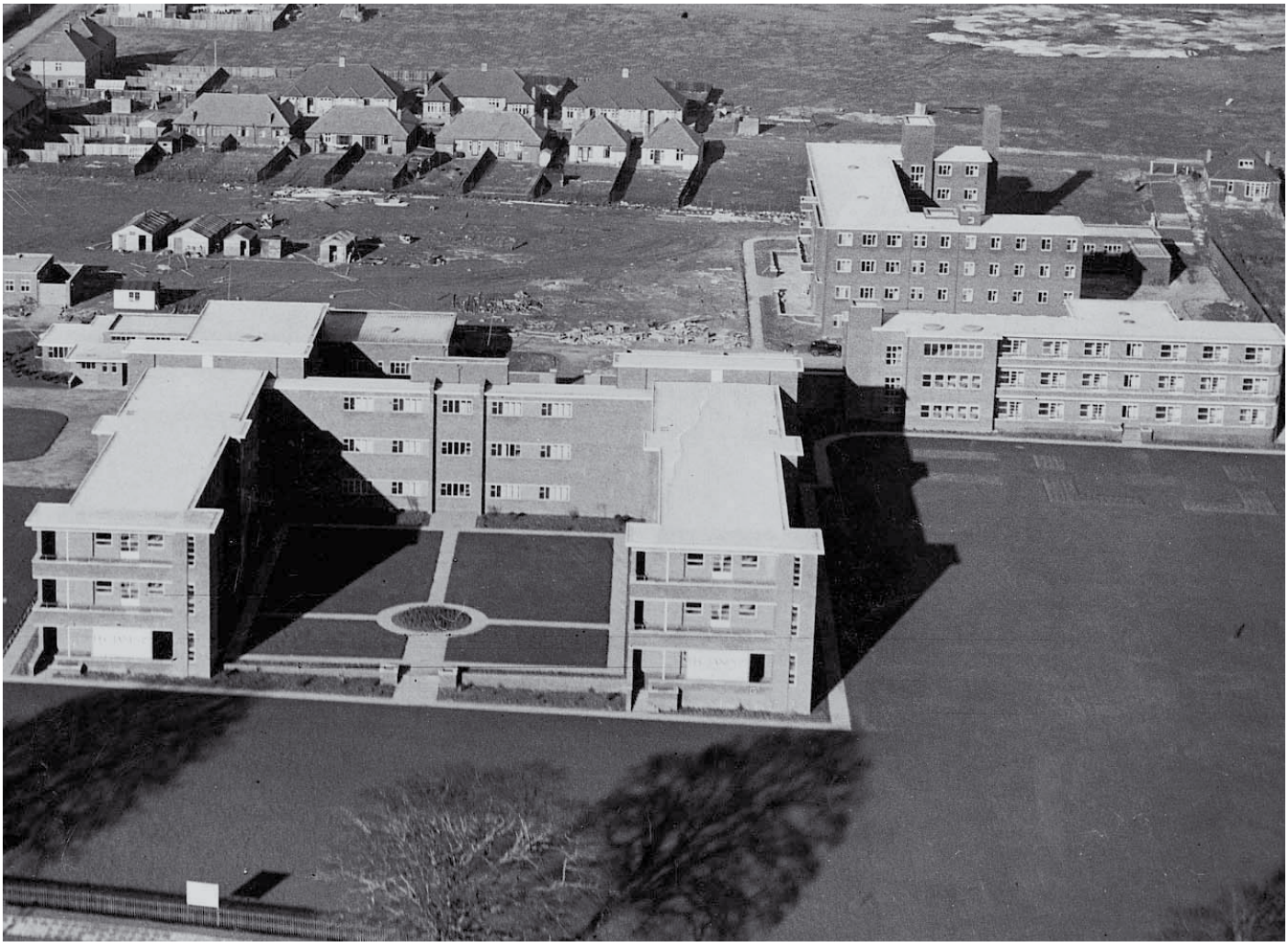
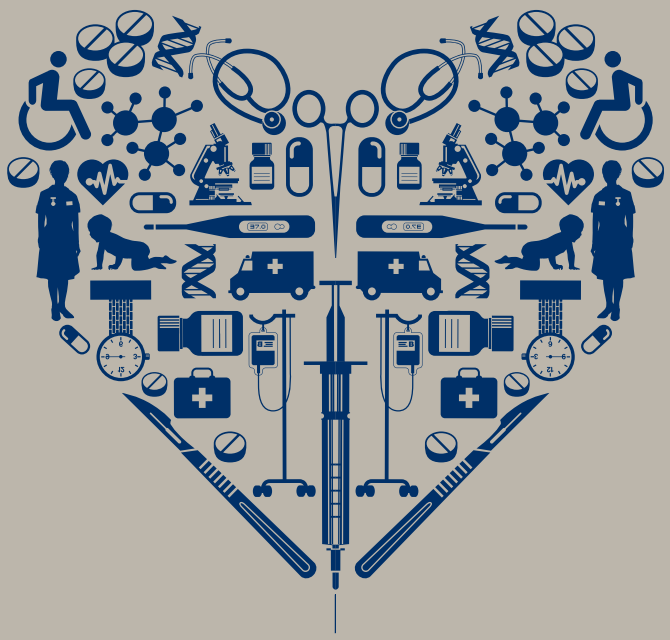
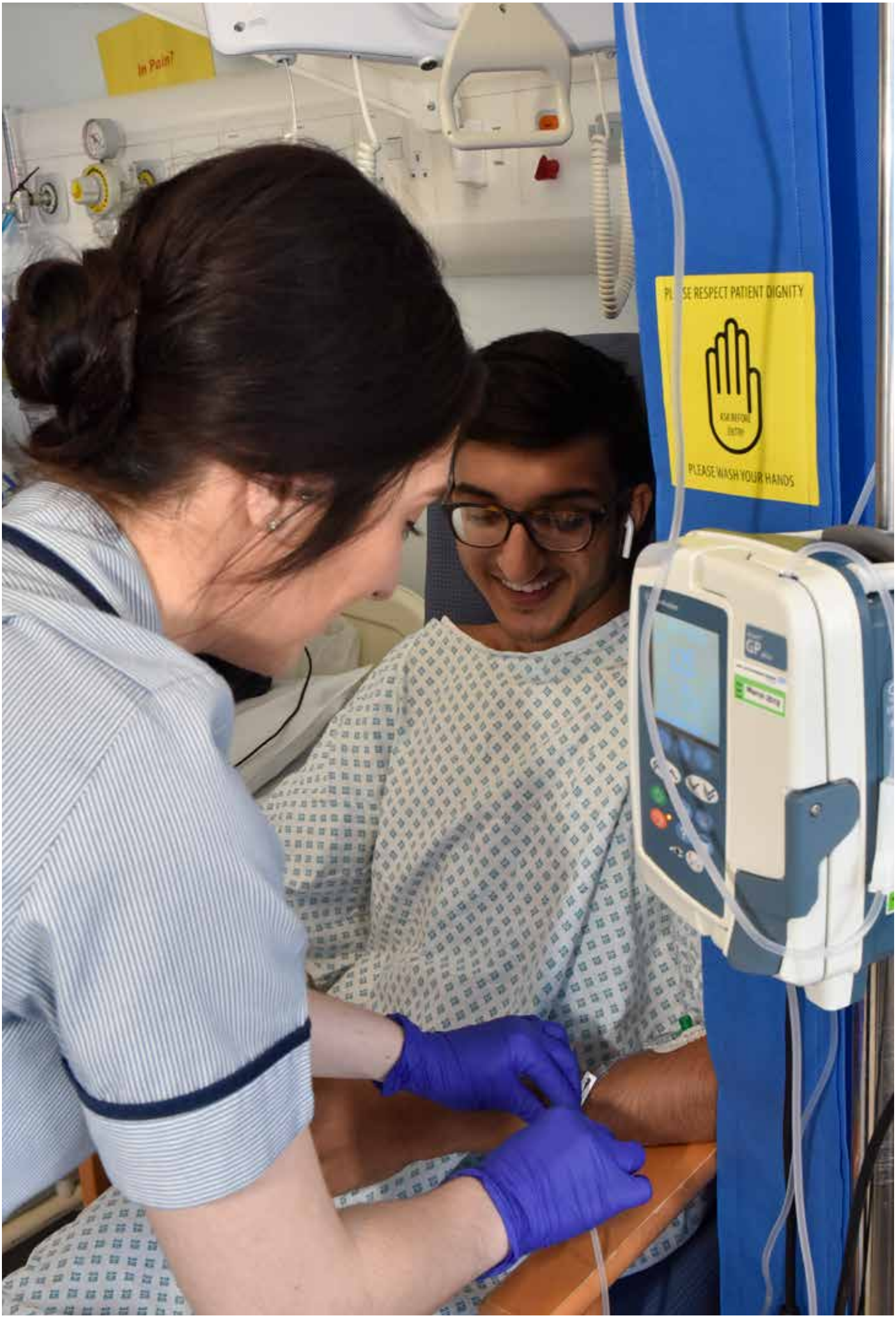


Introduction




In Pain?
SE RESPECT PATIENT DIGNITY
PLEASE WASH YOUR HANDS

About this Report

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

The report is structured as follows:

Introduction

Statements from the Chairman and the Chief Executive

Executive Summary

An overview of the Annual Report

Strategy

The Trust strategic vision, performance against 2018/19 objectives and the corporate objectives for 2019/20

Operational Performance Report

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

Our Patients, Our Staff and Our Partners

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

Governance Report

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

Financial Performance Report

Includes performance against financial targets and any risks for the future

Annual Governance Statement and Annual Accounts

Includes the Annual Governance Statement and the annual accounts

Quality Account

Includes details of the progress against quality objectives for 2018/19, the plans for 2019/20 and the annual quality statements.

Chief Executive Introduction

Dear Colleagues

The Trust has continued its excellent performance in ensuring patients can access our services quickly either through our emergency pathway, as elective outpatients or as a cancer referral. We also met our required surplus amounting to 3% of our turnover and as a result, received performance bonus funding taking our final surplus to £22.6m. This financial performance has been achieved by good operating efficiency (we have the NHS record lowest 'weighted average unit' – this is the measure used by the Model Hospital to measure productivity).

During the year we have concentrated much of our efforts on laying solid foundations to enable us to continue our future success. Whilst some of these changes have been related to our estate (such as our electrical works, our preparedness to create a new energy centre, our new operating theatres and our new endoscopy decontamination unit) the most important ones relate to our people and our services. The publication of the CQC's report and its confirmation of our 'Good' rating (and all core services as at least 'Good') provides us with a platform to achieve our goal of providing 'Outstanding' services. Our quality improvement approach, led by our new Director of Quality, Catherine Thorne, will be our way of achieving that aim.

In the summer staff engagement event we presented the final piece of our work on vision and values with the translation of those values into behaviours. Our foundation for the future is our staff and we recognise that our success has been built on delivering a culture which supports staff to 'live' those values every day.

We are also continuing to build the foundations for our partnership with Bedford Hospital. The development of a plan to bring our pathology services together from April 2020 demonstrates what can be achieved when the two organisations work together with a shared vision. We will continue to look to gain approval for the redevelopment of the hospital and proposed merger with Bedford.

We have engaged actively with the Integrated Care System as we see this as a major part of the solution to achieve a more sustainable local health economy and stem the rising demand for our services. Central to this will be the digital strategy which aims to link up all parties in the system in delivering care to our local patients. We will play a leading role in the delivery of the infrastructure which will support this aim.

In all this is great thanks to a dedicated workforce who were recognised by CQC as 'Good' and who we acknowledge in our vision statement as central to our future success in serving our local population.

David Carter
Chief Executive

Chairman's Statement

Last year I started my statement by addressing the Hospital's performance over that winter ravaged by snow, cold and flu. This winter may have been, on the face of it, less severe in terms of the snow but, as anyone who lived through it will remember, the lack of precipitation was made up for by keen biting winds. Since the year just closed, we experienced our highest number of daily attendances, 550, at A&E; only 10 years ago this figure would have been averaging below 200. The fact that this Hospital managed to survive that pressure and cancelled operations because of equipment, rather than staffing failure - is a tribute to the quality and determination of all those at the Hospital. This was further confirmed by the results of our patient survey, conducted nationally, which makes it very clear that our services are particularly (better than the average) appreciated by those who use them. In part this is because we continue to lead the country on all the core statistics, taken in aggregate, for access to our services – A&E, general medicine, cancer and diagnostic tests. David Carter has addressed this in greater detail in his introduction.

We, as a Board, supported by our excellent group of Governors, are very clear that our "day job" is to maintain that level of service to our local community. But we also have to be aware how the nature of that responsibility is changing:

- We now are expected to participate much more actively in delivering care outside our Hospital boundary while GP services are, themselves, being encouraged to consolidate into "hubs". We are keen to do this.

- All the trends in healthcare are for 24/7 services, which can only be delivered effectively and safely in larger units. Partly because of this drive we are keen to merge with Bedford Hospital and are in regular dialogue as to how this might happen.

- However, in honour of our key commitment to our community which is growing at a significant rate and which, with the Oxford/Cambridge area, is expected to grow much more, we cannot honestly do so unless we have the resources to support that endeavour. Our capital bid of around £100m was not included by the Department of Health funding approvals. We are in active dialogue with the Department as to how that funding evaluation is to be honoured.

This all places additional strain on our executive team which strives to deliver our core performance targets listed above at the same time as doing so efficiently.

We are second highest (i.e. cheapest) in the Weighted Average Unit cost score across the hospital sector and, very unusually, achieve a surplus of around 3% of revenue – all of which, of course, gets reinvested in the services. Our ability to achieve this last year rested in part with our Finance Director, Andrew Harwood, who sadly left at the end of the calendar year after serving the Hospital (always achieving financial targets) for 19 years. His Deputy, Matthew Gibbons, is currently acting in the post and demonstrates the same discipline.

We also welcomed Liz Lees who joined us as our Chief Nurse from June 2019 and Catherine Thorne in a new post as Director of Quality & Safety Governance, between them combining responsibility, with our Medical Directors, for coordinating our core objective of patient service.

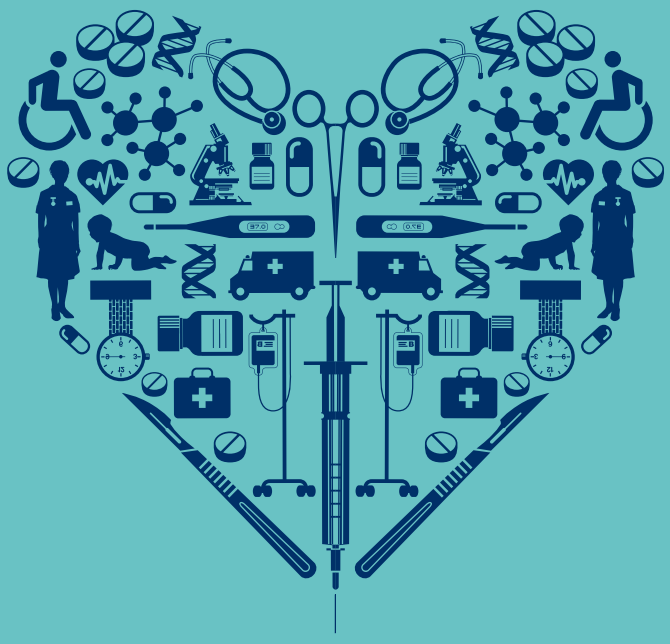
At the Non-Executive level, we have to say a very warm thank you to those who have left us: John Garner, who consistently demonstrated a determination to put patients from all walks of life and backgrounds absolutely at the forefront of the Hospital's agenda, and David Hendry, who was called back to do his duty and serve as Chief Finance Officer to Crossrail having chaired with great attention, sympathy and effort, our Audit Committee for nearly four years. We wish them both well. We welcome onto the Board Non-Executives Mark Prior who joins us to chair our Redevelopment Committee, and Simon Barton to replace David Hendry as Chair of Audit. We are very fortunate to have been able to choose from such a strong list of candidates – perhaps a final confirmation of the regard in which the Hospital is massively held.

Finally, and personally, I am particularly pleased that the community is increasingly wanting to participate in the hospital's services; from the support we are seeing in support of our Helipad Appeal (an 80th Birthday present to the Hospital that turned 80 on 14 February 2019), in the way in which tradespeople have volunteered to bear the entire responsibility for converting 265 Dunstable Road to parent accommodation for those whose children are in our NICU facility and in the way in which the Luton Mosques have volunteered to commit money raised over Ramadan to our Helipad Appeal.

But, while we should feel confident and appreciated, these are uncertain times and the Hospital takes all reasonable precautions, even in the context of Brexit, to maintain its capability in all the circumstances that this Board can reasonably predict.

Simon Linnett
Chair

Strategy



Annual Report Executive Summary

Strategy for 2019/20

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

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

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

Corporate Objectives 2019/20

The Board of Directors have reviewed the Corporate Objectives for 2019/20 to ensure they reflect the strategic vision of the organisation. The Trust's Quality Strategy directs our plans for the year and the detail of this is in the Quality Account. The five objectives are:

1. Deliver the Quality Priorities outlined in the Quality Account

2. Deliver National Quality and Performance Targets

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

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

5. Optimise our Financial Plan

Service Developments 2019/20

The Trust and the Divisions have outlined their plans for the year. This is a combination of national requirements, service redesign, new service provision and managing additional capacity.

Performance in 2018/19

Performance against Objectives 2018/19

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

- We have significantly improved in our HSMR over the year
- We have seen a 40% reduction in respect to mortality from sepsis
- We have a achieved a significant reduction in the number of cardiac arrests
- We have maintained a falls rate of 4.89 which is below the national average of 6.63 for the number of falls and continue to look for improvements to reduce falls further
- We implemented Needs Based Care for respiratory patients which has demonstrated a reduction in length of stay
- We achieved good results in the National Audit of Care at the End of Life
- We signed up to the NHS England Always Event campaign
- We have worked with the Trust's retail outlets to achieve the required 'sugar' reduction in the food and drink provided
- We continued to achieve the national targets for A&E and Cancer. We were only one of three Trusts that met the A&E target. However, we have not met the 18 week target for the year despite still being one of the best performing against this target nationally. Delivery of the six week diagnostic target was achieved for the year.
- We have continued to develop services to support our strategic vision and provide services in line with our population. We have also collaborated with our partners in the ICS, in particular around improving clinical outcomes and sustainability of secondary care, resulting in the announcement to pursue a merger with Bedford Hospital NHS Trust as detailed in the strategic vision.
- We have continued to recruit and support staff throughout the year and achieved excellent engagement scores through our bi-annual Engagement Events where over 2500 staff attend each event.
- We have achieved our financial target for 2018/19 and further developed Service Line Performance Framework to maximise devolution of authority with accountability, while maintaining strong governance and assurance by the Board of Directors.

Maintaining Performance

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

Improving Quality

Following development and launch of a Quality Strategy last year the Trust has confirmed its commitment to that strategy through the appointment of an Executive Director of Quality and Safety Governance to provide leadership to our quality improvement plans, with specific objectives around maintaining the Trust's Care Quality Commission's (CQC) rating of good together with developing a programme of work to support the organisation on its journey to Outstanding.

A delivery plan is now in place which aims to enhance and support an organisational culture where quality improvement is part of our day to day business and to encourage an environment where our staff feel empowered to identify improvement need and then create the change with sustained improvement.

This programme of work will be overseen by a steering Board with a membership that includes the Medical Director, Chief Nurse and is chaired by the Director of Quality and Safety Governance. The group will provide regular updates to the Clinical Outcomes, Safety and Quality subcommittee of the Trust Board.

Operational Performance

The Trust has continued to deliver performance in line with the best hospitals in the country. We have worked hard to turn around challenged departments to achieve key indicators. The Trust maintained a very good performance against the national standards for 18 weeks for treatment from the point of referral when compared nationally. However, the Trust struggled to maintain the 92%. A recovery plan and monitoring processes were in place and by the end of the year the performance had improved to 91.7%, but was not sustainable over the 92% performance threshold.

The activity at the L&D has increased which impacts on the staffing requirements and our ability to provide

services. The Trust has managed to deliver against this increase. However, this will be under constant review across our partner organisations to determine actions to safely improve efficiency.

Our last CQC Inspection report was received in December 2018 and the Trust received a 'Good rating'.

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

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

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

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

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

We are successfully reducing our carbon emissions and have in place sustainable development management plan (SDMP).

Emergency Preparedness, Resilience and Response (EPRR) Performance
All NHS organisations need to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety.

The Trust has measured itself as substantially compliant against the 2018/19 EPRR Core Assurance Standards; this rating has been confirmed and upheld by NHS England and Bedfordshire Local Health Resilience Partnership. This is an improvement on the Trust's 2017/18 assessment.

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

We received 551 formal complaints in 2018/19 but are challenged with responding to the complaints within the 35 day standard. The Board receives assurance that the quality of the responses is good as very few are re-opened. Ongoing action is being taken to improve compliance with the standard. We also receive many compliments from our patients that outweigh the complaints and in 2018/19 we received over 4,500.

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

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

We have continued our staff engagement events throughout 2018 holding one in the summer and one at Christmas. Over 2500 staff come to each event and this has made a significant impact on our staff engagement scores and communication between managers and staff.

Our Volunteers
Volunteering in the NHS is now getting much recognition and policy priority from NHS England and from the Department of Health and Social Care as it is a key enabler in transforming the way the NHS works with people and communities. Volunteering was one of the themes of the NHS70 celebrations and was a priority in the NHS Five Year Forward View, In September 2018; NHS England announced £2.3 million of funding to support HelpForce work with NHS Trusts to develop their volunteering services. Additionally, volunteering and social action now forms part of the NHS Long Term Plan – NHS England have committed to backing HelpForce to double the number of volunteers in the NHS over the next three years.

Our Volunteer Strategy is about maximising the potential of volunteering here at the Luton and Dunstable University Hospital and 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.

Equality and Diversity
During 2018/19 further progress has been made on the work being done to help embed Equality, Diversity and Human Rights (EDHR) areas into corporate strategies and thinking.

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

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

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

Finance
A financial surplus for the 20th successive year was achieved with a 2018/19 surplus of £22.6m. Whilst the Trust delivered the Control Total, delivering it relied on non-recurrent items to offset the additional costs of temporary staffing that are very much part of the challenging environment in which the Trust operates. It should be noted that the £22.6m surplus includes a £18.4m performance bonus (known as Provider Sustainability Funding) which recognised the achievement of agreed performance and financial targets.

Fundraising and Charitable Donations
During the 2018/19 financial year the Luton and Dunstable Hospital Charitable Fund received £1,640,000 from 1371 donations from grant-giving trusts, companies, individuals, community groups and legacies.

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

Top 5 Risks

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

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Clinical Operational	1. Workforce Pressures 2. Capacity pressures and responding to demand 3. Implementation of integrated care 4. The need for robust and whole system working	High	High	Workforce plans in place. Board approved action plans with Trust partners where appropriate. Length of Stay, Discharge Project and Needs Based Care initiative. Ongoing collaborative work with BLMK ICS and Local Health system, in particular Bedford Hospital.	Weekly Senior Team and Executive meetings. Monthly Clinical Outcomes, Safety & Quality Committee and ongoing reporting to the Board. Board of Directors strategic oversight.
Finance	Delivering the financial challenge in 2019/20 including Commissioner plans, agency spend and CQUIN	High	High	Monthly review of key income, expenditure, capex, cash, balance sheet and quality performance metrics. Monthly performance review meeting with Divisions led by Executive Directors. CQUIN forms part of the Quality Account.	Monthly reports of cumulative financial performance incorporating clear forecasting and an alert mechanism to identify issues that allow corrective action. Monthly Finance, Investment & Performance committee review. Monthly review of the Quality Account priorities at the Clinical Outcome, Safety and Quality Committee. Introduction of Monthly Service Line Executive Review Framework

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Present Hospital Campus	Going forward the Trust site will not be consistent for capacity or clinical requirements for good patient care. Backlog Maintenance	High	High	Robust management and governance arrangements in place to manage ongoing risks and hospital re-development project. Finance, Investment and Performance Committee (FIP) oversight of backlog maintenance plans and strategy. DH involvement.	Board oversight of developments with DH and NHSI. Board review of Full Business Case and approval of actions. Finance, Investment & Performance committee review.
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legalisation	High	Moderate	Board approved action plans in place.	Regular monitoring / Assurance from Board Sub-Committees.
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event	High	Low	Ensure that the Emergency and Business Continuity plans are frequently reviewed, communicated and understood by key staff. Ensuring Brexit plans are fully developed.	Ongoing review and testing of Business Continuity plan relevant adaptation of plans. Oversight by Board Sub group.

Economy, Efficiency and Effectiveness

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

2019/20 Strategic Approach

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

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

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

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

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

- we have a highly deprived young urban population in Luton with a life expectancy of one year less than the average for England, and a dispersed, ageing, more affluent population in Bedfordshire;
- the continued population growth, twice the national average, will have 150,000 (20-25%) more people living in the ICS area by 2032, and we are part of the Oxford/Cambridge Arc which has the aspiration of 1m new houses across the Arc by 2050;
- we have a national reputation for our delivery of emergency care but there is increasing recognition, locally and nationally, that the future of emergency care is much more integrated between organisations and needs to be more focussed on the complete emergency pathway;
- as a medium sized Trust we are increasingly identifying the need to develop critical mass to deliver the care that is required, (e.g. services over seven days, consultants in-reaching into admission wards, sufficient elective work within a specialty to service efficient theatre lists and to allow sub-specialisation);
- we are in an area of the South East which has the most acute workforce challenges and we are disadvantaged by being positioned just beyond the area which receives outer London weighting;
- we are at the forefront of IM&T developments in the NHS;
- we have a poor estate that needs redevelopment to support the significant growth in demand and address high backlog maintenance;
- we have a complex geography serving three CCGs, three local authorities over two STPs with three community providers and two mental health providers.

Our strategy represents a response to these drivers.

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

This has led to the development of our vision statement:

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

This vision statement is based on the idea that we will deliver outstanding care through a sequence of events – we will recruit the best people, we will develop and nurture them when they are here, and we will support them to create high performing teams. Outstanding care will not be delivered without this sequence. The Trust completed a piece of work in 2018/19 to develop a set of shared values for the organisation and brought this to a conclusion in the Summer 'Good, Better, Best' Event demonstrating how those values translate into day to day behaviours. The value which was most important to our staff was 'teamwork' and this now is a key part of our vision statement.

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

Our patients – building on our retention of our 'Good' rating from the CQC in 2018 we are implementing our Quality Strategy to set out the Trust's path to 'outstanding' and we appointed to our new post of Director of Quality in 2018/19 to give Board leadership to its delivery. We want to deliver care in the right place (our development of Arndale House is the biggest development outside the hospital walls in its history). We want to deliver that care in a timely way (we achieved the diagnostics target throughout 2018/19). We want to deliver that care in a safe way (our HSMR has continued to fall in recent years). However, our communication with our patients needs to be better. The Global Digital Exemplar (GDE) programme will deliver a patient portal allowing patients to better manage their own care and our medical model needs to meet the changing needs of our patients. We are changing from an age based model of inpatient care to one where the patient is seen by the right specialist team, irrespective of their age, with focus on continuity of clinical staff to the patient.

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

Our future – at the moment the integration work with Bedford Hospital (BHT) remains paused as we wait to hear further news on the Trust's capital proposal. Our proposed acquisition of BHT is to provide a new Trust for the people of Luton and Bedfordshire, creating the scale necessary for efficient, high quality care. This is a proposed merger of two good hospitals and we have committed to maintaining the core services of A&E, paediatrics and maternity on the Bedford site. We have a long history of working together and already provide some joint clinical services to the county and beyond, such as vascular surgery, head and neck cancer services, cervical cancer screening services, neonatal intensive care, and stroke services.

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

The delay to the proposed merger has created uncertainty and this has not been helpful in ensuring the workforce strategy of both hospitals is progressed quickly. The arrangement whereby the Chief Nurse of L&D provided the role on a part-time basis to BHT has ceased from 1 April 2019 given the difficulty of keeping this role in place for an extended period. However, the Trusts are progressing the plan to integrate the two pathology services following the repatriation of services from Viapath from 1 April 2020. This will be actioned outside of the merger process through a contractual joint venture.

The Trusts remain ready to re-start the process of integration once the capital funding is in place.

Our approach – the L&D has a dynamic and innovative culture. We believe in the need to continue this approach to maintain the levels of high performance and good financial stewardship. Two key enablers are (i) IT, with the Trust at the forefront of technology though the GDE programme and (ii) service line management with devolution and autonomy, with accountability, to allow clinically led fast and safe decision-making and drive value. We will continue to give our staff the tools, incentives and support to deliver not just high quality care, but to promote a culture of continuous improvement. The focus in 2019/20 will be the development and implementation of our approach to Quality Improvement.

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

The Trust fully supports the objectives of the community and primary care programme of the Integrated Care System (ICS), developing more services out of hospital and ensuring that the local populations needs can be met in a different way in future. This will require change:

primary care delivered at scale, integration of IT systems, more proactive and reactive community interventions and L&D is determined to play its part in the leadership and delivery of out of hospital care. We will continue to be a full partner in place-based developments (e.g. the Luton Provider Alliance) and the wider ICS programme and look to outreach more of our services (e.g. Arndale House and the proposals for a Dunstable community 'Hub'). The Trust has developed an innovative project in Luton with Cambridge Community Services to work in partnership to develop a joint approach to case management of a distinct cohort of complex patients using this as a foundation for more targeted use of transformation funding and a different approach to risk management for community services. The Trust is looking to ensure this collaboration delivers change in 2019/20 and is looking to further continue its input by exploring the option of managing primary care services.

Our estate – the hospital estate has grown up over many decades, responding to changing need through piecemeal development and has now reached a critical juncture where the approach of 'patch and mend' has become a serious impediment to strategic objectives and operational delivery. Clearly a new hospital build would provide the best solution but there is an acceptance that this is not a practical or affordable proposition. We have exhausted all options in the search to find a solution which is deliverable, affordable and makes the most impact on the most pressing needs of the services but also provides the best solution of growth and resilience. The current 'Acute Services block' proposal concentrates on those services on which the ageing deteriorating estate is having most impact but which will need to be provided on the hospital site now, and in the future,: maternity delivery suite and theatres, NICU, critical care and operating theatres. We are also developing a strategy to refurbish the wards most in need of development with a linked helipad to further enhance our emergency services. Whilst the funding for the hot block remains uncertain, the Trust is ensuring that its major infrastructure risks (energy, heating and ventilation) are being addressed through schemes in 2019/20 and 2020/21.

Summary

In 2019/20, whilst the merger with Bedford and the redevelopment of the L&D site remains uncertain, the Trust will continue to build the foundation and infrastructure for the future – our electrical and energy schemes will be underway, our GDE programme will provide the digital platform and our work with CCS will provide a model of integration which sets the path for the ICS.

Maintaining our Performance

A key priority for the Board of Directors is to sustain the level of delivery against national quality and performance targets delivered by the Trust in recent years. This is increasingly challenging in the context of workforce and physical capacity pressures and will increasingly require us to work and think differently to some of our traditional models of care delivery. Working with commissioners to improve planned care pathways and reduce unnecessary face to face contacts, and to ensure that patients only attend hospital for urgent and emergency care when there is really no alternative will be fundamental to continue to support growing numbers of patients within service constraints.

Maintain and Develop Key Clinical Specialties

- Ensure continued delivery of core clinical services to secure our future in terms of clinical excellence, financial sustainability and reputation.
- Develop clear annual plans and extend the performance framework at service line level, using Getting It Right First Time (GIRFT) and Model Hospital information to inform opportunities to reduce clinical variation and for continual improvement.
- Ensure that specialty plans give consideration to the 'necessary volume' to ensure the economies of scale required for the delivery of seven day services and financial and clinical sustainability.

Develop Opportunities for Integration and Partnership with:

- Provider Alliance – L&D Chief Executive now chairs the Alliance
- Integrated Care System
- Bedford Hospital – Ongoing integration through pathology and the digital strategy
- Enhanced Models of Care programme to align system incentives for out of hospital care with Cambridge Community Services and Luton CCG

Ensure Sustainability

- Continue to improve the patient experience and safety, for example, through improving communication and the provision of information to patients and greater access to consultant-led care.
- Ensuring the maximum use of information to deliver safe and efficient care by using digital patient information wherever possible, and support information systems at all levels of the organisation.
- Directing our capital resources at those service changes which will allow sustainability of performance
- Maintain financial sustainability, delivering a comprehensive programme of efficiency projects which meet the need for tariff efficiency, support the refresh of core infrastructure and underpin the financing of the redevelopment programme.
- Continue the greater focus on performance at specialty level in order to benefit fully from service line management and provide additional direct engagement between clinical leaders and the Board of Directors.
- Continue to review and strengthen performance by the use of internal and external expert review.
- Use the framework of the backlog maintenance review completed in 17/18 to deliver capital improvements that address the priority issues either through redevelopment or replacement.
- Continue to progress update of business continuity accountabilities, processes and mitigations ensuring they are still current and fit for purpose.

Corporate Objectives 2019/20

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

1. Deliver the Quality Priorities outlined in the Quality Account

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

2. Deliver National Quality and Performance Targets

- Deliver sustained performance against all CQC standards.
- Deliver nationally mandated waiting times and other indicators.

3. Implement our Strategic Plan

- Work collaboratively, as lead partner, with BLMK ICS (local Health Economy) in delivering integrated care and maximising sustainable clinical outcomes of secondary care.
- Develop the 'Enhanced Models of Care' approach with partners in the Luton Provider Alliance to ensure patients are supported in out of hospital care reducing time spent in hospital.
- Implement preferred option for the re-development of the site enabling us to progress plans to merge with Bedford hospital.

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

- Secure the workforce needed to deliver core services, significantly reducing dependency on agency staff and using innovative staffing models to continue the reduction in vacancies.
- Embed the organisational values agreed in 2018 to ensure a culture where all staff are highly motivated to deliver the best possible clinical outcomes.
- Deliver excellence in teaching and research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

5. Optimise our Financial Plan

- Deliver our financial plan

Service Developments planned for 2019/20

Strategic and Corporate:

- **Continue to implement systems and processes to reduce the amount of time that patients are spending in hospital** – The Trust will continue to implement the Needs Based Care model whilst further developing the discharge processes and optimising the same day emergency care services.

- **Continue to invest in seven day services and delivering diagnostics at the time of need** – The Trust is committed to the seven day services programme and will monitor this though the Seven Day Services Assurance Framework reported to the Board.

- **Continue to meet the required NHSI Governance standards** – The Trust will work to achieve the NHSI Governance standards for A&E, 18 weeks, cancer and diagnostics.

- **Support delivery of the cancer treatment and faster diagnosis** – The Trust will be ensuring that imaging, pathology and interventional diagnostic access times support delivery, Participate as one of ten nationally selected areas for roll out of targeted screening for lung cancer with low radiation dose CT and Jointly bid with Bedford Hospital to become one of 13 national HPV screening providers.

- **Pilot and implement the new unplanned care access standard set out in the Powis Report** – The Trust is one of the 14 Trusts piloting the new standards in ED and will continue to work to protect our excellent position against the 4 hour emergency access target and implement change as needed to ensure that we meet the new.

- **Deliver key developments for the Estate Infrastructure** – the Trust will deliver the new endoscopy decontamination until, two new theatres and significantly enhance the site electrical resilience.

- **Continue the delivery of the Global Digital Excellence transformation programme** – The Trust will support improvements to the end-user experience and roll out the integrated inpatient care co-ordination platform. Further progress will be made with upgrades to existing systems and also to develop clinical and patient portals.

- **Work towards integrating L&D and Bedford Hospital pathology services** – The Trusts will continue detailed planning and operational design of each element of the laboratory services and the IT integration to support the delivery of integrated pathology services from March 2020.

Surgical Division:

- **Launch the Orthopaedic elective ward** - In the Winter of 2018 the development of a designated 14 bedded orthopaedic elective surgical ward was completed. Opening this unit in the summer of 2019 will allow a reduced length of stay, better patient experience and improved outcomes for patients. This is in line with the Getting it Right First Time (GIRFT) program recommendations.

- **Increase elective orthopaedic work load** – We aim to assist neighbouring Trusts in managing their long waiting times by transferring the care of some patients to us. This will reduce waiting times for patients and allow us to improve productivity through theatres and wards.

- **Improved NOF pathway** – A renewed drive to improve outcomes for patients who fracture their hips is central to our plans this year. Redesigning pathways and roles will ensure our improvement continues.

- **Increase emergency theatre capacity** – in the autumn of 2019 we will be adding an additional 15% to our midweek daytime emergency capacity. With this we aim to improve experience and outcomes of our emergency patients.

- **Open two additional theatres** – in the summer of 2019 the construction of two new theatres will be complete. These theatres will provide additional capacity for a range of specialities and will allow us to reduce the waiting time for surgery, improving our performance against key targets.

- **Refurbish existing theatres** – the completion of the new theatres will allow us to launch a programme of thorough repair and maintenance on our existing theatre stock. This will dramatically reduce the rate of theatre failures and patient cancellations.

- **Expand the Breast Service capacity** – The service has is seeking to appoint an experienced overseas training post to support the services capacity. This will help build our relationships with overseas training schemes and help maintain the quality of our services.

- **Recruit an additional four anaesthetists** – As part of the theatre project we will be recruiting additional specialist anaesthetists in the following fields, Pre-Operative Assessment, Trauma, Complex Airways and General Anaesthetics.

- **Recruit an additional OMFS consultant** – in 2019 the Trust will be appointing an additional consultant in OMFS to work with Bedford or Milton Keynes. This will strengthen our OMFS network and build on the recommendations of the Getting it Right First Time (GIRFT) program

- **HCQ screening program** – Hydroxychloroquine HCQ is a drug used in the management of patients within the Rheumatology service. Our Ophthalmology service will begin the routine screening of patients on this drug to monitor its long term effect on patients eyesight. This is part of a national recommendation.

- **Launch nurse led injections for Age related Macular Degeneration** – To improve access to this important service we will be launching nurse led injection clinics. This will boost our capacity and ensure we can continue to provide this service in a timely manor

- **Reduce cancelled operations** – Capitalising on our new Pre-Assessment hub we will be running an improvement program that works to identify and tackle the causes of cancelled operations. It will reduce DNAs and the number of occasions that patients are not ready for their surgery

- **Begin outpatient based Transperineal(TP) biopsy service** – The Urology service are launching an outpatient based TP biopsy service. The TP biopsy is a key procedure in the diagnosis of prostate cancer. These cases are currently undertaken in theatres and use a lot of theatre capacity. With this new service patients will be able to access this test sooner in their pathway and we will be able to use the released theatre time to improve the service for other patients.

Medicine Division:

- **Undertake Speciality Medicine Out patient Transformation** – Through enhanced focus on opportunities for greater efficiencies to meet the service line activity plans and excellent patient experience. To include strengthening the central outpatient and speciality interface and developing innovative ways of working to manage an increasing demand. This will be supported by use of Model Hospital data and GIRFT feedback.

- **Expand renal services to provide greater resilience** – This includes an expanded in-reach service to the wards and ITU/HDU. In addition the provision of additional out-patient capacity, including dedicated low clearance clinics for high risk patients. This requires effective collaborative working with E&N Hospital Trust to meet the needs of the local population, including developing patient pathways to ensure optimal time to transfer/intervention.

- **Implement the Cardiology Needs Based Care Model** – Implementation follows successful Consultant recruitment, providing timely specialist senior decision making at the front door, across 7 days. This supports greater opportunities for admission avoidance and early discharge with an option for out-patient review in dedicated 'hot clinics'. Job plan modelling supports continuity of care with the expectation of an optimal patient experience, clinical outcomes and length of stay.

- **Implement the Gastroenterology Needs Based Care Model** – The process of recruiting two additional Gastroenterology Consultants is underway. Once the new Consultants are in post, implementation of Needs Based Care model will begin which will involve in-reach into the Emergency Assessment areas and Ambulatory Care providing specialist input into patient care earlier in their stay and aiming to reduce their length of stay.

- **Implement Unified Clerking for the emergency pathway** – The aim is to develop a unified clerking approach for patients on the emergency pathway. This will be through developing improved clinical pathways, with shared clerking processes and documentation, and underpinned by the fostering of a collaborative team approach across the whole emergency floor.

- **Further develop integrated care pathways and a risk stratification approach** – The L&D are currently working with Luton's community services provider (Cambridge Community Services) to test an integrated clinical model that proactively manages patients care in the community. The approach involves managing a cohort of patients using; a risk stratification methodology, case finding, assessment, care planning and coordination for complex patients. A key aim is to develop how hospital services can support system wide care pathways and as a result reduce unnecessary admissions and hospital bed usage. Part of this initiative is to create a shared system data set that provides real time information and supports clinical teams to manage people's care in a proactive way.

- **Further utilise Same Day Emergency Care** – To expand existing pathways and look at new groups of patients with urgent healthcare needs who can benefit from diagnostic tests and treatment in a single day to avoid an overnight stay and improve patient experience.

- **Develop and improve the ED triage process** – Work has started on an ED triage system based on the resource requirement of each patient rather than their presenting complaint. This model of ESI (Emergency Severity Index) triage aids in the earliest identification of, not only, the sickest patients on presentation but also those that have a high nursing resource requirement.

Women & Children's Division:

- **Continue to improve facilities for parents whose babies are on our neonatal unit** – We have purchased additional parental accommodation across from the hospital and with the support of our community this will be renovated and made into additional parental accommodation to support parents with very pre term and sick babies in our neonatal intensive care unit.

- **Further develop the paediatric services transition pathways with medical and community teams** – These developments will ensure young people have the understanding, skills and resilience to continue to effectively manage their conditions into adulthood. There will be focused work for patients with complex Neurodisabilities and epilepsies.

- **Implement the Gynaecology Health Centre (GHC)** – Following its opening in March the unit will continue to develop and through 2019/20 we will relocate our early pregnancy unit and emergency Gynae service into the new unit. We will then go onto develop a day unit to care for women suffering from Hyperemesis (Severe antenatal sickness). This will reduce the need for them to stay overnight in hospital but receive the much needed hydration and support they need in a dedicated unit.

- **Continue to develop the services for our most vulnerable women** – With the support of our Service users and our team of dedicated Maternity staff we will continue to develop programme to enhance the care of our most vulnerable women and provide much needed continuity of care through their pregnancy journey. Further involvement events are planned for 2019/20 to share experiences of both Families and Professionals together.

Diagnostics, Therapeutics & Outpatients Division:

- **Continue to work towards the consolidation of Pathology Services** – The development of the full business case for Pathology integration, harmonisation of equipment and IT infrastructure and clinical consultation to finalise the models of laboratory specific implementation plans for the consolidation of pathology services across Luton and Bedford will progress during the course of 2019-20. The objective is to achieve transition to the new, wholly NHS owned and delivered service by the end of March 2020.

- **Expand Clinical Haematology service provision** – To support demand for services, plans to develop both pharmacist and specialist nurse clinics are underway to build additional capacity and relieve pressure on consultant clinics. The service is also looking to introduce specific inpatient chemotherapy administration to improve patient pathways and best facilitate staff recruitment and retention.

- **Progress a business case to support the provision of a 3rd CT scanner** – To keep pace with demand and quality performance standards, fulfil clinical service developments and deliver against trauma network requirements, the Imaging department will progress a business case for a third CT scanner, to be located adjacent to ED.

- **Further develop the Cardiac MR service** – Given the Trust now has 3 MRI scanners and has capacity, the Imaging department will develop the business case in support of an imaging led cardiac MRI service, providing opportunity to repatriate activity that is currently performed at Harefield Hospital, reducing waiting times for patients.

- **Develop a networked vascular intervention service** – Development of a robust and resilient vascular intervention service is recognised to be an STP wide priority and requires the critical mass of collaboration between Trusts to achieve 24/7, 365 coverage. There is opportunity to develop this across the STP, and to look to other neighbouring Trusts' participation for mutual benefit.

- **Develop an Imaging staffing strategy** – In line with GIRFT recommendations, the service will be supporting increased recruitment and training of in-house radiographers to contribute to chest plain film and cross-sectional reporting and to develop radiographer led MSK joint injection clinics, as well as increasing the cohort of specialist radiologists to the department.

- **Deliver enhanced outpatient services** – Outpatients will be implementing the business plan to enhance outpatient service support to clinical services,

providing expanded call centre operational hours and an evening booking team. The service will also be developing a digital strategy to initiate new ways of delivering clinical activity and patient communications to facilitate better resource utilisation and efficiency and the upgrade of patient waiting facilities to Zone B will be implemented.

- **Procure a new automated drug dispensing system** – Pharmacy will develop the business case and procurement specification for a replacement robotic dispensing system and an extended cold room for drug storage purposes.

- **Implement the actions from the therapy service reviews** – In line with reviews undertaken in 2018/19, therapy services will be developing business cases with clinical services in support of identified needs, such as increased dietetic support to gastroenterology services, paediatrics in support of NICU, diabetes, oncology and allergy clinics as well as critical care support. Efficiency recommendations following the therapies administration team review will also be implemented.

Performance against Corporate Objectives 2018/19

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

Objective 1: Deliver the Quality Account Priorities

The Quality Account priorities were:
Priority 1: Improving Patient Experience
Priority 2: Improve Patient Safety
Priority 3: Deliver Excellent Clinical Outcomes
Priority 4: Prevention of Ill Health

Performance against these priorities is detailed in Appendix 1, the Quality Account section of this report.

Objective 2: Deliver National Quality and Performance Targets

a) Delivering sustained performance with all CQC outcome measures

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

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

The Trust was subject to a CQC inspection during August and September 2018 and the report was received in December 2018 and the Trust was rated as 'Good'.

b) Delivering nationally mandated waiting times and other indicators

- During 2018/19, the L&D:
- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- Met all of the quarterly cancer targets for the year. The Trust has delivered one of the most consistent cancer performances in the country particularly on 62 day cancer waits.
- The Trust maintained a very good performance against the national standards for 18 weeks for treatment from the point of referral when compared nationally. However, the Trust struggled to maintain the 92%. A recovery plan and monitoring processes were in place and by the end of the year the performance had improved to 91.7%, but was not sustainable over the 92% performance threshold.
- Had excellent performance for C Difficile maintaining a low rate of 5 (one of the lowest in the country and below the de minimis of 12) against an agreed contract threshold of 6.
- Reported 1 MRSA Bacteraemia which is also under the de minimis of 6 for reporting to NHS Improvement.
- Met the six week diagnostic target for the year.

Objective 3: Implement our Strategic Plan

a) Progress plans to work collaboratively with BLMK STP (local Health Economy) in delivering integrated care and maximising sustainable clinical outcomes of secondary care.

The Trust has continued to work across the BLMK footprint to support the Integrated Care Systems. The L&D Chief Executive has continued to chair the A&E Delivery Board. In March 2019, the L&D Chief Executive took over as joint chair of the Provider Alliance with the Chief Executive of Cambridgeshire Community Services NHS Trust.

There has been a continual collaborative approach for discharging patients from the hospital. A new app was introduced to track patients and their ongoing care requirements and daily sitreps led by the Executive to put in place senior leadership to resolve any delays. This has been a collaborative approach and impacted length of stay.

The Trust has continued to work across the STP/ICS to progress the digital agenda to support the work to deliver an integrated care portal to enable sharing of records across all health and social care systems locally.

b) Implement our preferred option for re-development of the site

- Re-development proposals for the site are set out in an Outline Business Case approved by the Trust Board in October 2015. An Outline Business Case for development of the Acute Services block, which

was one of the key elements of the re-development proposals, was completed in December 2017. This was a key element to support the Full Business Case for the proposed merger with Bedford hospital. The Trust continues to pursue funding from NHSI for an Acute Services Block.

- The Trust has completed the work to create a satellite outpatient department at Arndale House. The Sexual Health Services team, the Dermatology service and part of the Phlebotomy service are now operating from the building. Feedback from patients has been positive.

- The spaces vacated on the site by the transfers to Arndale House have now been refurbished. A new Pre-Assessment unit has now been built on the ground floor of the Surgical Block. The Gynaecological service has now moved into the old GUM space at the front of the hospital. The Outpatients area has now expanded in zone B.

- The refurbishment of the MR suite was completed in December 18. The Trust is now operating three modern digitalised MRI machines. Refurbishment of the Imaging department continues. The new SPECT-CT scanner in the Nuclear Medicine department will be commissioned in April 2019. Work to address patient dignity issues in the main X-ray corridor will commence in the summer of 2019.

- The construction of a new Endoscope Decontamination Unit will be completed in May 19. This brings the cleaning and maintenance of endoscopes up to current standards.

- Construction of two additional theatres and a new Day Surgery Unit is underway. This work will be completed in September.

- Work to upgrade the High Voltage infrastructure on the site is underway. This is a critical piece of work to deliver the resilience in electrical supplies that is required. Two new sub-stations are under construction, and a third in the Surgical Block will be refurbished. In addition, three new site generators, with a capacity to support the predicted site demand of 5MW, will be provided. This work will be completed in December.

- Centrica have been selected as the Preferred Partner to deliver an Energy Performance Contract following a tender exercise in the summer of 2018. The first stage is now complete. Work is now focussed on supporting a planning application for a new energy centre building, and on developing the form of contract. Construction work is scheduled to commence in January 2020.

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

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

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.

In June 2018 changes to the Tier 2 points based immigration system saw doctors and nurses excluded from the government's cap on skilled worker visas, meaning the restriction was lifted on the numbers that can be employed from non-EU countries. This removed a key barrier to the delivery of the Trusts overseas recruitment strategy.

The applicant tracking and recruitment software system implemented last year has enabled the Trust to improve communication with candidates and maintain a competitive time-to-hire. We have used the system to develop recruitment tracker tool which enables real-time workforce planning which has led to the Trust ranking in the top quartile in the Model Hospital data-set for time-to-hire.

The recognised national shortage of registered nurses remained a key challenge for the Trust. As well as continuing with cohort recruitment and regular advertising the Trust has worked hard to deliver its strategy to recruit both EU and non EU nurses. The Trust ran campaigns to recruit nurses from Italy and Portugal and carries out bi-weekly interviews of overseas nurses.

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.

- The Trust joined cohort two of the NHS Improvement (NHSI) Retention Direct Support Programme aimed at supporting Trust's to reduce turnover of nursing and midwifery staff. The Retention Matters Project was initiated with a strategic focus on four areas: improving data, transfer window/career conversations, working flexibly and retirement.

This project has carried out in-depth analysis of the drivers for turnover and implemented an electronic exit questionnaire to improve data capture and an "Itchy Feet" survey tool. Monthly "Itchy Feet" clinics have been introduced to provide Nurses and HCAs who are thinking of making a change a space to have career based discussions with the senior nursing team who facilitate interventions that will address their aspirations and reduce the likelihood of them leaving the Trust.

- The Trust approved a business case to invest in the Medical Workforce Team and the early results have enabled improved workforce planning, recruitment and the development of a comprehensive rota review programme to ensure working patterns meet both educational and service needs. A combination of investment in the Medical Workforce Team and exclusion of doctors from the annual immigration cap has enabled the development of a successful overseas recruitment pipeline and improved candidate experience that has enabled the Trust to recruit overseas doctors within 10 weeks. This has resulted in early success in filling vacancies in the Surgical Division

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

The Trust recognises that communicating and engaging with our staff is a key part of our success. Having a committed and engaged workforce contributes directly to the quality of the care we provide to our patients. Feedback from the 2019 Staff Survey showed that staff reported that communication between them and senior management has improved and there was good communication between staff and their immediate managers. Messages are delivered in a variety of ways both within individual teams and departments and across the Trust as a whole.

Our seventh 'Good, Better, Best" staff engagement event was a great success. More than 80% of our staff participated during the week in July 2018. The focus of the event was on the Trust Values and an acting company put on a learning event to provide staff with a simple strategy to help with avoiding and dealing with challenging situations.

The Good, Better, Best Christmas staff engagement event was held in December 2018 with more than 2500 members of staff attending the sessions. Themes this Christmas included further development of what our values mean to different people, an update on the Hospital Redevelopment Programme Hospital and gave us an opportunity to thank staff for their hard work and dedication over the year.

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

Medical education continues to be a priority for the Trust. In 2018 the Trust undertook some major development to the facilities within the Centre of Multi-Professional Training and Education (COMET). The facilities now include a simulation suite to provide both high and low fidelity simulation training. The John Pickles Lecture Hall had a face lift which included the addition of a pictorial timeline, highlighting the achievements of the Trust, NHS and Medical Education department since the hospital was opened in 1939.

Postgraduate

A major objective of the current Director of Medical Education is to implement as many of the eight high impact actions to improve the working environment for Junior Doctors and in December 2018 the creation of a common room located within COMET became a reality. This new facility provides an area to take rest breaks and improves access to food and drink 24/7. In addition there are regular Junior Doctor Forums to improve communication between trainees and managers / better engagement with the Board and the Annual Mess Ball celebrates staff achievements and rewards excellence.

As part of a collaborative piece of work on improving Junior Doctors' working lives Health Education East of England (HEEoE) centralised the study leave budget nationally, in order to ensure that trainees receive the funding they require to progress through their specialty curriculum across the whole length of their programme. This entailed the introduction of a new study leave policy and process which the Trust successfully implemented during 2018.

A recent initiative has been introduced to ensure all trainees are clinically confident and fully supported when returning to training following a sustained period of absence.

During the summer of 2018 a small number of students, both medical and non-medical, were provided with the opportunity to work with clinicians to support QI projects and audits. Students had the opportunity to broaden their understanding of clinical audit, assisting with writing up a project, potential publication and obtaining

a better understanding of departmental and clinicians' working practices. As this proved popular there are plans to continue this in 2019 and beyond.

Trainee Physician Associates
Building upon the successful collaborative working partnership between the Trust and the University of Hertfordshire, the Trust welcomed ten Trainee Physician Associates (TPAs) to undertake their clinical placements at the Trust throughout 2018/19. All ten TPAs successfully completed their Objective Structured Clinical Examination (OSCE) at the end of 2018.

Undergraduate
The Trust has continued to receive positive feedback from University College London (UCL) with UCL medical students rating the Trust as a positive learning environment which they would recommend to other students. The most notable achievement in 2018 was the creation of the high and low fidelity simulation suite which, in line with 'Outcomes for Graduates (Tomorrow's Doctors)' July 2015 has improved the learning and teaching environment and received positive feedback from students and UCL.

Having previously received the Health Education England, "Sally Hernando Innovation Award" 2017, throughout 2018 the Trust has continued to improve on its commitment to provide medical students with lendable i-Pads containing curated selections of library resources and links to documentation. This too has received positive feedback from UCL and medical students.

Following the most recent change to the Final MBBS exam, the Trust successfully implemented the introduction of an electronic marksheet where our in-house examiners used electronic tablets to score each candidate.

Throughout the remainder of the year the Undergraduate Directors are hoping to create a student hub to provide an improved study and social space for the students.

Objective 5: Optimise the Financial Plan

Delivering our financial plan

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

A programme of Executive Board meetings and performance meetings was in place that provided additional structures and assurance to the Board of Directors. Focussed plans in relation to agency costs were implemented during the year.

To improve efficiency across the health economy we have continued to work closely with the Integrated Care System (ICS) Plans through the Collaborative Savings Initiative.

Service Developments delivered during 2018/19

During 2018/19, the Division of Surgery including Cancer:

- **Recruited Middle Grade Doctors in Urology** – Due to the success of the Urology One Stop model we expanded and developed the service further with recruitment of additional middle grade staff that supported the existing consultants with service developments whilst also supporting Urology on-call.

- **Implemented Mitomycin Hyperthermia (MMC-H) Urology at low volume** – Mitomycin hyperthermia (MMC-H) is a treatment for bladder cancer. L&D has implemented this service at low volume with plans to increase provision.

- **Implemented a new model for Pre-operative assessment** – The Trust completed a review of the pre-assessment process that culminated in the implementation of a pre-operative assessment hub. This process improves the risk of patients being cancelled on the day of their surgery that benefits clinical outcomes, patient experience, utilisation of theatres and financial performance.

- **Refurbished the discharge lounge** – The Division completed the refurbishment that supports a better patient experience and ensures that patients flow through the hospital.

- **Provided a new junior doctors' room** – A new junior doctor's room was co-located with the discharge lounge to offer better facilities for the doctors and improved clinical adjacencies.

- **Implemented a Pharmacy Hub** – The pharmacy hub was co-located next to the discharge lounge to provide a more comprehensive range of drugs that reduced the medicines dispensing time.

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

- **Began to deliver restorative dentistry**– we have begun to deliver a Restorative Dentistry service at the L&D that provides crucial support to the regional Head and Neck Cancer Treatment service provided at the Trust.

- **Launched a new Referral Management Service in Oral Maxillofacial (OMFS) and Orthodontics** – A new service was launched by NHS England from the 1st April 2018, with a rapid independent triage of all routine referrals to OMFS and Orthodontics from Dentists.

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

- **Provided an additional Bariatric Clinical Fellow** – Due to high demand of the service we recruited a bariatric clinic fellow, working closely with existing consultants, to be trained in all aspects of bariatric surgery, running clinics, and will initiate the research projects and support bariatric MDT. This has been a successful implementation.

- **Developed the capacity for an Orthopaedic elective ward** – We developed a 14 bedded orthopaedic elective surgical ward in line with the GIRFT program recommendations and during 2019/20 the Trust will implement this as a specialty area.

During 2018/19, the Division of Medicine:

- **Further Implemented Needs Based Care (NBC)** – The Needs Based Care implementation continued to be aligned with workforce recruitment. The impact of the model has been demonstrated though a reduction in bed days and length of stays. The Respiratory model was implemented in June 2018 providing specialist senior clinical decision making at the front door across 7 days. This is supported by a dedicated respiratory bedbase and options for early discharge or admission avoidance with access to dedicated 'hot clinics'.

- **Greater utilisation of service line management/ reporting** – The Division has refined service line reporting that continued to support financial planning and decision making across the Division. The governance and assurance of service lines has been supported by the introduction of Executive Performance Meetings.

- **Relocated Luton Sexual Health Services** – Luton Sexual Health moved to a purpose built town centre facility in May 2018. Client and workforce experience is positive. The enhanced ability to provide a fully integrated service is reflected in the increased number

of attendances. This will be further enhanced with the implementation of online/postal chlamydia screening services and an enhanced outreach model.

- **Relocated Dermatology Services** – Dermatology services moved to a purpose built town centre facility in June 2018. Client and workforce experience is positive. This has provided increased capacity for specialist therapies. Photodynamic therapy (PDT) will commence in 2019. Teledermatology was piloted and implemented following a successful business case to support greater efficiencies following off site working. GIRFT feedback following a visit in December 2018 was positive; an action plan is in place and is monitored via the monthly Directorate and Executive Performance Meetings.

- **Provided additional outpatient capacity** – The vacated outpatient accommodation on-site has supported additional out-patient capacity across all clinical divisions. This includes opportunities for one stop, MDT clinics including respiratory sleep and lung cancer clinics.

- **Further developed Ambulatory Care services** – With the commencement of a new Matron for Acute & Emergency Medicine in June 2018, links have been made with the National Clinical team who are providing a review of the current set up within Ambulatory Care which should be completed by Summer 2019. The neutropenic sepsis pathway has been added to the suite of ACC pathways available after joint working between the ED and Acute teams, and the ACC team has been further strengthened with the establishment of a clinical lead role.

- **Introduced planned appointments for GP Heralded Referrals** – An Urgent Connect admission avoidance phone line for GPs has now been established within ACC so an acute consultant is readily available every day to provide advice and guidance to GPs. This allows appropriate decision making to take place with patients accessing the right service in a timely manner. Access to the medical take list is now available at the Streaming desk within ED so that GP heralded patients can be sent straight to the assessment areas if capacity allows ensuring a better patient experience.

- **Continued Overseas Medical Recruitment** – Overseas recruitment continued with the established model with the University of Colombo Sri Lanka with two visits last year with the successful recruitment of over 20 doctors for all specialities in the Trust. The Royal College of Physicians (Edinburgh) have confirmed we are able to recruit MTI doctors on their behalf, allowing the Trust the option of offering Tier 5 & Tier 2 Visas. A further visit is planned for late 2019.

- **Established a Frailty Unit** – The Frailty Unit was established in April 2018, with positive results. The Team continue to work with the CCG & Integrated Community MDT with a developed Safety Huddle in the community to ensure patients are picked up and managed at the earliest opportunity, this is supported by clinicians from the L & D, and there is a telephone hotline available to liaise with secondary care.

- **Introduced Emergency Department Technicians** – Two roles are now an established part of the ED workforce and further recruitment is planned for 2019/20. This role has been invaluable in enabling early decision making and providing improved patient flow through the department. The development of the number of technicians will enable the department to provide a service for all specialty patients from Summer 2019.

- **Continued to monitor, assure and learn from mortality case reviews** – The Divisional Mortality meetings continue in Medicine with the aim of sharing good practice and learning, the Trust mortality data continues to report an improving picture and structured judgement reviews are taking place.

During 2018/19, the Division of Women and Children's Services:

- **Made further improvements to the Neonatal unit** – We have successfully implemented parents being on the unit during ward round by supplying noise cancelling head phone for parents to use to give some privacy. We have extended visiting to include siblings by use of a newly decorated sitting room and improved kitchen facilities for parents. This is coupled with upgrading the expressing facilities to enable new mothers to provide valuable breast milk for their pre-term babies.

- **Developed the GP/Consultant connect service** – We have had a number of successful education sessions with GPs and primary care staff primarily on a Saturday enabling doctors to attend. Audience of in excess of 30 have been common place. These provide updates on practice, a sharing of ideas between clinicians to prevent admissions where possible through support for parents and ensuring those that need to be in hospital are identified rapidly.

- **Practice teams and pharmacists are working to ensure parent information and teaching is consistent. Where there are practical concerns practices can refer to the community rapid response team for follow up**

- **Opened the new Gynaecology Health Centre** – The Trust opened to its first patients in March 2019 and feedback during these early days has been positive from both patients and staff. We have started with Gynaecology outpatients and further services will move into the unit in the coming months.

- **Provided further training for our Fertility Nurses** – Our Fertility nurses were successfully trained to support the fertility service and provide nurse scanning for patients undergoing IVF treatment. We have started a training programme for Midwives to support Growth scanning the first of whom will qualify in July 2019.

- **Completed the Children's Oncology Unit** – We are very proud to have opened the newly designed oncology suites on the children's ward. Children and parents are very pleased with the results. Our thanks to all those that supported the fund raising to make this happen.

- **Continued to hold events to raise awareness of the services provided** – The MAMMA events and development of the maternity voice partnership involving users of our maternity services has proven to be a great success, giving valuable insight into the family journey. This partnership working is the key to developing effective maternity choices and enhanced care.

During 2018/19, the Diagnostics, Therapeutics and Outpatients Division:

- **Further developed the work to consolidate Pathology Services** – Both Luton and Dunstable and Bedford Hospitals further developed their strategic business plans for combining Pathology Services across both Trusts. Both hospital boards approved the Outline Business Case for this development and the proposed target operating model, and committed funding to enable the IT infrastructure integration work to commence in anticipation of a combined pathology service commencing as from April 2020.

- **Implemented community based phlebotomy service** – In line with the Trust strategic objectives to deliver more community based services and free up space for acute service developments on site, GP and routine anticoagulation phlebotomy services were moved to Arndale House in Luton, whilst outpatient related phlebotomy has been relocated to zones B and C of Outpatients. The benefit has been to dramatically reduce patient waiting times for phlebotomy and facilitating both an appointment and walk in service.

- **Implemented new diagnostic testing services in Pathology** – Across microbiology and blood sciences, new screening and rapid diagnostic testing services have been introduced, including PCR testing for flu in paediatrics and ED, antibiotic sensitivity testing to enable faster and better targeted treatments for patients and FIT testing for the earlier detection of bowel cancer.

- **Completed the MRI redevelopment** – Imaging services completed a very significant MRI redevelopment programme, replacing two MRI scanners, and extending the suite to facilitate a third scanner. The state of the art technology is already delivering faster, better image quality and will enable further, more specialised cardiac diagnostic services to be developed, as well as delivering improved access for cancer pathways and waiting times for both inpatients and outpatients.

- **CT SPECT and digitisation of x-ray equipment** – Replacement of the gamma camera in Nuclear Medicine with state of the art CT SPECT is near completion and will extend the range of nuclear medicine diagnostic services, as well as provide much needed additional CT capacity in the evenings, over the coming year. Digitisation of x-ray scanners and replacement of fluoroscopy equipment is improving image quality and efficiency in the department to keep pace with demand.

- **Switched off paper referrals** – Outpatients services have successfully implemented the national programme to transition to electronic GP referral, eliminating paper referrals. The two year CQUIN programme to improve utilisation of advice and guidance has also successfully increased take-up to timely advice for appropriate clinical management of patients in primary, and where necessary, secondary care.

- **Responded to the Breast Screening national incident** – The division recognised that L&D Breast Screening services provided a magnificent response to the national incident, facilitating additional women needing to be screened in 2018/19.

- **Supported Needs Based Care** – Therapies and Pharmacy have worked in tandem with Medicine to deliver against their recruitment, implementation

and quality / efficiency programmes to support emergency and acute inpatient services.

- **Repatriated the diabetes dietetic services to be delivered by the Trust** – Therapies, and specifically dietetic services have worked with medicine to facilitate bringing this service in-house and within the management umbrella of therapy services, improving service resilience.

- **Completed therapy service reviews** – Therapies have undertaken comprehensive service reviews during the course of 18/19, to determine how these services can best be delivered to meet the needs of clinical services and patients and in the context of Trust and Divisional strategic objectives. These reviews will be translated into specific strategic service plans, to be implemented during 2019/20.

- **Supported the GDE e-pharmacy programme** – Pharmacy have continued their proactive contribution to the Trust's digital exemplar programme and national imperatives to improve medicines security and the Falsified Medicines Directive, as well as introducing local initiatives, such as language specific drug labelling to improve drug compliance and patient safety.

Improving Quality

Following development and launch of a Quality Strategy last year the Trust has confirmed its commitment to that strategy through the appointment of an Executive Director of Quality and Safety Governance to provide leadership to our quality improvement plans, with specific objectives around maintaining the Trust's Care Quality Commission's (CQC) rating of Good, together with developing a programme of work to support the organisation on its journey to outstanding.

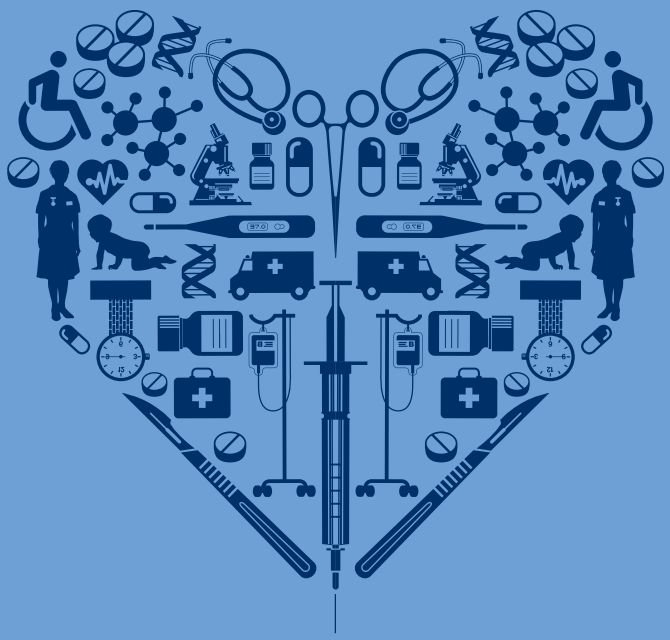
A delivery plan is now in place which aims to enhance and support an organisational culture where quality improvement is part of our day to day business and to encourage an environment where our staff feel empowered to identify improvement need and then create the change with sustained improvement.

This programme of work will be overseen by a steering Board with a membership that includes the Medical Director, Chief Nurse and is chaired by the Director of Quality and Safety Governance. The group will provide regular updates to the Clinical Outcomes, Safety and Quality subcommittee of the Trust Board.

More information about the Trust's approach to improving quality is within Appendix 1 - The Quality Account.


LUTON AND DUNSTABLE UNIVERSITY

Operational performance report



Principal activities of the Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 90,000 admitted patients, over 400,000 outpatients and Emergency Department attendees and we delivered over 5,300 babies.

We serve a diverse population most of whom are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile. There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 Luton Annual Public Health reports states that in many cases, Black and Minority Ethnic (BME) communities have poorer health outcomes when compared to the overall population and these are linked to infant mortality, access to services due to awareness, language and cultural barriers, early onset dementia and diabetes. The Index of Multiple Deprivation 2010 also indicates that Luton is becoming more deprived. The Luton Annual Public Health Report 2015/16 (most recent published report) focussed on school aged children and identified particular issues in relation to language, poverty, obesity and activity, looked after children and mental health.

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

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

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

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

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

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

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

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

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

Review of Operational Performance

Key performance targets 2018/19

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

Activity

- During 2018/19, the L&D:
- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- Met all of the quarterly cancer targets for the year. The Trust has delivered one of the most consistent cancer performances in the country particularly on 62 day cancer waits.
- The Trust maintained a very good performance against the national standards for 18 weeks for treatment from the point of referral when compared nationally. However, the Trust struggled to maintain the 92%. A recovery plan and monitoring processes were in place and by the end of the year the performance had improved to 91.7%, but was not sustainable over the 92% performance threshold.
- Met the six week diagnostic target for the year.
- Had excellent performance for C Difficile maintaining a low rate of 5 (one of the lowest in the country and below the de minimis of 12) against an agreed contract threshold of 6.
- Reported 1 MRSA Bacteraemia which is also under the de minimis of 6 for reporting to NHS Improvement.

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

L&D Performance against CQC and NHS Improvement Targets

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

Regulatory Quality CQC Performance

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

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

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

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

CQC Assessments

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

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

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

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

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

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

The last CQC inspection was August - September 2018 and the report received in December 2018 gave the Foundation Trust and Hospital a rating of 'Good'.

The Trust received two regulatory notices and these were for mandatory training and infection control compliance and an action plan is in place that is monitored by the Clinical Outcome Safety and Quality Committee.

Quality of Governance

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

Regulatory Performance Ratings

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

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

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

Segmentation
The Trust is in segment 1. This segmentation information is the trust's position as at 24th April 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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

Area	Metric	2018/19 Scores	2017/18 Scores
			Q4
Financial sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	2	2
	Agency spend	4	4
Overall scoring before overrides		**2**	2
Score of 4 override		**Yes**	Yes
Overall scoring after override		**3**	3

We had no formal interventions

Activity Performance Analysis

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

Point of Delivery	18-19 Outturn	19-20 Plan	Growth
GP Referrals (General and Acute)	70,696	73,017	3.30%
Other Referrals (General and Acute)	61,233	63,309	3.40%
Total Referrals (General and Acute)	131,929	136,326	3.30%
Consultant Led First Outpatient Attendances	105,200	107,304	2.00%
Consultant Led Follow-Up Outpatient Attendances	226,334	232,219	2.60%
Total Consultant Led Outpatient Attendances	331,534	339,523	2.40%
Total Outpatient Appointments with Procedures	74,312	76,244	2.60%
Total Elective Admissions - Day case	37,227	37,376	0.40%
Total Elective Admissions - Ordinary	7,686	7,717	0.40%
Total Elective Admissions	44,913	45,093	0.40%
Total Non-Elective Admissions - 0 LoS	18,771	20,160	7.40%
Total Non-Elective Admissions - +1 LoS	29,594	31,784	7.40%
Total Non-Elective Admissions	48,365	51,944	7.40%
Total A&E Attendances excluding Planned Follow Ups	107,940	113,337	5.00%
Type 1 A&E Attendances excluding Planned Follow Ups	107,940	113,337	5.00%

In 2018/19 our commissioners anticipated substantial CIP reductions in both planned and emergency care. Despite

their endeavours, expected reductions in activity did not occur and emergency activity, in particular, has shown significant increases. Routine GP referrals have remained broadly steady across the year, but with significant increase in the proportion of urgent cancer referrals. Referrals from Hertfordshire and Bedfordshire continue to rise above the rate of referral for Luton.

The Hospital performed well to accommodate over-performance in unplanned activity without compromising a range of national target indicators with the exception of 18 weeks due to the cancellation of elective patients to accommodate A&E attendance as per national instructions. Increasingly the Trust is looking to services such as hospital at home and ambulatory care to absorb the demand and further integrated working with community services and local authorities is essential to mitigating the growth in admissions by reducing length of stay. The Trust has been successful in reducing the number of patients staying in the hospital over 21 days and saw much lower contingency bed usage in winter 2018/19 compared to winter 2017/18. However significant temporary staffing costs were incurred in managing the additional activity.

Research Performance

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

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

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

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

This practical support includes:

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

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

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2018/19 and who were recruited during that period to participate in research approved by a Research Ethics Committee was 1421. This research can be broken down into 168 research studies 147 Portfolio and 21 Non-Portfolio). Education and Performance

Education and Performance

Medical Education

Medical education continues to be a priority for the Trust. In 2018 the Trust undertook some major development to the facilities within the Centre of Multi-Professional Training and Education (COMET). The facilities now include a simulation suite to provide both high and low fidelity simulation training. The John Pickles Lecture Hall had a face lift which included the addition of a pictorial timeline, highlighting the achievements of the Trust, NHS and Medical Education department since the hospital was opened in 1939.

Postgraduate

A major objective of the current Director of Medical Education is to implement as many of the eight high impact actions to improve the working environment for Junior Doctors and in December 2018 the creation of a common room located within COMET became a reality. This new facility provides an area to take rest breaks and improves access to food and drink 24/7. In addition there are regular Junior Doctor Forums to improve communication between trainees and managers / better engagement with the Board and the Annual Mess Ball celebrates staff achievements and rewards excellence.

As part of a collaborative piece of work on improving Junior Doctors' working lives Health Education East of England (HEEoE) centralised the study leave budget nationally, in order to ensure that trainees receive the funding they require to progress through their specialty curriculum across the whole length of their programme. This entailed the introduction of a new study leave policy and process which the Trust successfully implemented during 2018.

A recent initiative has been introduced to ensure all trainees are clinically confident and fully supported when returning to training following a sustained period of absence. There are a number of mechanisms in place to support the return to clinical practice, including:

- Individualised SuppoRTT plan
- Access to ring fenced places on pre-existing specialty specific courses and regional teaching days
- Period of enhanced shadowing two weeks prior to the trainee's return date
- Return to Clinical Practice Days
- Additional funding for bespoke training may be available
- A contribution towards childcare costs when attending shared parental leave in touch (SPLIT) days & keeping in touch (KIT) days may be available.

The results of the General Medical Council National Training Survey 2018 indicated there were 10 below outliers (red flags) and 14 above outliers (green flags). The results of the survey were discussed at various forums within the Trust with action plans completed and implemented.

In addition to providing quality placements to doctors in training the Trust also employs a growing number of Locally Employed Doctors (LEDs) and the Trust has recognised the need to support this group by appointing a LED Tutor. The priorities for this new role will be to formalise rotations, improve recruitment and retention and provide development opportunities to those in post.

During the summer of 2018 a small number of students, both medical and non-medical, were provided with the opportunity to work with clinicians to support QI projects and audits. Students had the opportunity to broaden their understanding of clinical audit, assisting with writing up a project, potential publication and obtaining a better understanding of departmental and clinicians' working practices. As this proved popular there are plans to continue this in 2019 and beyond.

Trainee Physician Associates

Building upon the successful collaborative working partnership between the Trust and the University of Hertfordshire, the Trust welcomed 10 Trainee Physician Associates (TPAs) to undertake their clinical placements at the Trust throughout 2018/19. The TPAs undertake a two-year postgraduate medical education programme to develop clinical capabilities, competencies and reasoning to undertake the duties required in primary and secondary care. The TPAs clinical placement at the Trust consists of a rotation through the Medicine, Surgery, Emergency Medicine, Paediatrics and Obstetrics and Gynaecology departments. All 10 TPAs successfully completed their Objective Structured Clinical Examination (OSCE) at the end of 2018 and during August/September 2019 will be completing their and sitting the Physician Associate National Exam. The Trust will be welcoming another nine TPAs in April 2019.

Undergraduate

The Trust has continued to receive positive feedback from University College London (UCL) with UCL medical students rating the Trust as a positive learning environment which they would recommend to other students. The most notable achievement in 2018 was the creation of the high and low fidelity simulation suite which, in line with 'Outcomes for Graduates (Tomorrow's Doctors)' July 2015 has improved the learning and teaching environment and received positive feedback from students and UCL.

Having previously received the Health Education England, "Sally Hernando Innovation Award" 2017, throughout 2018 the Trust has continued to improve on its commitment to

provide medical students with lendable i-Pads containing curated selections of library resources and links to documentation. This too has received positive feedback from UCL and medical students.

Following the most recent change to the Final MBBS exam, the Trust successfully implemented the introduction of an electronic marksheet where our in-house examiners used electronic tablets to score each candidate.

Throughout the remainder of the year the Undergraduate Directors are hoping to create a student hub to provide an improved study and social space for the students.

Medical Revalidation

We have a general growth year-on-year in our medical workforce with 434 registered on our web-based portfolio, L2P at the end of March 2019. All doctors receive support to undertake an annual appraisal so that they are prepared for the 5-yearly recommendation for Revalidation to the General Medical Council. The whole process is monitored and supported so that the individual doctor is ready to present a full range of evidence based on the total scope of their practice each year. We continue to also buy licences for each doctor so that they can complete a multi-source feedback exercise with both colleagues and patients at least once during the 5-year cycle. Each doctor is assigned a facilitator who supports the feedback and ensures that the process is thorough. The quality of appraisals has improved significantly since the introduction of Medical Revalidation in 2012. This has benefitted our medical workforce. The majority of doctors revalidate successfully within each annual cycle and a small number are deferred for legitimate reasons but then complete the process at a later date. Our performance is reported on a quarterly and annual basis to NHS England and is also benchmarked against Trusts. We compare well with other organisations.

Pre-Registration Education for Nurses and Midwives

We currently provide placements for pre-registration nursing and midwifery students from the University of Bedfordshire and the University of Hertfordshire. We provide placements for pre-registration nursing students on the adult, child and mental health programme in preparation for becoming registrants. We also support students from other universities with elective placements; in 2018 we were able to support 18 adult nursing students in this way. The quality of our placements is monitored quarterly in collaboration with the University of Bedfordshire during the Quality Educational Placement Learning (QPEL) meetings. The performance of the Trust and the University is measured and an action list compiled which is reviewed at the next meeting. All placement areas are audited annually to ensure that they remain fit for purpose and that student capacity for that area is accurate. Any actions following this audit are monitored by the University Link Lecturer, the Trust's pre-registration lead and the clinical area lead.

We have received student feedback twice from the University in 2018 and have shared this information with Matrons, Ward Managers and mentors during mentor updates. During mentor updates some time is spent discussing the feedback and what actions could be taken as a result. In 2018 pre-registration non-medical students were invited to participate in the National Education and Training Survey along with medical pre-registration students. The full results of this survey have not been released yet. Each student, depending on year, is allocated a qualified mentor who has undertaken a recognised mentorship course. Third year students on their final sign off placement are allocated a sign off mentor who is responsible for signing them off to go on to the Nursing and Midwifery Council (NMC) register. As well as supporting students through mentorship, clinical areas are being encouraged to use a coaching model and peer-assisted learning (C-PAL) to support students to become more independent learners and better prepare them for registered practice. This is due to be rolled out Trust-wide and has already starting in Maternity. In addition nursing and midwifery staff are being prepared for changing roles for supporting pre-registration learners in line with new NMC standards published in 2018.

The number of adult pre-registration nursing students has decreased, while the number of child pre-registration nursing students has increased at the University of Bedfordshire. The number enrolled on the midwifery pre-registration course remains static. There also continues to be cohorts of MSc pre-registration nursing students attending placements in the Trust. These are individuals who have already obtained a health-related first degree and are able to obtain a nursing registration following a condensed two-year degree.

Career Pathways into Nursing

In September 2018, two Healthcare Assistants (HCAs) successfully completed the flexible nursing course and have become registered nurses and both are now employed as Band 5 nurses in the Trust. Another two HCAs have commenced the 18-month nursing degree apprenticeship in February 2019 and are due to complete the course in the summer 2020.

In March 2019, nine trainee Nursing Associates completed their programme and are able to register with the NMC as Nursing Associates. All are going to apply for Nursing Associate positions in the Trust. Another

12 HCAs have just commenced the Nursing Associate Apprenticeship at the University of Bedfordshire and are due to complete the course early in 2021. Once registered as Nursing Associates, staff will be eligible to apply for the 18th month nursing degree apprenticeship, following a period of preceptorship.

We are hoping to continue enabling our current workforce to follow these pathways in the future. These courses are a commitment for the individual and the area supporting and releasing them, therefore careful selection of applicants must continue.

Health Education England is keen to increase the numbers of Nursing Associates in particular and is exploring what support Trusts need in order to achieve this.

Pre-Professional Workforce

All new clinical support staff, with no previous care qualification, undertake the Care Certificate to ensure they have the knowledge and skills to care for our patients safely. This must be completed by permanent staff within 12 weeks and Bank staff within 6 months, of commencement of employment. During the recruitment process, it is identified whether new staff are able to complete an Apprenticeship in Health. If so they are enrolled onto this after they have completed the Care Certificate. Support is offered to those who may not initially be suitable for the Apprenticeship in Health to complete this at a later date. The Apprenticeship in Health then enables them to apply for the Nursing Associate course in the future. This provides a pathway into nursing for those staff who wish to progress further in their careers.

Preceptorship

Preceptorship is a period of 6-12 months designed to support newly registered nurses and midwives transition into registered practice. The programme is open to all NMC registered UK trained nurses, all non-UK trained nurses, Nursing Associates, Return to Practice nurses and those returning to the Trust following a long break or time spent working in a setting outside a hospital. The programme is filled almost equally with UK trained and non UK trained nurses. During the programme staff are expected to reflect on their progress and complete a competency document outlining their development. The programme is well evaluated and just under 100 staff have been through the programme in the last year.

Nurse Revalidation

All nurse and midwifery registrants are now required to demonstrate they remain fit to practise to another third party every three years in accordance with The Code, 'Professional standards of practice and behaviour for nurses and midwives' (2015). We are approaching the end of the first three year cycle and as a Trust have been 100% compliant with the requirements.

Overseas Nurses

We continue to recruit overseas nurses into the Trust, predominantly from India, Philippines and the Caribbean. Prior to arriving in the UK these nurses must have passed the International English Language Testing System (IELTS) in all four domains or the Occupational English Test (OET). Following Trust induction they commence 7.5 hours per week on a base ward and 30 hours per week preparing for an objective structured clinical exam (OSCE) at an NMC test centre. This preparation programme runs on average for six weeks prior to sitting the exam. The Trust maintains a 100% pass rate after the second attempt with the majority passing on their first attempt. Once the OSCE has been passed these nurses are eligible for a UK nursing registration with the NMC and commence work in the Trust as a Band 5 Staff Nurse. Over the next six months each nurse will complete their preceptorship programme.

All European Union (EU) nurses now have to provide evidence to the NMC that they meet the English language requirements they set by successfully passing the OET, prior to being able to register to practise in the UK. We are not currently recruiting from the EU but we do have 10 EU nurses who are working at Band 4 level whilst they prepare to sit the OET.

Personal and Continuing Professional Development (CPD)

An annual training needs analysis informs our plans for continuing education. It also enables managers to prioritise staff development that meets services needs as well as the professional development of individual staff. This complements discussions at appraisal when individual personal development plans are developed with staff and their career aspirations discussed as part of a talent management conversation. The funding for CPD is provided by HEE through the Learning Development Agreement (LDA) and we are required to report quarterly on our spend and identify how the training meets national requirements, outlined by HEE. In addition, we develop and publish our comprehensive training brochure which covers a wide range of programmes including mandatory training; health and safety, clinical skills, leadership and management development, apprenticeship qualifications, communication skills and IT training.

Registered staff update their clinical knowledge and skills through attending advanced specialist education courses which have been funded by Health Education East of

England. We are in the process of increasing the number of staff on the Advanced Clinical Practitioner pathway, which is still currently funded by HEE. We currently have staff in theatres, NICU, paediatric and pharmacy completing these pathways. In order to ensure the most appropriate and cost effective access to courses we enrol staff onto courses at a number of different Universities.

Apprenticeships

We currently have 200+ staff on apprenticeship standards/frameworks across the Trust. These frameworks and standards include Leadership and Management, Team Leading/Supervisor, Senior Healthcare Support Worker, Business Administration, Engineering, Property Maintenance Operative and Accountancy.

Our latest cohort of CMI Team Leading Level 3 apprentices commenced their first workshop in March 2019.

Participants involved in cohort 5 of the Operational Department Manager CMI Level 5 Diploma have commenced their learning and all participants were motivated and engaged at their first workshops.
In late January 2019 two of our qualified Clinical Support Workers with a Foundation Degree started an 18-Month Pre Registered Nursing Pathway Apprenticeship. This is an 18 month apprenticeship programme which will enable participants to reach qualified nursing status in due course. It is intended that other qualified Nursing Associates will commence their training later this year and these participants are scheduled off the wards at the University of Bedfordshire for two days a week.

Mandatory Training

All our key mandatory training is aligned to the Skills for Health Core Skills Mandatory Framework (CSTF) and this standardisation enables us to accept the training that staff have received at other healthcare organisations when they join as new employees. We have also now aligned the Trust refresher periods with the CSTF removing the differential periods between classroom and e-learning training.

Access to e-learning has increased as staff can now access the on-line learning platform on mobile devices on- and off-site. Staff can also attend regular supported e-learning sessions and use the Library where a number of computers are suitable for accessing all the e-learning modules including for clinical applications. We have adapted the mandatory training days for clinical staff so that additional participants can sign in to complete individual modules.

We are improving our compliance in relation to mandatory training which is a Care Quality Commission (CQC) requirement following the last inspection in 2018. A detailed action plan has been presented to CQC and divisions are using their monthly divisional reports to identify individuals who need to update their training. The annual appraisal process also includes the requirement to complete all mandatory training and this will continue with the implementation of the new Agenda for Change pay progression developments from 1 April 2019.

Corporate Induction

The Corporate Induction programme has been completely revised with the introduction of a marketplace with stalls presented by a range of corporate services for new staff to visit. The first day is very much a 'welcome to the L&D' event led by the Chief Executive and it has been well evaluated. To accompany the new programme, we have written guidance on local induction which is a comprehensive basis for becoming established in both a new department and role. It is essential that all managers welcome and support staff in new roles to ensure good staff retention and development for the benefit of services and patients.
Leadership Development

NHS Staff Survey results for 2018 indicate that immediate managers support, develop, train and appreciate their teams. Those managers take a positive interest in the health and wellbeing of their staff and value their work. Senior managers are also visible, try to involve staff in important decisions and act on feedback from their colleagues. All of this is a positive indicator of the benefits of the range of management and leadership development that has available in the last year. It also shows that the Good, Better, Best events in July and December each year which involve a significant proportion of staff have had a positive impact on staff engagement and relations.

Training and Development continues to offer a range of leadership development opportunities from our highly-rated 'Seven Habits' programme to full national qualifications such as the Chartered Management Initiative (CMI) Level 5 course (17 on programme in 2018) and the CMI Level 3 Team Leading course (23 on programme in 2018).

The Band 6 leadership programme for nurses had 41 participants in 2018 and continues into 2019. We are planning to review the Band 7 programme for nurses and other non-medical clinical professionals to update the content and ensure that it reflects current thinking.

New consultants are offered access to a specialist external short course that helps to prepare them for the challenges of holding a responsible senior medical role. These new colleagues are also offered the opportunity to have a mentor who is a very experienced consultant in the Trust.

Senior medical leaders are encouraged to undertake the NHS Healthcare Leadership Model 360° feedback to evaluate their impact with their colleagues. In addition, there are a number of self-reflection tools that are available as well as individual coaching.

We actively promote excellent short courses that are available through the East of England Leadership Academy so that our leaders can keep abreast of regional and national developments such as systems thinking and working across boundaries in line with the direction of travel of the NHS.

Culture

The work that we have undertaken with our staff to develop a set of values with behaviours that describe both positive and negative aspects has now been completed. The Values are now included in our appraisal paperwork so that each member of staff will have a chance to think about how they contribute to each one in their daily work. We plan to develop a suite of values-based questions that will be tested with focus groups of managers so that, again, they are consulted on and owned by our staff. Those questions will then form part of an approach to values-based recruitment that will be grown at the L&D so that it reflects our culture, aspirations and beliefs as an organisation.

Sustainability/Climate Change Performance

Introduction

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

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

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

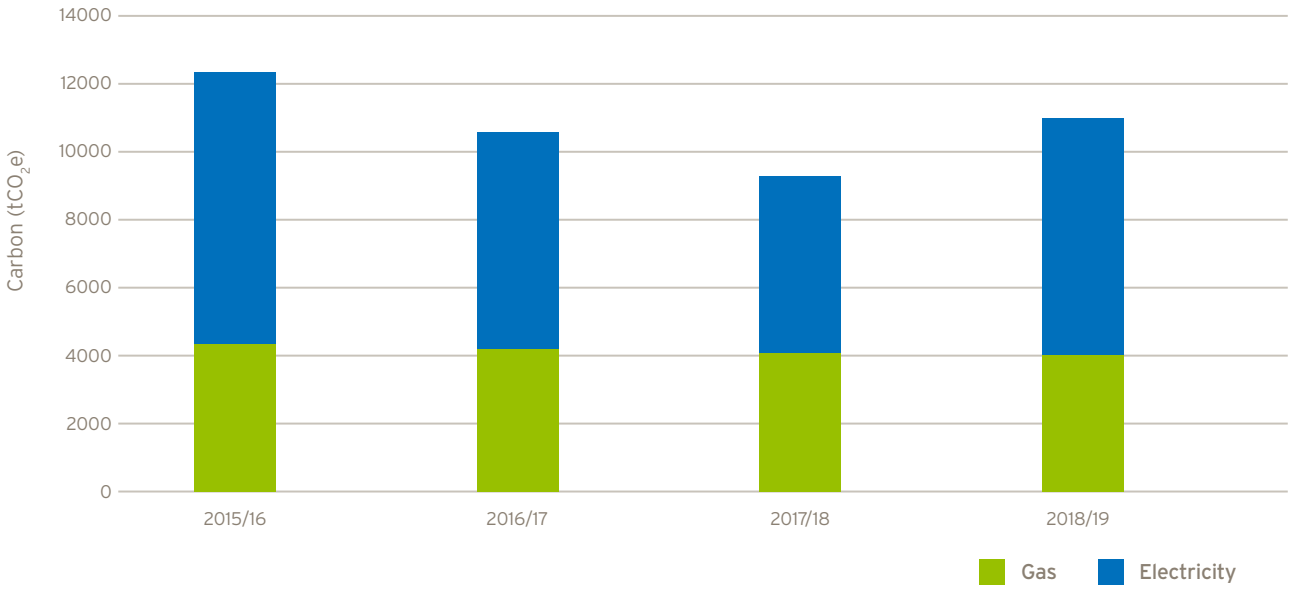
Performance

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

Energy

We have spent £2,540,565 on energy in 2018/19, which is a 14% increase on energy spend from last year due to increases in commodity and transmission costs.

Carbon emissions - energy use



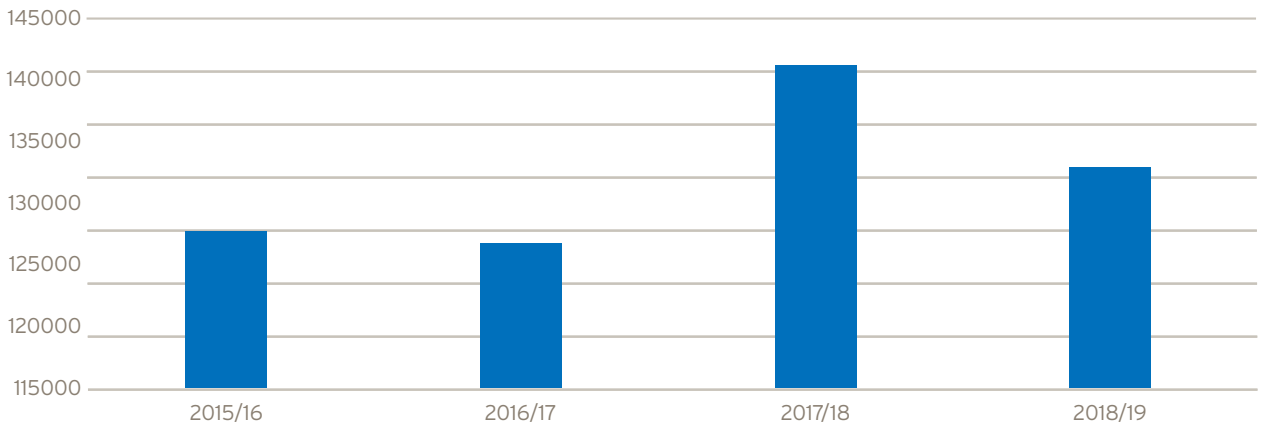
Power and heating is supplied to the Trust via the consumption of electricity and gas. Both are measured in kWh.
The consumption of both utilities is influenced by the seasons and has remained fairly constant over the last four years with minor reductions in gas due to boiler improvements and thermal efficiency schemes.

Electrical consumption has seen a steady decrease due to the fitting of LED lighting and improved plant control. A large reduction has been made this year by recharging consumption from other organisations

Gross expenditure on the CRC Energy Efficiency Scheme to cover emissions generated in 2018/19 is £170,000.

Water

Volume



2018 / 2019 saw a reduction in water consumption due to the fixing of leaks and the continued use of water saving measures.

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

Looking Forward

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

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

Energy centre

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

Improved controls

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

Energy efficient equipment

Site wide LED lighting replacement is planned as part of the Centrica Energy centre project as is solar panel utilisation. In all projects we aim to ensure that wherever possible any replacement electrical / mechanical equipment is more efficient than the item it replaces.

Emergency Preparedness, Resilience and Response Performance

Introduction

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

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

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

Summary of Core Standard requirements

In accordance with the Civil Contingencies Act 2004, the Trust is recognised as a Category 1 responder and subject to the relevant related governance and legislation.
The NHS England Core Standards are divided into the following ten domains:

- Governance
- Duty to assess risk
- Duty to maintain plans
- Command & Control
- Training and Exercising
- Response
- Warming and Informing
- Cooperation
- Business Continuity
- Chemical Biological Radiological Nuclear (CBRN)

The Trust is required to state an overall assurance rating measured against 64 core standards. The definitions of these ratings are detailed below:

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

Each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 2018/19 'deep dive' was Command and Control. The self-assessment against the deep dive standards does not contribute to the organisations overall EPRR assurance rating, these are reported separately.

Performance

This year's self-assessment has seen an improvement, bringing all of last year's substantially compliant standards to fully compliant. For 2018/19 the NHS England EPRR Core Standards have been fully revised and updated. The revision has included new standards and therefore the Trust has been unable to achieve full compliance, and has measured itself as Substantially Compliant (94% compliance). The Trust declared itself as fully compliant against the 'deep dive' Command and Control standards.

Theme	Compliance Level	Comment/Rationale
Emergency Planning, Risk and Resilience Core Standard Topics		
Governance	Full	
Duty to assess risk	Full	
Duty to maintain plans	Full	
Command & Control	Full	
Training & Exercising	Substantial	**Core Standard 28** - There is a requirement for all Strategic and Tactical Commanders to maintain a continuous personal development portfolio demonstrating training in line with National Occupational standards, and/or incident/exercise participation. Working with T & D to record all EPRR activities on individual's ESR.
Response	Full	
Warning & Informing	Full	
Cooperation	Full	
Business Continuity	Substantial	**Core Standard 50** – Organisations' IT Depts are required to certify that they are compliant with the Data Protection and Security Toolkit on an annual basis. The Trust is compliant in 9 of the 10 standards and is working to achieve compliance in the access control standard. **Core Standard 53** – There is a requirement for the Trust to have a process for internal audit, and report outcomes to the Trust Board. The revised Business Continuity policy will include a programme for internal and external audit. **Core Standard 55** – There is a requirement to have a system in place to assess the business continuity plans of commissioned providers or suppliers, and assurance that these providers arrangements work with the organisation's BC plans.
CBRN	Full	

Brexit Preparations

The Trust used the Emergency Planning and Business Continuity processes to support readiness for any Brexit implications. The Trust has been following national guidance and complying with sitrep requirements when required. Risks, particularly in relation to the provision of medicines, have been added to the Trust Risk Register and the issue is a standing item on the Board and Executive discussions.

Going forward

A comprehensive work programme for 2018/19 will address the four substantially compliant core standards, progress will be tracked through the Emergency Preparedness and Business Continuity committee, with an aim of being fully compliant in the 2019/20 Core Assurance Assessment.

Awards and Congratulations

Our hospital

The L&D celebrated its 80th birthday

Everyone was proud to celebrate the hospital's 80th birthday on 14th February. It was wonderful to meet former patients who came back to share their stories. We also welcomed a few people who lined the streets waiting for Queen Mary to come and open the hospital in 1939.

There was a fantastic atmosphere around the hospital, with performances in the main reception from Ferrars Junior School choir, Dallow Road Primary School choir and the L&D hospital choir. There was also a Service of Celebration held for all faiths where a candle was lit to mark the occasion.

The Service was opened by Edward Philip, great grandson of the first benefactor of the L&D, local businessman and Chairman of the Helipad Appeal. There were then prayers and reflections from Christian, Muslim, Hindu and non-religious guests, and Janet Graham, Governor and former L&D nurse, gave a fantastic history of the hospital and amused the congregation with stories about what went on around the wards back in the day.

Patients waiting for outpatient appointments were offered a cup of tea and cake from volunteers to help make the day memorable and around the hospital there were numerous cake and memorabilia sales. The Fundraising Team had a pledge board, face painters and surprised staff and patients with a visit by Luton Town FC mascot Harry.

The Mayors of Luton, Dunstable and Houghton Regis joined Simon Linnett (Hospital Chairman), Matt Gibbons (Director of Finance) and Edward Phillips (Chairman of the Helipad Appeal) to judge a cake competition.

Both BBC Look East and ITV Anglian covered the birthday in the news reinforcing just how important the L&D is to the community it serves.

To commemorate the 80th birthday, a permanent exhibition has been installed on the first and second floor of the main hospital so please do pop along if you want to see it. It includes photographs from when the L&D was opened by Queen Mary and our 'Dig for Victory' efforts during the war. There is also a commemorative brochure for staff, patients and visitors. If you would like one, please email communications@ldh.nhs.uk

Our birthday cake was generously donated by Barnfield College.

Paul Young opened the new Pre-Assessment Unit

Luton pop legend Paul Young came to officially open the new Pre-operative Assessment Unit at the Luton and Dunstable University Hospital (L&D), much to the delight of staff. Paul told staff about his experiences of growing up in Luton and congratulated them on their impressive work looking after the local community.

Pop legend Paul Young with staff at the opening of the L&D's new Pre-Assessment Unit.

The new unit brings together almost all hospital pre-assessment in one place, replacing at least five other locations, and has a dedicated pharmacist and anaesthetist to give expert advice at the time of assessment. Patients have the opportunity to go straight from their outpatient clinic to the drop-in service, reducing the number of visits they have to make to hospital.

All patients can now be pre-assessed as soon as they know they are having surgery, meaning that any clinical concerns can be identified more quickly and a plan put in place for their procedure.

It also means that there are lots of pre-assessed patients who can be offered their surgery at short notice when other patients have had to cancel at the last minute. This is good news for both our patients and for the hospital.

Third MRI scanner suite opens at the L&D

Luton and Dunstable University Hospital (L&D) was delighted to welcome the Mayor of Luton, Councillor Naseem Ayub, to the official opening of its MRI suite transformation on 1 February 2019.

The MRI suite transformation is now complete consisting of a new departmental layout with installation of a 3rd state of the art Ingenia 1.5T magnet, new dedicated inpatient bed bays and new dedicated outpatient seating/changing areas. The transformation also includes replacement of existing magnets with dStream Philips upgrades, a new supporting infrastructure inclusive of chilled water supply and air handling unit.

The overall suite provides our patients with a friendly, comfortable, calming environment reducing patient anxiety and maximising the interaction between staff, patients and relatives. Significantly improved waiting times are to be delivered through the additional scan capacity and also with reduced scan times and a new wide-bore magnet with InBore Experience further reduces patient anxiety and claustrophobia through an immersive, multi-sensorial experience during the scan

New facilities for young cancer patients

Thanks to fundraising efforts from the local community and other donors, children receiving treatment for cancer at the Luton & Dunstable University Hospital (L&D) will now be cared for in a suite of newly refurbished rooms opened in October 2018 which have been specially designed to make their stay as comfortable as possible.

Children between the ages of one and 16 with cancer or leukaemia are admitted to the Children's Wards at the L&D for ongoing treatment which can last from several months to years. Those with leukaemia are on a treatment programme of 2-3 years and during that time they may require hospital admission every month in addition to attendances for day procedures such as transfusions. An admission lasts on average 3-4 days and in some cases lasts months.

These young patients have to be treated in isolation, because of their very high risk of infection, so they have no access to the paediatric play room, teaching room or communal facilities. Having to spend time in hospital, whether it's a day or a month, is distressing for everyone, but for children it is even harder.

The newly refurbished suite has created a third more space, and the rooms have been specially designed to adapt to children of different ages, with storage for toys, as well as space on the floor marked as a play area. There is also adjustable lighting so that children suffering with light sensitivity due to treatment or their condition are not stuck in a room with halogen lighting. There is also a small integrated kitchenette and sofa bed so that parents can stay with their child, as well as a movable desk so parents can work on a laptop.

New Community Hub health centre in Luton town centre

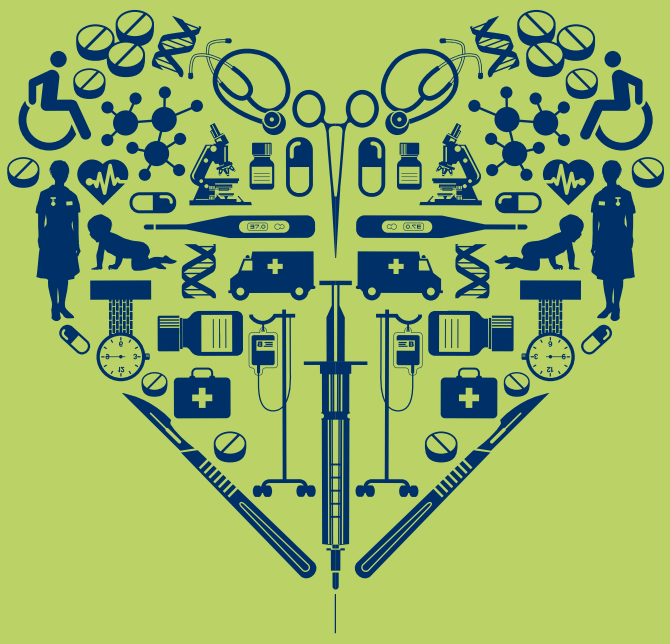
From the 4th June 2018, the Luton and Dunstable University Hospital (L&D) relocated adult GP phlebotomy (blood tests) and anticoagulation phlebotomy services, Sexual Health services and its Dermatology Outpatient Clinic to a newly refurbished, central location in Arndale House, based in The Mall, Luton.

Patients are able to access the central hub via a variety of public transport routes and those travelling by car will be reassured that Arndale House offers greater parking options that are less expensive compared to the hospital site.

Patients enjoy a more comfortable, newly renovated clinic with free Wi-Fi, shorter waiting times and all the local amenities that The Mall has to offer. Each service is accessible via the Community Hub's shared lobby before patients are directed to dedicated entrances for each department, giving patients discreet access and improved confidentiality.

For phlebotomy, the move has seen the introduction of optional timed priority appointments, where patients will be allocated a blood test within a one hour time slot should they choose, with the option to walk in and wait if they prefer. Adult phlebotomy and anticoagulation services are the only services to be moved, making up just one third of total bloods taken at the hospital. The other two thirds, including inpatient and paediatrics remain at the L&D.

Our patients, our staff and our partners



Our Patients

The organisation continues to value and listen to feedback from people who use our services. Patient, carer and public feedback gives us a source of intelligence to help drive quality improvement and develop services. We continue to use four key methods to gather feedback, which are;

- The Friends and Family Test (FFT)
- National Patient Surveys and Websites
- Feedback through the Patient Advice and Liaison Team (PALS)
- Key stakeholder involvement

We collect information from the following groups;

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

We improved our response rate for the National Inpatient Survey in 2018 by 4% up to 40% compared to the previous year. Patients told us that their overall experience with us was similar to 2017. In the 2018 Maternity Survey, new mothers told us that we continue to provide a similar quality of services compared to 2017. All national surveys listed above, with the exception of the Children and Young People's Survey, are conducted annually.

Our patients complete the FFT survey in all areas and they tell us that they are more likely to recommend our services compared to the national average. We collect the information weekly and feed this back to teams so that, where necessary, they can look at ways to make improvements quickly rather than waiting for monthly results. The weekly reporting has proved successful as teams actively seek out their results each week. This has resulted in a significant increase in the response rate for our Emergency Department and Inpatient areas. We now see a monthly response rate well above the national score in these two areas and have done so for a number of consecutive months this year. Further details are within Appendix 1 the Quality Account.

Patient Advice and Liaison Service (PALS)

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

The PALS Team currently co-ordinate access to the Interpreting Service, which is available for our patients. In quarter three this year we appointed a new provider for the service and staff now book their own interpreters, rather than request them through PALS. This has improved the booking process enabling staff to see what is happening with their bookings using an online portal. We will continue to work towards increasing our use of telephone interpreting, which will make interpreters more easily accessible for patients and staff, as well as support efficiencies for the organisation. Outpatients and Maternity Services continue to be the highest users of interpreting services. The top four languages remain unchanged from 2017. These are Polish, Romanian, Bengali and Urdu which account for over 80% of requests made.

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

Key Stakeholder Involvement

Both Healthwatch Luton and Luton Clinical Commissioning Group (CCG) have undertaken announced quality visits this year. The teams visited various wards and the visits included interviews with staff, patients and family/carers. The overall feedback from the visits was positive with some recommendations for improvements. For example, ensuring that patients whose first language is not English are aware that any information we have can be translated into their chosen language. We have also undergone two inspections from the Care Quality Commission (CQC), one announced and one unannounced. Like Healthwatch and Luton CCG, the inspection teams spoke with patients and staff, to gather their views. It is useful to get feedback from these organisations as sometimes patients and staff may be more likely to give honest and open feedback to someone who does not work at the hospital. The outcome of the CQC inspection is covered in more detail elsewhere in the Annual Report.

NHS Choices

We continue to review feedback left on the NHS Choices Website as another measure of what our patients tell us about our services. To date this year there have been 251 reviews posted on the NHS Choices website. The overall star rating for the Trust was 4 stars, which has been retained since last year. There are five subgroups, cleanliness, staff co-operation, dignity and respect,

involvement in decisions and same sex accommodation. We scored 4 stars in each category.

Patient and Public Participation Group (PPPG)

The PPPG has continued to be active in 2018/19. The Strategy for Patient and Carer Experience and Public Involvement has been reviewed and changes will reflect new Trust objectives and values. The group has met regularly throughout the year, and with good input from Hospital and Public Governors, as well as the public and service users, crucial issues have been raised which underpin quality improvement work in the Trust.

Service User Groups/Engagement

Service User Groups in place last year have continued to meet in 2018. The Breast Care Support Group is thriving and a new group for patients with metastatic disease has been set up. An additional group is planned for younger patients who develop breast cancer. The Patient Experience Team has also supported Medical Lectures this year. This has allowed patients in certain disease groups to give feedback about their experiences at the hospital. These have included respiratory medicine, stoma care and dementia. Engagement meetings have taken place with local groups and these have been particularly successful with the Roma Community.

Patient Stories

The Clinical Outcome, Safety and Quality Board (COSQ) has continued to invite patients to share their experiences with them throughout the year. Individuals shared their experiences through a story, which it is a powerful way to hear their concerns and compliments. We can then compare their story with information gathered from other patient feedback e.g. the FFT to drive improvement. The stories have also allowed patients and their families to tell us about their good experiences so that good practice can be cascaded throughout the organisation.

Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. During the reporting period we received **551 Formal Complaints** (a reduction of 50 on 2017/18). A breakdown of complaints (by month, by category) is contained within the Quality Account.

All the complaints were investigated through the complaints process by the General Manager for the appropriate division and a detailed response addressing the issues raised sent to the complainant.

The majority of complaints were resolved at local level and did not require review by the Parliamentary Health Service Ombudsman (PHSO). General Managers, Service Managers and Matrons have continued to be proactive in the management of complaints by making early contact with complainants to discuss their issues. This approach resulted in a number of complaints being resolved without having to go through the formal process and produce a written response; therefore they were resolved informally. Some of the complaints were resolved at hospital level, whereby Local Resolution Meetings (LRMs) were held with either General Managers, the Chief Nurse, Deputy Chief Executive and/or the Chief Executive. Where appropriate relevant clinical staff were also involved in the LRMs.

Unfortunately, 5 complainants asked the PHSO to review their complaints, four of which were reported prior to this year. Out of the 5 cases with the PHSO at present, two remain opened and we await reports. Two complaints were not upheld by the PHSO and one was partially upheld.

In order to monitor the effectiveness of the complaints process weekly tracker reports continued to be sent to divisions throughout the year to enable them to update the Chief Nurse and central Complaints Team with progress. It also provided divisions with the platform to highlight challenges experienced when aiming to keep within required timescales, identifying support required from the Executive Team. The quality of the investigations being carried out and the standard of those responses remained very high.

During the year an external review of the complaints process was undertaken, which has resulted in a number of recommendations and changes to the process and support documentation is part of ongoing developments. We have continued to make improvements to our complaints process in line with these recommendations. Some changes already in progress include the following;

- Rebranding the Patient Affairs Team to become the Complaints Team, in line with other organisations reducing confusion with the teams' role.
- Merging the Patient Advice and Liaison (PALS) and Complaints Teams to provide a better resource and increased expertise, which we would hope prevents concerns escalating to formal complaints.
- Review and update the current Complaints Policy
- Development of a Standard Operating Procedure to underpin the policy.

Compliments

During the reporting period approximately 4,500 compliments (nine times more than complaints) were received directly by the staff or service, and cascaded to the staff and/or service involved by the respective manager.

Below are some of the compliments we received:

Ambulatory Care
"Just amazing. People who will go above and beyond, day and night. Very caring, polite and courteous. Nothing was too much trouble."

Neurophysiology
"Staff were helpful and understanding, taking my mum's health/mobility and language issue into account. They wanted to ensure the test is done rather than turn away. A great example set."

Ward 10 – Respiratory
"Nothing has been too much trouble for anyone. The care has been first class and sincere. Watching the staff look after everyone with such varying illnesses with compassion, has been humbling."

Oral and Maxillofacial
"Efficient, the times for appointments were kept to time. Friendly staff. Clean, modern clinic. Excellent surgeon who made me feel well informed about my treatment and at ease. Well done!"

Ward 17 – Stroke Unit
"Dedicated staff who are very good in what they do. All options are looked into and investigated."

NICU
"I can only say my baby and i have received the best care from staff and service has been excellent. the facilities are very adequate "

The Chaplaincy Service

This has been a year when the Chaplaincy has continued to develop the care and support we offer as we seek to better meet the needs of the Trust and the communities we serve. We are continuing to focus on developing spiritual care and support at the end of life, to establish new volunteer roles, ensuring that the care we offer meets the spiritual, religious and cultural needs of the diverse communities we serve.

We have continued to enlarge our team of volunteers and have welcomed new people from a variety of faith and community groups into the team. This year the team was able to offer support to over 30,000 people –patients, visitors and staff – over the past twelve months this is 10,00 more than five years ago thanks to the commitment and hard work of our Chaplains and volunteers.

We have continued to work more closely with the Chaplaincy team at Bedford Hospital and have identified a number of ways that we can bring our teams together as we support the people of Bedfordshire and help one another. We have also recruited a Muslim chaplain to further support the team.

Safeguarding Children and Adults

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

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

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

Actions taken and measures in place are as follows:

- Reports are presented to the Clinical Outcome, Safety and Quality Committee annually on safeguarding children and young people and there is a clear reporting structure in place to raise issues throughout the year.
- Audits and reviews are carried out to check and satisfy ourselves that our systems and processes are effective.
- Clear procedures are in place in the Emergency

Department (A&E) and staff receive regular update training on safeguarding.

- Clear procedures are in place to ensure that the Trust is working with other organisations to safeguard children and adults.
- Disclosure and Disbarring (DBS) checks are made on all new staff adhering to the NHS Employer guidelines and the Trust is compliant with safeguarding guidelines.
- Training in safeguarding children and young people and adults is one of the key components of the corporate induction programme for all new starters and is included in the annual mandatory refresher training which is being made available as e-learning.
- All training arrangements have been reviewed.
- A Named Nurse, Named Midwife and Named Doctor have specific responsibility for safeguarding children and young people across all parts of our hospital – they are clear about their roles and are given sufficient time to enable them to fulfil their responsibilities.
- A Named Nurse and Named Doctor have specific responsibility for safeguarding adults.

Our Staff

Our success is delivered through our people and as such our staff continue to be our most valuable asset when it comes to delivering clinical excellence, quality and safety to our patients. We strive to attract the best people, value and develop them so that the teams they work in deliver outstanding care to our patients. We 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.

Vision, Values and Behaviours

Following the selection of the Trust's values by staff in 2017, in summer 2018 staff were asked what behaviours they wanted to see more of and what they wanted to see less of as part of each of the values. This has been summarised and shared with staff so they know what is expected of them and feel fully involved in developing the culture. We want these values to lie at the heart of 'how we do things round here' so that they become how we work with each other, how we care for our patients and how we interact with stakeholders.

The next stage of this exciting project will be to ensure that we really use our Values to recruit, develop and support both individuals and teams at 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.

In June 2018 changes to the Tier 2 points based immigration system saw doctors and nurses excluded from the government's cap on skilled worker visas, meaning the restriction was lifted on the numbers that can be employed from non-EU countries. This removed a key barrier to the delivery of the Trust's overseas recruitment strategy.

The applicant tracking and recruitment software system implemented last year has enabled the Trust to improve communication with candidates and maintain a competitive time-to-hire. We have used the system to develop recruitment tracker tool which enables real-time workforce planning which has led to the Trust ranking in the top quartile in the Model Hospital data-set for time-to-hire.

Registered Nurses

The recognised national shortage of registered nurses remains a key challenge for the Trust. As well as continuing with cohort recruitment and regular advertising the Trust has worked hard to deliver its strategy to recruit both EU and non EU nurses. The Trust ran campaigns to recruit nurses from Italy and Portugal and carries out bi-weekly interviews of overseas nurses.

There remains a challenge around required English language tests which extends the time it takes to recruit a nurse from overseas but changes made last year helped to speed up the recruitment process. The NMC adjusted the International English Language test (IELTS) pass rate from 7 in all factors to accept a 6.5 pass mark in the written element and also recognised a new Occupational English Test.

The OSCE (Observed Structured Clinical Examination) is an exam which overseas nurses need to pass before they can gain their NMC registration. It is often viewed as a barrier to recruitment however the Trusts fast track OSCE training programme has reduced the length of time it takes to gain NMC registration and continues to achieve one of the highest first time pass rates in the country with the Trust cited as an example of best practice by test providers.

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.

Healthcare Assistants

The recruitment of Healthcare Assistants has been a challenge for the Trust over the last year. We have undertaken monthly open days and associated campaigns over the past twelve months to ensure vacancies are kept to a minimum and that we maintain a critical mass of bank workers. We reviewed our selection process and improved the numeracy and literacy assessments which improved the conversion rate for the number of applications to the number of offers made. The same day assessment and interviews has maintained the high calibre of new recruits and enabled the Trust to continue not to use any agency workers to cover Healthcare Assistant vacancies.

Nurse and HCA Retention

The Trust joined cohort two of the NHS Improvement (NHSI) Retention Direct Support Programme aimed at supporting Trusts to reduce turnover of nursing and midwifery staff. The Retention Matters Project was initiated with a strategic focus on four areas: improving data, transfer window/career conversations, working flexibly and retirement. This project has carried out in-depth analysis of the drivers for turnover and implemented an electronic exit questionnaire to improve data capture and an "itchy feet" survey tool. Monthly "Itchy Feet" clinics have been introduced to provide Nurses and HCAs who are thinking of making a change a space to have career based discussions with the senior nursing team who facilitate interventions that will address their aspirations and reduce the likelihood of them leaving the Trust.

Medical Workforce

The Trust approved a business case to invest in the Medical Workforce Team and the early results have enabled improved workforce planning, recruitment and the development of a comprehensive rota review programme to ensure working patterns meet both educational and service needs. A combination of investment in the Medical Workforce Team and exclusion of doctors from the annual immigration cap has enabled the development of a successful overseas recruitment pipeline and improved candidate experience that has enabled the Trust to recruit overseas doctors within 10 weeks. This has resulted in early success in filling vacancies in the Surgical Division.

EU Settlement Scheme

The Trust values the contribution and commitment of all our overseas staff from EU and non-EU countries. In light of the uncertainty around Brexit the Trust participated in the testing phase of the government's new EU settlement scheme. This scheme will provide our EU staff with continued rights in the event of either a deal or no-deal Brexit scenario.

In order to demonstrate our support for staff the cost for registering under the scheme was met by the Trust and a series of workshops were held to provide advice and support for our staff to apply for settled or pre-settled status. Following the testing phase the fee for the scheme was abolished and the Trust will continue to reassure and support our staff to register under the EU settlement scheme over the coming year after it re-opens for applications from March 2019.

eRostering

The delivery of high quality, compassionate care relies on having the right people, with the right skills, in the right place at the right time. The provision of a well-planned staff roster, based on the needs of our patients matched to the resources available is fundamental to ensure the delivery of safe effective care.

The Trust has implemented eRostering across the bed base and Theatres and uses real-time data to ensure rosters maximise the effective use of resources and inform operational workforce needs. A roster productivity review programme to improve the quality of rosters, minimise the use of agency and contribute to high quality patient care has been established and will continue in the coming year. We successfully implemented the use of the eRostering system for our administration and clerical bank staff removing the need for paper timesheets and streamlining the bank booking process.

The Trust also invested in eRostering technology for medics and established a project that will see the first deployment within the Medicine Division in May 2019 followed by a divisional based deployment.

Nursing Associate

We currently have 12 Health Care Assistants who are on an apprenticeship to qualify as Nursing Associates and they will be able to work on the wards in an enhanced role, for example, completing drug rounds with some limitations in their scope of practice. In March 2019, nine staff completed the Nursing Associate qualification funded by Health Education East of England and will now be interviewed to be recruited into the role substantively.

The Trust has contracted formally with the University of Bedfordshire to deliver both the Nursing Associate and the 18-month Nursing degree and two staff have started the 18 month course to qualify as nurses. It is our intention to support Nursing Associates to apply for the Nursing degree to increase the number of qualified nurses in our workforce.

Needs Based Care

The Trust continued 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 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 contract management and common processes to ensure best value for the use of agency staff without risks to patient safety. The Bedfordshire and Hertfordshire consortium expanded its membership to include other Trusts in the region and led to the formation of an collaborative working group across the whole of the East of England focussing on consistency and value from locum agencies across a wider geography. This work continues to deliver savings to the Trust and provide consistency within the local agency market.

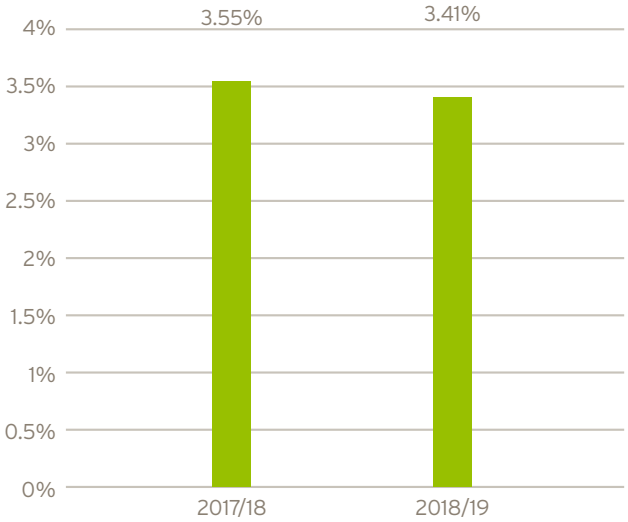
Consultant Job Planning

The Trust recognises the importance of ensuring alignment between meeting patient demand and the availability of senior medical staff. 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. A team based approach to job planning has been embraced by a number of services and work will continue to embed this process where appropriate.

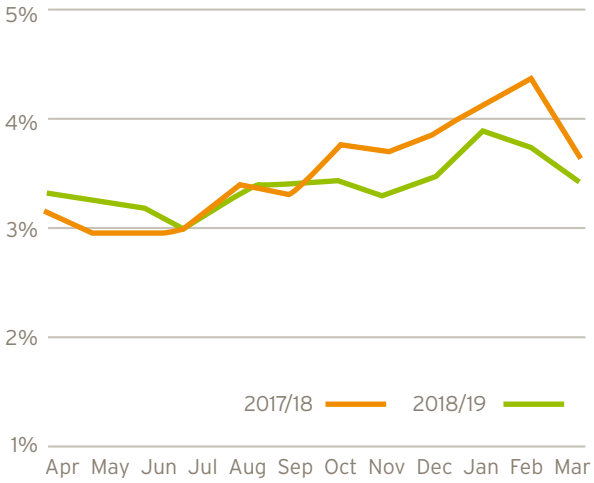
Sickness Absence

The Trust has continued to monitor sickness absence. For this financial year there has been an overall reduction in the absence rates and is lower than the NHS National median of 4.35% and places the Trust in the lowest quartile for absence

Full year sickness absence rates 17/18 vs 18/19



% Sickness absence rates



The Trust is also required to report the calendar year data for sickenss absence. The table below demonstrates a slight increase during 2018. However, the average working days lost to sickness absence per WTE remains lower than the national average which is 10 days.

L&D Staff sickness absence (number)	2018	2017
Total days lost	29,883	27,016
Total staff years	3,794	3,747
Average working days lost (per WTE)	8	7

Trade Union Facility Time Disclosures

The Trust made their submission on the 30th July 2018 for the year 1 April 2017 to 31 March 2018. The 2018/19 submission is published in July 2019.

Employees in your organisation
1,501 to 5,000 employees

Trade union representatives and full-time equivalents
Trade union representatives: 44
FTE trade union representatives: 39.76

Percentage of working hours spent on facility time
0% of working hours: 26 representatives
1 to 50% of working hours: 18 representatives
51 to 99% of working hours: 0 representatives
100% of working hours: 0 representatives

Total pay bill and facility time costs
Total pay bill: £1934934.00
Total cost of facility time: £15894.87
Percentage of pay spent on facility time: 0.01%

Paid trade union activities
Hours spent on paid facility time: 1320
Hours spent on paid trade union activities: 163.5
Percentage of total paid facility time hours spent on paid TU activities: 12.39%

Communicating and engaging with our staff

The Trust recognises that communicating and engaging with our staff is a key part of our success. Having a committed and engaged workforce contributes directly to the quality of the care we provide to our patients. Feedback from the 2019 Staff Survey showed that staff reported that communication between them and senior management has improved and there was good communication between staff and their immediate managers. 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
- Employee and team of the month award
- 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
- Medical Staff Committee and Junior Medical Staff Committee
- Non-Executives attend the clinical divisional meetings
- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

Staff Involvement Group

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

Staff Involvement Group Newsletter

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

Engagement events 2018

Our seventh 'Good, Better, Best'' staff engagement event was a great success. More than 80% of our staff participated during the week in July 2018. The focus of the event was on the Trust Values and an acting company put on a learning event to provide staff with a simple strategy to help with avoiding and dealing with challenging situations.

The Good, Better, Best Christmas staff engagement event was held in December 2018 with more than 250 members of staff attending the sessions. Themes this Christmas included further development of what our values mean to different people, an update on the Hospital Redevelopment Programme and gave us an opportunity to thank staff for their hard work and dedication over the year.

Our Volunteers

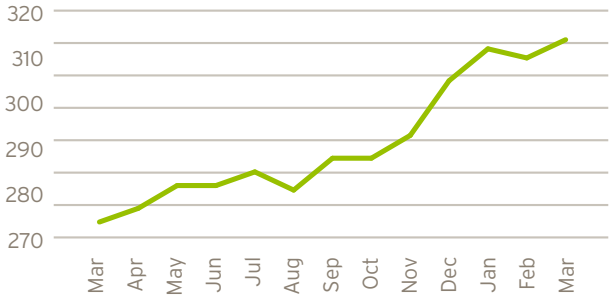
Volunteering in the NHS is now getting much recognition and policy priority from NHS England and from the Department of Health and Social Care as it is a key enabler in transforming the way the NHS works with people and communities. Volunteering was one of the themes of the NHS70 celebrations and was a priority in the NHS Five Year Forward View, In September 2018 NHS England announced £2.3 million of funding to support HelpForce work with NHS Trusts to develop their volunteering services. Additionally, volunteering and social action now forms part of the NHS Long Term Plan – NHS England have committed to backing HelpForce to double the number of volunteers in the NHS over the next three years

Our Volunteer Strategy is about maximising the potential of volunteering here at the Luton and Dunstable University Hospital and 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 also responsible for overseeing external organisations working within the Trust, such as the RVS, Carers in Bedfordshire, BLISS and Hospital Radio and also organisations and 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 compiles their eNewsletter which is sent out to members nationally. She also assists in organising their bi-annual training seminars.

We currently have 309 (as at 31/03/2019) volunteers working alongside our paid staff in a variety of roles. This is an increase of 15.4% on the last year. Additionally we have five staff who volunteer hours outside of their regular roles.

Number of Volunteers



Our volunteer base is made up as follows:

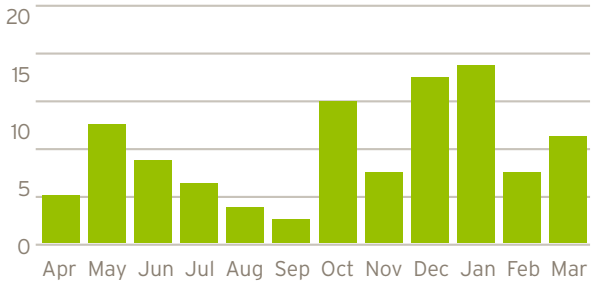
Age (years) as at 31/03/2019	Number of Volunteers	%
18 - 24	36	11.65
25 - 49	50	16.18
50 - 65	69	22.33
66 - 79	132	42.71
80 and over	22	7.11

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 56 leavers in 2018/2019, 5% are now employed by the Trust and a further 3.5% went on to employment within healthcare. 3.5% went in to health related education. The majority of volunteers (30%) leave because of a change in personal circumstances.

Additionally we have welcomed 14 students this year who have joined us as part of our newly introduced Student Volunteering Programme. Working with local Sixth Form Colleges, we have offered places to young people wishing to gain an insight into a ward environment before going on to apply for a medically related course at university. These volunteers assist on the wards at mealtimes, giving out meals, and after a comprehensive training, helping to feed patients.

This year we had a total of 93 new volunteers start, and 56 volunteers leave.

Starters 2018/2019



Leavers 2018/2019 with reasons

Attendance Lapsed	10
Change in Personal Circumstance	18
Did not meet expectations	1
Dismissed from role	1
Dissatisfied with placement	1
Education	2

Employment - Healthcare	2
Employment elsewhere	3
Employment in Trust	3
Illness	3
Moved Away	3
Not Known	3
On hold for more than 6 months	2
Other Volunteer Role	4

65% of our volunteers are White British. 31.2% of volunteers are from a BME background, which is an increase of 4.4% from last year - although it is still under representative of our local community. To redress this there will be a targeted recruitment drive in 2019/2020 within local communities.

During 2018/2019, our Trust volunteers gave us a total of over 28,100 hours, which at mid-point band 2 is the equivalent of £253,743 or 15.3 full time band 2 staff.

A number of external organisations joined us to give their support as part of their Employee Volunteering Programmes. In June, staff from Nationwide Building Society returned once again – they assembled and painted a number of picnic benches for our staff and patients to use in outside areas to enable them to relax away from their busy everyday lives. TUI also came back to us in September to undertake work in the garden of the NICU parents accommodation.

We are proud that two of our volunteers have been recognised both locally and nationally for their contribution to the Trust and our patients. Richard Moisey (Main Reception Volunteer) was the winner of the 'Service With A Smile' category at the Luton's Best Awards in November having previously been awarded a certificate in March by the High Sheriff of Bedfordshire for his services to the community. Eileen McMahon (Skin Camouflage Volunteer) is well deserving of the Lifetime Service Award that she won at the National NHS Unsung Hero awards in Manchester at the beginning of March. This resulted in an article in the local press and an interview with Eileen broadcast by BBC Three Counties Radio.

Mr and Mrs Pattni (Main Reception Volunteers) independently organised a 'Bollywood' afternoon of music and dance which raised over £4000 towards the Trust Charity's Helipad appeal.

Volunteers have assisted Medical Education with the OSCS Exams which has resulted in a donation to Voluntary Services to the sum of £28,80. This will be used to support the cost of Uniforms and Volunteer 'Thank You' Events.

In June, we took a number of our volunteers for afternoon tea to Stockwood Park, and we held our annual Long Service Awards and Annual Thank You 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's Chairman, Simon Linnett and then a 20 year Long Service Award presented by our CEO to to Pat North and Jeanne Botsford, both 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 2018/19 the Trust has continued with initiatives, to promote opportunities for staff to adopt a healthier lifestyle either on site or by promoting external facilities that are conducive to good health.

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

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

Annual Health and wellbeing event

In June 2018, the annual health and wellbeing awareness raising day entitled 'spring into summer' took place. Attendance levels have increased year on year, and we had over 300 members of staff attend, with many participating in the activities. Awareness raising stands and activities

included: Chair based fitness exercise demonstrations by Active Luton, Latin infusion dance demonstrations, Laughter yoga, Batak reaction game, smoking cessation, smoothie bikes, Blood pressures, Heights/weights and Body Mass Index, healthy eating, a nutritionist performing health snacks demonstrations, table tennis and a skipping challenges, and a company promoting ergonomic posture correction and active working products.

This year, 76.7% of our frontline staff were vaccinated against flu, which was marginally higher than the year previous and amongst the highest uptakes when compared to other NHS Acute Trusts.

Employee Assistance Programme

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

Health Checks for staff

The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. A company commissioned by Luton Borough Council provides free health checks to those over the age of 40 and up to the age of 74. Whilst this is national scheme we have been able to continue to secure dates for this service to be brought on site to our staff. Since October 2013 sessions have been available on a monthly basis with over 580 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk factors. The results are shared with the individual and their GP, and where necessary onward referrals made.

Fruit and Vegetable Market Stall

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

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

Wednesday Walking

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

On site Eye tests

Following requests from staff, we invited a specialist company to come on site, for the purpose of providing free comprehensive eye tests to our staff.

They were on site from early December 2018 to early February 2019, for a total of 34 'testing' days.

During this time 602 members of staff were seen, 61% were advised the need for vision correction.

NHS staff survey

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

The response rate to the 2018 survey among trust staff was 52 % (2017: 54 %). Scores for each indicator together with that of the survey benchmarking Group 'Acute Trusts' are presented below.

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group -average	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.0	9.1	8.9	9.1	9.0	9.2
Health and wellbeing	6.0	5.9	6.1	6.0	6.2	6.1
Immediate managers	6.9	6.7	6.9	6.7	6.8	6.7
Morale	6.1	6.1		Not measured		Not measured
Quality of appraisals	6.0	5.4	5.8	5.3	5.9	5.3
Quality of care	7.6	7.4	7.6	7.5	7.6	7.6
Safe environment – bullying and harassment	7.9	7.9	7.9	8.0	7.7	8.0
Safe environment – violence	9.5	9.4	9.3	9.4	9.3	9.4
Safety culture	6.8	6.6	6.7	6.6	6.7	6.6
Staff engagement	7.2	7.0	7.2	7.0	7.3	7.0

Commentary

A sample survey was conducted in 2018 and this seeks the opinion of 1250 staff. The response rate was 52% and although slightly lower than the 2017 response rate (53%) it was still higher when compared to the average of all Acute Trusts (44%).

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

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

Areas for improvement

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

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

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

Future priorities

- We will embed the new policy on preventing harassment and bullying of our staff from members of the public reinforcing the action that will be taken against the very small minority who behave in an aggressive manner towards our staff. The training on Prevention of Bullying and Harassment will be reviewed to ensure it still meets the needs of the Trust.

- We offer a range of training to support staff who experience stress and this will be promoted and we will ensure that there are enough places on offer.

- Where there is evidence of local MSK concerns, we will offer further advice and guidance as well as local training with our Moving and Handling Trainers.

- As we now have a full set of new organisational Values with behaviours that describe what staff like to see and what they do not, we will ensure that these are fully embedded through annual appraisal and Values-Based Recruitment. We will also promote these Values to all our external stakeholders to ensure that they are aware of how we wish to conduct our services and what we expect from everyone.

Equality and Diversity

During 2016 - 2018 work focussed on measures to embed Equality, Diversity and Human Rights (**EDHR**) areas into corporate strategies and thinking. This included and remains supported by the umbrella framework for EDHR Strategy, a well-attended EDHR committee, and EDHR featuring on Board level and committee reports and presentations.

The Trust continues to update and add to the "need to know" briefing appendices under the EDHR Framework. These appendices cover both key delivery areas and most recent developments within the field of EDHR practice. For instance simple, more engaging guidance to the Gender Pay Gap Reporting and the Workforce Disability Equality Standard.

2019 will be the Trust's fifth year of comprehensive reporting with valuable data that helps enable informed decisions about service and workforce changes and objectives. The 5 annual reports (which are; Workforce Equality, Patient Equality, the Workforce Race Equality Scheme WRES, the Gender Pay Gap report and the new Workforce Disability Equality Standard WDES), include benchmarking, comparison and analysis and will all be available to view on the Trust website between July and August 2019.

The Trust uses data, service and workforce changes to plan objectives, initiatives and actions that will improved Patient and Workforce experience and Trust performance.

Examples of Trust identified objectives in relation to this and to the Equality Delivery System EDS2 for both Patient and Workforce Experience include:

1. **Setting up an EDHR Task and Finish Group and the Trust's 4th WRES action Plan** For all Trusts, there is a local and National WRES Report. The WRES measures data indices for any gap in experience between White and BME staff, so that any less favourable experience can be addressed. The Trust analyses, compiles and shares a summary report of results and the Trust's position in benchmarking.

2. **Through the 3 WRES indicators in the National Staff Survey related to conduct, the Trust found that the conduct experience was not good for staff in general.**

   To capture work in this and other key areas the Trust set up an EDHR Task and Finish Group in late 2017 with key areas to improve on; (1) The level of poor conduct experienced by staff in terms of abuse, harassment or discrimination from patients, public or other staff; (2) Low declaration levels (workforce and patients) of disability, sexual orientation and religion or belief; and (3) The level of BME representation, progression and belief in fair and equal opportunities for career progression and access to roles. There is still work to be done but some of the initiatives can be seen below and the progress report for 2018 can be viewed under the WRES report section.

3. **Celebrating NHS Employers EDHR week.** Between May 14th and May 18th 2018, the Trust, EDHR Committee, Chaplaincy and Trade Unions set about holding daily events that addressed conduct, speaking up, declaration and value of data. This included:

   - **Board Members Signing Social Partnership Trust Pledge** for their commitment to address poor conduct in the workplace
   - **Children's paintings** and narrative about bullying, unkindness and its impact.
   - **Staff pledges to support the good conduct initiative** (255 were received)
   - Where and how to **speak up about poor conduct**
   - **Sharing training and development** in relation to conduct and wellbeing
   - **"What's it got to do with you?"** getting confidence in sharing Equality Data initiative emphasising its value, anonymity and how to share data.
   - Interesting Myths and Facts about EDHR nationally, in the NHS and locally

4. **Organisational Values and Staff events.** To help with embedding good organisational culture the Trust has worked to develop and use Trust values that also embrace EDHR values of fair treatment, access, inclusion, dignity and respect. Conduct, values and inclusion initiatives have been a thread through staff events in 2018-2019 such as the annual all staff Event in the Tent. This helps to embed EDHR.

5. **Preparing the Workforce Disability Equality Standard WDES and declaration initiatives.** After the success of the WRES, the WDES has started in March 2019 with first reporting due this summer. The Trust undertook initiatives in 2018 to improve declaration of disability, as well as sexual orientation and Belief, but these had limited success even after the previous shift from a circa 56% to 33% non-declaration for these areas due to new recruiting processes and a new employee self-record system ESR. More initiatives are now planned as low declaration affects data validity and progress.

6. **Gender Pay Gap Reporting.** All organisations with over 250 staff must collect specific pay data details by gender annually on March 31st and publish a specific report with results and analysis by the following March.

This is the second year of reporting. The Trust, as for the NHS in general, has a higher ratio of female to male staff (80% to 20%). In the Trust's very senior management, our executive board is reasonably proportional to the workforce with female to male ratio at 75% to 25%. However, there is a general higher level of males in the highest pay quartiles, with the female to male ratio at 67% to 33%.

Lower female numbers in senior management impacts results. When some staff groups in higher quartile pay are excluded from the data (e.g. medical /dental grades or Ad-hoc Professionals/ Consultants) this has a significant impact. For instance, the general mean pay gap reduces from 29.2% to 10.97% in favour of male.

There is also a predominantly male workforce in the higher banded Medical/ Dental Professions where also a bonus (Local Clinical Excellence Award LCEA), is applied. Proportionally this means only 1.65% of staff receive a bonus of which this is 0.67% of female and 4.72% of male employees. This also impacts results for females.

In 2018 the mean bonus pay gap rose 10% to 43.7% (the median 20% to 65.4%). Pay and the bonus are currently incremental to tenure of service and to tenure in the award process. This means that more senior long serving consultants who are typically male will have higher remuneration and bonuses. Even though female consultants increased in number 5% to 30.8%, any impact on remuneration or bonus results will be slow as they need tenure.

The increase in the gender bonus pay gap has not affected the overall pay gap which has been circa 29% for both years. A new LCEA agreement will be applied to awards in 2020 and so will not impact results in the reports due at March the 30th in 2020. The Trust's report has laid out recommendations and actions to improve our Gender Pay Gap results.

7. **Transgender and Patient Experience.** Prior to this reporting year, the Trust reported an increased presentation of the transgender community. Response actions included staff briefings, provision of advice, supporting documents and new policy and guidance for patients and staff including conduct, and confidential handling. Further progress is now being made in different service areas, such as radiology in respect of increasing confidence in sensitive handling of patient care and information for male to female and female to male transgender e.g. in terms of smear test or pregnancy considerations.

8. **Accessible Information - Interpretation and Translation Services.** Last year the focus was on a review of Interpretation and Translation Policy, including consultation about policy and service needs in key clinical areas that handle and enable informed treatment decisions and consent for surgery.

   In 2018 to 2019, the focus was on the service provided. After a comprehensive project the contracted provision of Interpretation Services for patients or their principal carers has moved from being covered by a Service Level Agreement to being a service with a high level specification of requirements. This also involved a full EU procurement and evaluation of tender process to secure formal undertakings and management controls. This critical service now has a new comprehensive management contract which includes a back-up supplier.

   The aim was to ensure quality, equality and safety for the patient and workforce experience. Meeting key language and literacy means better service with access, inclusion, fair treatment, dignity and respect. Also PALS managed the interpretation bookings before but now this has devolved and PALS have more of an overview role which helps them to cover other needs for patients.

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

10. **Chaplaincy Muslim representation** – an example of how Equality data is used and improved includes using the Belief data for Patient attendance and our workforce to ensure our employed Chaplaincy Team are representative of the Beliefs of those who may use the service. The team are supported by a broad range of volunteers across different Faiths. However, the data helped the business case for a Muslim Chaplain and Spiritual Care Advisor to be employed which has been a great benefit to the team and the service. Belief data is reviewed annually to ensure proportional representation is maintained. The Chaplaincy Team give great support to the patients, workforce, EDHR agenda and community.

Not all of the Trust's work for areas of EDHR can be covered in this report and so the above are samples of key areas. More detail can be viewed here:

EDHR and the Care Quality Commission CQC Inspection 2018 during the Trust's inspection in January 2016 the EDHR agenda was being piloted by the CQC in their work. In 2018, EDHR was firmly in the CQC inspection and covered Governance and Reporting, Leadership from the top, EDHR in both Patient and Workforce Experience, culture and conduct, health inequalities and the community. There is a lot to do in the NHS for the EDHR agenda and CQC were keen to see that actions and progress were underway.

Trust Board Seminar and other Committees - EDHR Framework strategy and Equality Objectives must be reviewed every four years and be relevant to the Trust. However, objectives are reviewed annually as a result of our Annual Equality Reporting. EDHR review dates are now in line with corporate reporting and review for simultaneous consideration and embedding in all the Trust does, along with corporate vision, values and objectives. The annual data and analysis reports are also presented to, shared and discussed with, the COSQ Committee and Clinical Board.

There has been a lot to share and discuss from the results of our Equality reports, objectives and actions. This along with Trust Board and Executive team member changes, has meant that planned EDHR seminars for the Board have been delayed until the team is ready.

The EDHR Committee - reports directly to the Trust Board. It is chaired by a non-executive director and two directors attend. Staff, Public and Council Governors attend as well as a Patient representative. The circa 25 members make it a well-attended broadly representative committee from across the Trust and the protected characteristics. The Committee meets quarterly and sets up smaller focus and action groups as required. This includes the

EDHR Task and Finish Committee 2018 whose work is described earlier in this section.

Going forward the EDHR committee will be reviewing annual equality information and determining the next objectives which will include:

- Looking at a Staff EDHR Networks Strategy
- Measures for a representative workforce such as within Gender, Ethnicity and Disability with access to non-mandatory training and CPD, Pay Bands representation, recruitment and selection, Board representation
- Gender Pay Gap initiatives
- Declaration initiatives to improve disability, sexual orientation, religion or belief data
- Disability confidence – for both physical and mental disability

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

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

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

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

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

Staff establishment

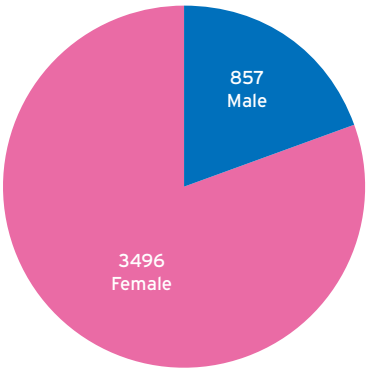
The number of staff at March 31st 2019 totalled 4353, an increase of 3.38% within the last year. As can be seen from the chart below the average annual increase in staff is 2.79%. Relevant against this data is that patient attendances have accrued by circa 5% each year.

Increases in Staff by number and percentage

Year ending	Staff total	increase	
At March 2015	3880		
At March 2016	3813	-67	-1.76%
At March 2017	3950	137	3.47%
At March 2018	4206	256	6.09%
At March 2019	4353	147	3.38%
Increase since March 2015 in staff		473	11.17%
Average annual increase in staff is			2.79%

Gender - the ratio of male to female remains constantly close to circa 20% male to 80% female with this year's ratio at 19.7% male to 80.3% female. Last year's ratio was 19%:81%.

Workforce by Gender



Gender Pay Gap Reporting at March 31st 2018 - as already mentioned in this annual report, the Trust's second Gender Pay Gap Report (for year ending 2018) was published in March 2019 and can be viewed on the Equality and Diversity Section of the Trust's website.

Gender distribution across the workforce

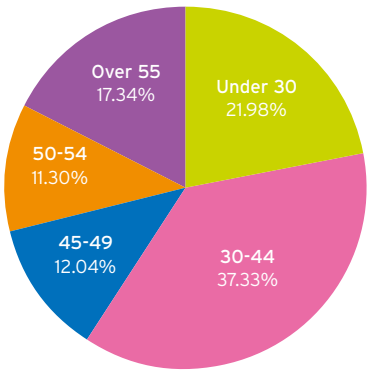
	Male	Female	Total
Executive	2 (29%)	5 (71%)	7
Senior Management 8a and above	213 (44%)	273 (56%)	486
Workforce	857 (20%)	3496 (80%)	4353

Age Profile - Over the five reporting years the workforce has increased in size but there is relatively the same proportion of staff in the age groups covered. The majority of staff are aged between 30-54 years of age. The challenge for the Trust remains the significant proportion of staff in the over 55 age range who may opt for retirement. Age is an area of high declaration as date of birth is required for all employees.

Workforce by age groups at March 2018 and 2019

	2018		2019		
Age groups	%	No	%	No	Ratio
Under 30	21.92%	922	21.98%	957	Same
30- 44	36.99%	1556	37.33%	1625	Increase
45-49	12.01%	505	12.04%	524	Same
50-54	12.93%	544	11.30%	492	Decrease
over 55	16.14%	679	17.34%	755	Increase
		4206		**4353**	

Workforce by age band



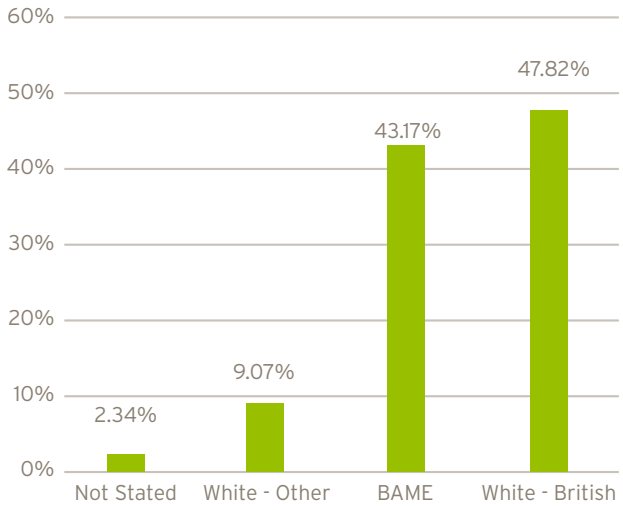
Ethnicity - The Trust is one of the most diverse organisations in the UK. This is an area of high declaration since only 2.34% did not declare (with 4% last year, 3.5% the year before). The proportions of staff in the three groups of White, Black Minority Ethnics (BME) and White Other remain relatively comparable to last year at 47.82% (45.42%); 43.17% (38.9%) and 9.07% (9.77%) respectively.

NB - As for patients the Trust has seen a slow steady increase in the proportions of BME and a decrease in White British. The increase in BME this year was 4.27% or 185 staff. BME and White minority ethnicities now make up 52% of the workforce.

Workforce by Ethnicity Year ending March 2019

White Other European	102
White - British	1977
White - Any other White background	293
Other Specified	3
Not Stated	102
Mixed - White & Black Caribbean	35
Mixed - White & Black African	17
Mixed - White & Asian	26
Mixed - Any other mixed background	30
Filipino	56
Chinese	28
Black Unspecified	4
Black or Black British - Caribbean	155
Black or Black British - Any other Black background	22
Black or Black British - African	290
Asian Unspecified	6
Asian or Asian British - Pakistani	235
Asian or Asian British - Indian	443
Asian or Asian British - Bangladeshi	90
Asian or Asian British - Any other Asian background	299
Any Other Ethnic Group	140

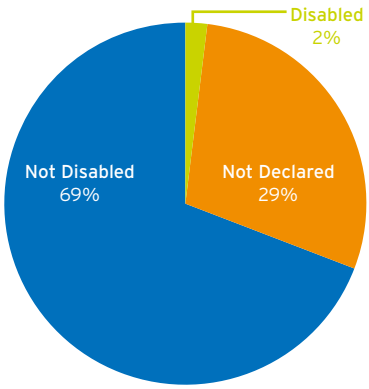
Workforce by ethnicity



Disability, Sexual Orientation and Religion or Belief Declaration – As for patients, all these workforce areas have low declaration and further initiatives are planned to encourage more declaration to keep data capture relevant. These are deemed more sensitive areas and more confidence is needed to ensure awareness of the purpose and value of this data capture as well as the privacy given in its controlled and generic use.

Disability – In 2018 and 2019, the percentage of disabled was 2% which is not a realistic figure against much higher national averages. Fewer staff did not declare their status from 35.6% in 2018 to 29% in 2019, however most of the higher declaration is reflected in the increase in the non-disabled category from 62.35% to 69%. There still needs to be higher declaration and confidence in knowing a disability and in declaring one.

Disability



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

Workforce Belief (and non-belief) At March 2019

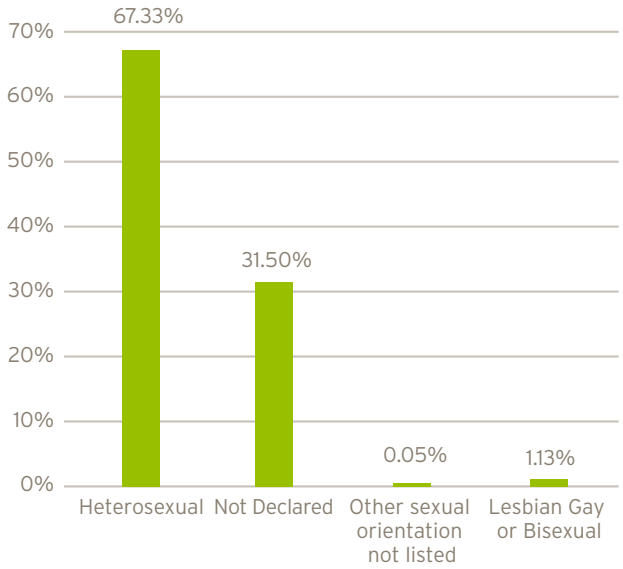
Belief	Staff in 2018	Staff in 2019	change in Numbers	% of Belief 2019
Christianity	1823	1779	-44	40.87%
Undisclosed	1336	1489	153	34.21%
Islam	303	317	14	7.28%
Other	289	288	-1	6.62%
Atheism	287	306	19	7.03%
Hinduism	114	118	4	2.71%
Sikhism	19	21	2	0.48%
Buddhism	17	17	0	0.39%
Judaism	10	10	0	0.23%
Jainism	8	8	0	0.18%
Grand Total	**4206**	4353		

Workforce By Religious Belief at March 2019

Judaism	8
Jainism	10
Buddhism	19
Sikhism	19
Hinduism	118
Other	288
Atheism	306
Islam	317
Undisclosed	1489
Christianity	1779

Sexual Orientation - Last year at March 2018, there was little variation in the declared data for heterosexual and for Lesbian, Gay or Bisexual staff at 67.5% and 1.09% respectively. In 2019 the figures are 67.33% and 1.13% respectively and so similar. However this year we have a new category of 'other sexual orientation' not listed at 0.05%. Non declaration levels remain high at 31.4% in 2018 and 31.5% in 2019 which affects validity of this data.

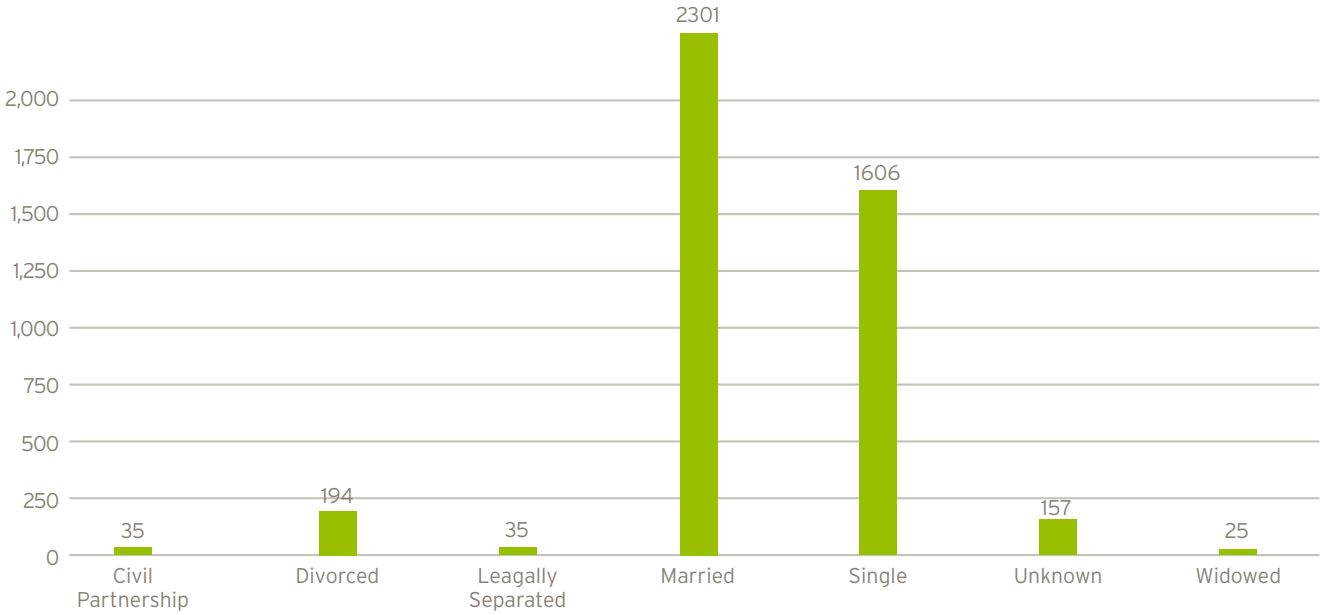
Workforce by Sexual Orientation



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

Partnership status - marriage and civil partnership - As can be seen from the graph below, the majority status for staff remains 'married' at 53% followed by single at 37%. By ratios this is similar to last year's data across all categories with a proportional increase. Data trends show a steady increase in civil partnerships (8 in 2016) with an increase from 26 to 30 staff in 2018, to 35 staff this year.

Workforce by Marital Status



Workforce Partnership status years ending 2018 and 2019

	y/e 2018		y/e 2019	
married	2202	52.4%	2301	52.9%
single	1554	36.9%	1606	36.9%
Divorced	197	4.7%	194	4.5%
unknown	159	3.8%	157	3.6%
Civil Partnership	30	0.7%	35	0.8%
legally separated	40	1.0%	35	0.8%
widowed	24	0.6%	25	0.6%
	4206	100.0%	**4353**	100.0%

Working with our Partners

The Trust contributes to nationally recognised and statutory partnerships through:

- Ongoing collaboration as part of the Integrated Care Systems (ICS).
- Part of the Luton Provider Alliance with Luton Borough Council, Cambridge Community Services and East London NHS Foundation Trust.
- Work within the Local Maternity System for BLMK.
- A&E Delivery Board chaired by the L&D Chief Executive.
- Luton Transformation Board (including the Better Care Fund).
- Local strategic partnerships such as System Resilience Groups and Bedfordshire and Luton Local Resilience Forum.
- Local Safeguarding Children's Boards (LSCB) – Luton LSCB and Bedfordshire LSCB.
- Local Safeguarding Vulnerable Adult Boards for Luton and Bedfordshire.
- East of England meetings and events.
- Regular CEO meetings with Clinical Commissioning Groups (CCG) Chief Officers, Directors of Social Care and the Chief Officer of the Local Area Team.
- Role as lead organisation for the ICS digital transformation strategy around a shared patient record portal which enables intelligent viewing of appropriate information by primary care, secondary care, local authority and community and mental health service clinicians to ensure seamless, integrated care for the BLMK population.

Awards and Congratulations

Our staff

Engagement 2018 – Good, Better, Best Events

The Trust held two staff engagement events in 2018, one in July and one in December. Staff were invited to attend one of numerous sessions during the week long events to hear about the L&D's current news and aims for the next few months. Staff participated in developing the vision, values and behaviours, worked with a theatre company to support dealing with challenging people and received feedback on the CQC inspection report. They also gave the Board an opportunity to thank staff for their hard work. The events were very well attended and feedback from staff was extremely positive.

L&D honoured by Royal College of Physicians

Respiratory Admin Lead, Beverley Gardner, was awarded the PACES Champion Award by the Royal College of Physicians (RCP) for the commitment she has shown in helping to run the practical clinical exams which junior doctors need to pass in order to progress to registrar level.

L&D's Chief Medical Advisor, Dr Danielle Freedman, awarded honorary membership of prestigious Professional Society

Dr Danielle B. Freedman, was awarded the honorary member of the Association of Clinical Biochemistry & Laboratory Medicine (ACB), a title given to people who made a distinguished contribution to Clinical Biochemistry and Laboratory Medicine at an international level.

Dr Freedman, who is also a Consultant Chemical Pathologist and Director of Pathology at the hospital, is only the fifth woman to be awarded this accolade since it was established in 1955, and the fourth person coming from a District General hospital.

Danielle joined the L&D Hospital in 1985, after training as a Pathologist at the Royal Free hospital and specialising in Clinical Biochemistry and Endocrinology at the Middlesex Hospital Medical School.

During her time at the Trust, she has covered several crucial roles, including Divisional Director of Pathology, Radiology, Pharmacy and Therapies and has been the hospital's Medical Director between 2005 and 2010. Since 2015 she has been the Chief Medical Adviser to the Trust Board.

She also continues to teach undergraduate and postgraduate courses on the clinical aspects of biochemistry and laboratory testing in clinical care. A regular international speaker, Dr Freedman has been the recipient of several prizes, including the "Outstanding Speaker Award" by the American Association of Clinical Chemistry in 2009 and in 2014. She was the vice President of the Royal College of Pathologists between 2008 and 2011.

Dr Freedman has published over 100 articles about her work in scientific journals, and contributed to publications and books on clinical governance, thyroid disease, laboratory quality and the laboratory in the patient pathway.

Outside her hospital and teaching engagements, Danielle chairs the Lab Test Online – UK Board, a non commercial website designed to help patients and carers to understand the meaning of their test results and to aid clinicians in explaining them in lay terms to their patients.

Nurses Day 2018

Nursing staff around the UK and beyond recently celebrated International Nurses' Day 2018. The L&D recognised the hard work and dedication that nursing staff contribute towards the success of the Trust by hosting its annual Nurses' Day Conference and Awards.

In the run up to the celebrations staff and public nominated nurses and teams who they feel demonstrate compassion and show how they are 'Proud to Care'. Eligible winners needed to have demonstrated that they put patient experience and safety at the forefront of their daily work, while acting as a role model and providing exemplary care to patients.

The event which took place earlier this month saw seven awards being presented to individuals who have gone above and beyond in displaying outstanding commitment over the past year.

Congratulations to the following who picked up awards on the day:

Aimee Varney Award – Student of the Year
Fiona Brunker

Living the Values – Proud to Care
Charlie Cooper

Innovation in Care
Kelly Warfield
Clinical Support Staff
Kamel Saidi

Student of the Year
Catherine Murphy

Mentor of the Year
Catherine Beavis
Nurse of the Year

Katrina Polfrey
Team of the Year
Ward 17

The event consisted of reflections on the nursing achievements over the past year as well as departmental nurses highlighting their work.

International Day of the Midwife 2018

Each year, the International Confederation of Midwives (ICM) celebrates achievements and highlights the importance of the hard work undertaken by the nation's Midwives on International Day of the Midwife. ICM established the idea of the 'International Day of the Midwife' following suggestions and discussion among Midwives Associations in the late 1980s, then launched the initiative formally in 1992.

At the L&D, International Day of the Midwife was celebrated the day before with an award ceremony to recognise individuals who have gone above and beyond in displaying outstanding commitment over the past year. During the day local and national speakers also in attended to raise awareness of current midwifery topics.

The event on the 4th May 2018 saw nine separate awards presented to Midwives and teams, as voted for by their colleagues and the Midwifery Management team.

Huge congratulations to the following dedicated Midwives and teams for their efforts over the past year:

Midwife of the year
Jo Dunn

Midwifery Support Worker of the year
Sharon Sheridan

Student Midwife of the year
Michelle King

Head of Midwifery Award
Clayron Dyer

Consultant Midwife Award for service development
Giselle Cook

Team Award
Risk and Governance Team

Above and Beyond Award
Pauline Yamfam

Community Midwifery Matron Award
Emily Winter

'Special Thank You' Award
Trish Ryan

UCL Medical School Awards

In August 2018 the Top Teacher and Administrators were announced. The L&D had three winners:

Foundations of Health and Medical Practice

Dr Nicholas Herodotou, a Consultant in Palliative Care at the Luton and Dunstable University Hospital, was awarded the Top Teacher Award 2017-18 by University College London (UCL), for his lecture on Foundations of Health & Medical Practice. Dr Herodotou is a Honorary Lecturer at UCL's Medical School, where he delivers an annual lecture to first year medical students on palliative medicine. He also teaches clinical medical students at the L&D.

Year 6 Winners
Dr Helen Wagstaff is a locum registrar who has worked across the Trust and developed a training package for our newly qualified doctors.

Top Administrator Award
Throughout the academic year, the students are asked, via the online evaluation questionnaires, to

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

Long Service Awards

On the 3rd April 2019 we were delighted to celebrate the long service of 23 members of staff at the Luton Hoo. There was a combined 655 years service between them which is truly remarkable.

The loyalty, dedication and knowledge of each of these individuals is very much appreciated by the whole hospital.

They are: Beryl Adler, Natalie Baker, Noelle Binnington, Teresa Bottaro, Amanda Dixon, Mary Evans, Joanna Hogg, Bindu Lal, Kathleen Lee, Christina Liebermann, Anne-Marie Mead, Fiona Murphy, Susan Pethybridge, Karen Reep, Tracy Smith, Lesley Smith, Jayne Walker, Lucy Wheelhouse, Laila Yanny, Ranjit Thambyrajah, Jacky Simmons, Shiraz Quresi and Mauren Parish.

Our volunteers

Long serving L&D volunteer wins national award
Eileen McMahon, one of the Luton and Dunstable University Hospital's (L&D) longest serving volunteers has been recognised for the outstanding contribution she makes to the community, winning the Lifetime Achievement Award at the national Unsung Hero Award held in March.

Eileen has been a volunteer at the L&D for nearly 45 years, offering NHS skin camouflage treatment for patients who suffer from debilitating skin conditions, disfigurement or scarring.

Living with a visible disfigurement can pose a serious emotional and psychological challenge. Many people experience feelings of being self-conscious and may have low self-esteem, some even have to come to terms with being stared at and ridiculed or bullied. Skin camouflage can transform lives. Using her skills and experience, Eileen supports not just adults, but children too, patiently and diligently sharing her expertise, recommending products and teaching patients how to apply the prescription makeup and creams. This reduces the prominence of their condition, and gives them more confidence to face everyday life.

Volunteer Long Service Awards

On 3 January 2019, more than 100 volunteers once again attended our Annual Thank You and Volunteer Long Service Awards which were hosted by Trust Chair Simon Linnett. Simon and David Carter CEO presented the awards , including two to recognise 20 years of voluntary service to the L&D.

Award recipients were:

5 Years Awards

Taskin Ahmed	Andy Mann
Jean Biggs	Peggy Seng
Anne Curran	Victor Shekle
Maggie Davies	Hasmita Soni
Margaret De Winter	Kailas Tailor
Judy Levy	Victor Wakeling

10 Year Awards

Stan Boelman	Maggie Lane
Lindsay Box	Wendy Ley
Christine Craney	Mr Vaju Pattni
Diane Gomm	Mrs Nabu Pattni
Jean Jeffs	Marilyn Smith

15 Year Awards

Margaret Bush	Angela Pitkin
Julie Crawley	Penny Tilbrook
Pat Leonard	Diane Wells
David McDonald	

20 Year Awards

Jeanne Botsford	Pat North

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

L&D Volunteer recognised by the Pope for outstanding 30 year commitment

Luton and Dunstable University Hospital (L&D) volunteer Bernadette Lana – Roman Catholic visitor and Eucharistic Minister since the 1980s - has been presented with the honorary Benemerenti Medal for her services to the Catholic Church and the L&D.

The Benemerenti Medal is awarded by the Pope to members of the clergy and laity for service to the Catholic Church. Originally established as an award to soldiers in the Papal Army, the medal was later extended to the clergy and the laity for service to the church.

Volunteer, Bernadette Lana was awarded the medal last month and was presented with it by Fr. Michael Patey, the Parish Priest at St Martin de Porres Catholic Church and Chaplain at the L&D.

At the hospital's Volunteer Long Service awards, Bernadette was presented with a special award for her outstanding 30-year commitment by the High Sheriff of Bedfordshire, Vinod Tailor.

Volunteers are a valued part of the team at the L&D and contribute over 25,000 hours of their own time each year to give their support.

Luton's Best Award for our Volunteer for Service with a Smile

Richard Moisey, a volunteer at the L&D, has been recognised for the outstanding contribution he makes to the community, winning the Service with a Smile Award at the Luton's Best Awards held on 23 November 2018.

As a volunteer at the L&D since 2015, and one of the 'Meet and Greet' team, Richard is a Main Reception volunteer and is often the first friendly face that visitors and patients see when entering the hospital. Hospitals are difficult places to navigate and Richard is there to help direct patients to appointments, hold their hand, carry their bags if needed, or push them in a wheelchair.

Voluntary Services Manager, Karen Bush, explains why she nominated Richard for the award: "Richard is a true star and a wonderful ambassador for the Trust. His wonderful professionalism, dedication, unique personality and infectious humour all mean that our patients who walk in agitated and fearful about their visit are supported and calmed, and that applies to both young and old alike – they all love him.

Our Governors

The L&D became a Foundation Trust with a Council of Governors in 2006. Each Governor is able to stay for a maximum of three terms of office.

During 2018, three of our Governors reached the end of their third term which equated to six to nine years' service on the Council of Governors.

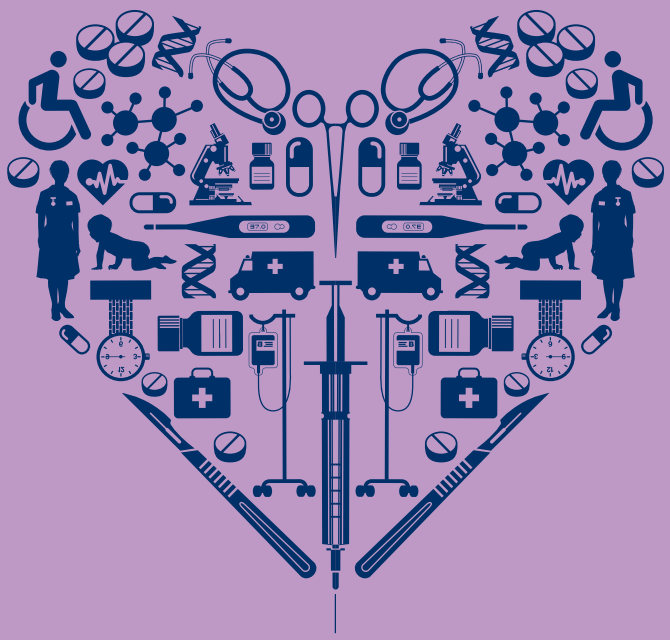
The Trust and the Council of Governors join in thanking them for all their hard work over the years. Their support by representing the views of the local people and staff, and helping the hospital to shape its plan for the future has been invaluable.

Ray Gunning
Bedfordshire Public Governor 2009-2018

Marie France Capon
Luton Public Governor 2009-2018

Jim Machon
Admin and Clerical Staff Governor 2012-2018

Governance Report



Board of Directors

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

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

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

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

Independent Professional Advice

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

The Role of the Chairman of the NHS Foundation Trust

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

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

The Role of Non-Executive Directors (NEDs)

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

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

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

Remuneration and Interests

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

Board of Directors 2018/19

Name	Post Held	Year Appointed	Term of Appointment	Status
Mr David Carter	Chief Executive	2018*	Permanent	
Mrs Cathy Jones	Deputy Chief Executive	2018**	Permanent	
Mr Andrew Harwood	Director of Finance	2000	Permanent	To January 2019
Mr Matt Gibbons	Director of Finance	2019	Interim voting	From January 2019
Mrs Liz Lees	Chief Nurse	2018	Permanent	
Dr Danielle Freedman	Chief Medical Advisor	2015***	Interim voting	
Ms Angela Doak	Director of Human Resources	2010	Permanent	
Ms Catherine Thorne	Director of Quality and Safety Governance	2018	Permanent	From October 2018
Mr Simon Linnett	Chairman	2014	3 Yr Fixed Term	To September 2020
Ms Alison Clarke	Non-Executive Director	2006+	Annual	To July 2019
Mr John Garner	Non-Executive Director	2012	3 Yr Fixed Term	To October 2018
Dr Vimal Tiwari	Non-Executive Director	2012	3 Yr Fixed Term	To September 2019
Mr Mark Versallion	Non-Executive Director	2014	3 Yr Fixed Term	To October 2020
Mr David Hendry	Non-Executive Director	2014	3 Yr Fixed Term	To October 2018
Mr Simon Barton	Non-Executive Director	2018	3 Yr Fixed Term	To September 2021
Mr Mark Prior	Non-Executive Director	2018	3 Yr Fixed Term	To October 2021
Mr Denis Mellon	Non-Executive Director	2017	Interim voting	To May 2019

* Appointed as Managing Director in May 2011 and became Chief Executive in May 2018
** Appointed as Director of Strategic Development in 2016 Deputy Chief Executive in May 2018
*** Appointed as Chief Medical Advisor (at the L&D since 1985)
\+ Reflects appointment to Board of Foundation Trust

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

Compliance with the NHS Foundation Trust Code of Governance

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

In relation to the more detailed provisions of the Code of Governance, the Trust were compliant with the provision with the exception of section B.1.2 from October 2018 to March 2019 the Board did not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

Independent Evaluation of Board Performance both Collectively and Individually

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

HM Treasury

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

Board Evaluation and Well Led Framework

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

The Trust understands and accepts that a periodic and rigorous board evaluation process represents best-practice and should be considered as part of any governance review. An external review took place in 2013 and the Board took assurance from the CQC inspection in 2016. The Board undertook a self-assessment in July 2018 and were subject to a further CQC inspection in August to September 2018 resulting in a 'good' result in the December 2018 report.

The Board of Directors continued to hold a number of seminars throughout the year and to assess the strategic direction of the Trust and ensured that PricewaterhouseCoopers (PwC - internal audit) provided independent review of progress within the clinical divisions.

Trust Directors: Expertise and Experience

Executive Directors

Mr David Carter
Chief Executive

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

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

Mrs Cathy Jones
Deputy Chief Executive

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

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

(Membership of Committees – CF, FIP, COSQ)

Mr Andrew Harwood
Director of Finance to January 2019

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

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

(Membership of Committees – CF, FIP, HRD)

Mr Matthew Gibbons
Acting Director of Finance from January 2019

Appointed Acting Director of Finance in January 2019, Matthew joined the L&D in 2002 from the NHS Graduate Training scheme and was Deputy Director of Finance from 2008. In a long career with the Hospital Matthew has played key roles in the successful Foundation Trust application in 2006, the introduction of Service Line Reporting and the development of a Finance team that has a strong track record of Financial governance & support for the Divisions

(Membership of Committees – CF, FIP, HRD)

Dr Danielle Freedman
*Chief Medical Advisor**

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

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

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

* Medical Directors David Kirby, James Ramsay and Robin White

(Membership of Committees – CF, COSQ, HRD)

Ms Angela Doak
Director of Human Resources

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

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

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

Mrs Liz Lees
Chief Nurse

Liz trained as a nurse at Guys St. Thomas Hospital in London and has been covering nursing and operational roles at all levels ever since in different wards and departments, from surgery to cancer and palliative care. She brings to the Trust her vast experience in both operational and clinical roles in the NHS. Liz was awarded an MBE for services to nursing in 2016.

Her insights of the challenges of bringing together clinical teams, taking the best of both and achieving the right balance, means that Liz is well placed to help shape the future here at the L&D as a larger, single Trust.

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

Ms Catherine Thorne
Director of Quality and Safety Governance – from October 2018

Catherine was appointed as Director of Quality and Safety Governance in October 2018 having previously held the role of Director of Corporate Development, Governance and Assurance at Northampton General Hospital NHS Trust from 2014 and prior to that as Director of Governance at London North West Healthcare NHS Hospital Trust from 2008.

Catherine started her career clinically within radiotherapy and oncology services, transitioning into a variety of senior NHS roles in quality assurance, service improvement and governance.

She has a strong commitment to the use of continual quality improvement in ensuring the provision of safe clinical services, delivery of excellent outcomes and fostering an atmosphere that provides a good experience for our patients and their families set within a learning environment for staff.

(Membership of Committees – CF, COSQ)

Non-Executive Directors

Mr Simon Linnett
Chairman

Simon Linnett is Vice Chairman at Rothschild in London. He has devoted a large part of his professional life to working within the public/private interface both nationally and internationally and is responsible for the bank's relationship with the UK government. He has had a long association with the health dialogue including the health reform process and the health debate generally and has engaged with various government bodies and other health institutions on this subject. Simon has previously headed Rothschild's global transport group and remains closely involved with its initiatives. He

has a strong personal interest in the "green" debate, seeking to influence discussion on emissions and chairing Rothschild's Environment Committee. Simon graduated from Oxford in Mathematics in 1975 and joined N. M. Rothschild & Sons Ltd where he has been ever since. Simon's external roles include: a Patron of the Independent Transport Commission; and Trustee of Exbury Garden Trust (a Rothschild family garden), Trustee of NESTA.

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

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

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

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

Mr John Garner OBE
Non Executive Director to October 2018

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

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

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

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

Dr Vimal Tiwari
Non Executive Director

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

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

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

Mr Mark Versallion
Non Executive Director

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

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

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

Mr David Hendry
Non Executive Director to October 2018

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

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

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

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

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

Mr Simon Barton
Non-Executive Director - From September 2018

Simon is a highly experienced Chief Financial Officer. He is an accountant and has 10 years' experience in investment banking. He has a broad range of experience in financial planning and analysis, a very strong history of developing and negotiating creative financial outcomes, fundraising and completing strategic transactions and an established record of adding value with innovative solutions.

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

Mr Mark Prior
Non-Executive Director – From October 2018

Mark is a chartered project manager and surveyor with over 35 years' experience in the construction and development sectors. He was Managing Director for E C Harris in the Middle East and grew a single location single service office of 30 staff, into a business, operating from Abu Dhabi, Dubai, Qatar and KSA, delivering outcome based project services, with over 700 staff.

He was Group Head of Transportation for EC Harris, building a sustainable and diversified portfolio of international business and focusing growth in project and construction services.

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

Mr Denis Mellon
Non-Executive Director

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

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

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

Record of committee membership and attendance

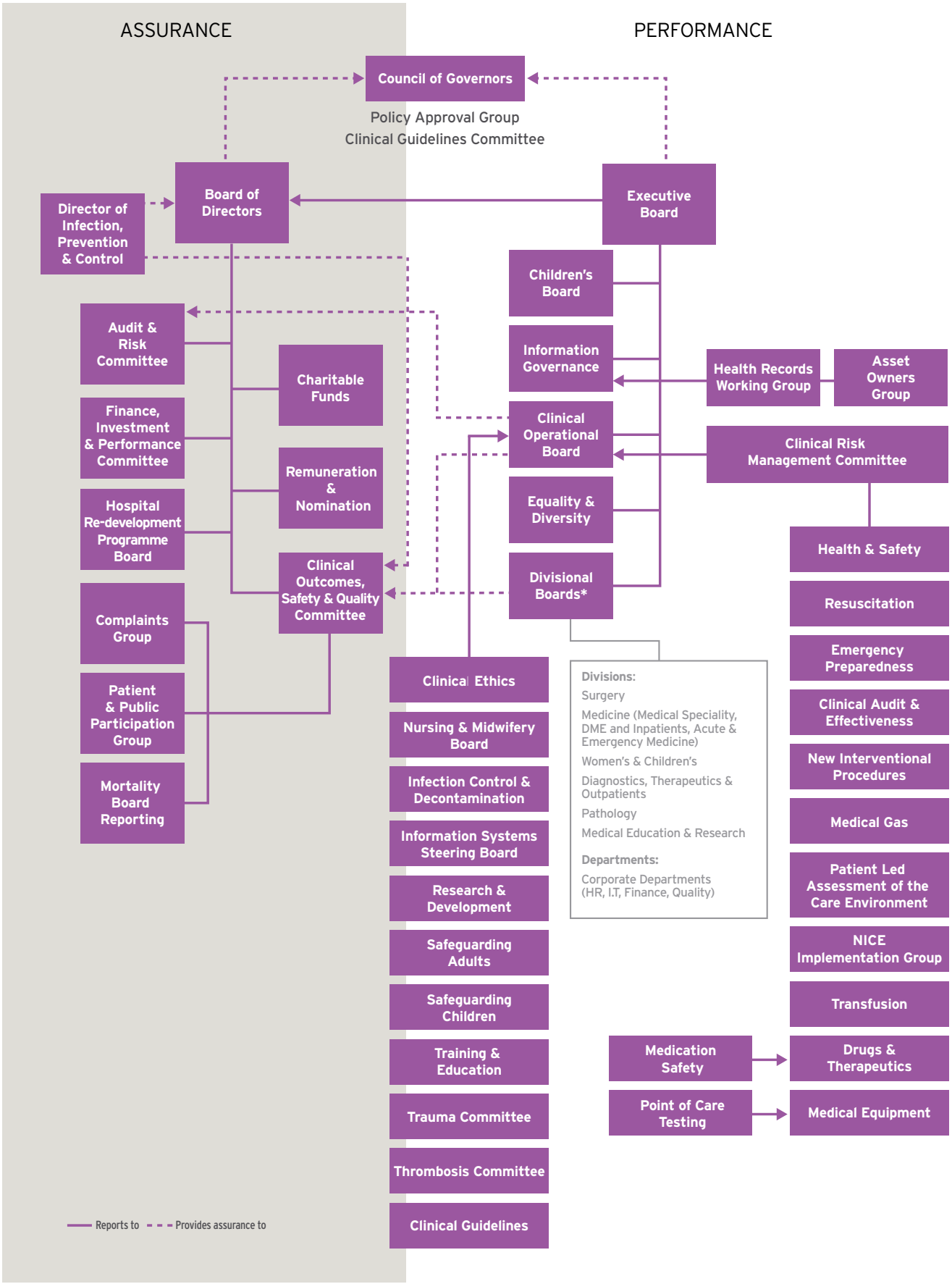
Total Meetings	Public Board Meetings	Private Board Meetings	Audit & Risk	Remuneration and Nomination	Charitable Funds	COSQ	HRD	FIP
David Carter	4/4	6/6			6/8	12/12	10/11	11/11
Simon Linnett	4/4	6/6		5/5	8/8		11/11	10/11
Cathy Jones	4/4	6/6			6/8	10/12	3**	10/11
Andrew Harwood to January 19	3/3	6/6			6/6		7/9	8/8
Matthew Gibbons from January 19	1/1	1/1			2/2		1/2	3/3
Liz Lees	3/3	3/4				*8/10	3**	**
Sheran Oke	1/1	2/2						
Angela Doak	4/4	6/6			6/8	*12/12		
Catherine Thorne	2/2	2/2			2/3	*5/6		
Medical Directors	*3/4	5/6				9/12		**
Alison Clarke	4/4	6/6	4/4	5/5	7/8	12/12		
John Garner to October 18	2/2	4/4	1/1	4/4	5/5		3/4	6/6
Vimal Tiwari	3/4	5/6	3/4	5/5	6/8	11/12		
Mark Versallion	4/4	6/6	4/4	5/5	6/8			9/11
David Hendry to October 18	2/2	3/4	2/2	4/4	4/5	5/7	1/1	5/6
Simon Barton from September 18	2/2	2/2	3/3		1/3	5/6		3/3
Mark Prior from October 18	1/2	1/2	2/3	1**			5/6	5/5
Denis Mellon	3/4	5/6	3/4	5/5			5	10/11

* Deputy

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

Committees of the Board of Directors

Luton and Dunstable Hospital Governance and Committee Structure



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

Audit and Risk Committee

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

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

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

Membership of the Audit and Risk Committee:

The Audit and Risk Committee membership has been drawn from the Non-Executive Directors and was chaired by Mr David Hendry (NED) until October 2018 and by Simon Barton from October 2018.

Audit and Risk Committee Report

The Audit and Risk Committee reviewed financial and operating performance and compliance against national and regulatory standards. A comprehensive work plan is agreed each year which ensures oversight and monitoring of risks, mitigations and issues relating to the financial statements, internal controls and compliance with regulatory, statutory responsibilities and internal policies and procedures which in turn enables action to be escalated as appropriate, i.e. officer attendance to explain critical risk or failure to implement internal audit recommendations and escalation to the Board where appropriate. An annual report of the Committee's activities and how the Committee has fulfilled its role is reported by the Chair of the Audit & Risk Committee to the Board and the Council of Governors. The Committee has had close oversight throughout the year of the Board Assurance Framework and principal risks on efficiency planning and sustainability. In depth reviews of the Scheme of Delegation, Preparation ahead of Well-Led governance review and E Rostering and Employment of agency staff. Unrated reviews were also carried out on the Trust progress towards the GDPR regulations, Clinical Coding and the Urgent GP Centre. Follow up work was also completed on Cyber Security and Medical Devices. In relation to CQC compliance with care standards, the Trust received a rating of Good from the CQC inspection in December 2018 and the Committee reviews regular reports from the Clinical Outcome Safety and Quality Committee and ongoing Quality Improvement initiatives.

Internal Audit

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

External Audit

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

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

The External Audit programme is scheduled to focus on key areas of risk and for 2018/19 the areas of audit risk were:

- The valuation of land and building
- Revenue recognition
- Expenditure recognition
- Management override of control

The ISA260 report presented on the 15 May identified that there were no material concerns or control weakness identified during the year.

The appointment of the auditor was made in 2012 as a result of a competitive process under a procurement compliant framework. The appointment was extended in 2014, 2016, 2017 and 2018 on the same terms. Each appointment is subject to Council of Governors agreement. Reports from External Audit are received and reviewed at each Audit and Risk Committee to assess the effectiveness of the external audit programme. External Audit confirmed they were able to complete the required testing against the controls in the fee agreed with the Trust.

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

Clinical Outcome, Safety and Quality Committee

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

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

Membership of the Clinical Outcome, Safety and Quality Committee:

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

Finance, Investment and Performance Committee

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

Membership of the Finance, Investment and Performance Committee:

The Finance Investment and Performance Committee membership included Board members, senior managers and clinicians and is chaired by Mr Denis Mellon (NED).

Hospital Re-Development Programme Board

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

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

Membership of the Hospital Re-Development Programme Board:

The Hospital Re-Development Programme Board membership included Board members, senior managers and clinicians and was chaired by Mr Simon Linnett (Chair) until October 2018 and Mr Mark Prior (NED).

Remuneration and Nominations Committee

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

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

- All aspects of salary.
- Provisions for other benefits, including pensions and cars.
- Arrangements for termination of employment and other contractual terms;
- Review the composition of the Board of Directors and make recommendations as to the appropriate make-up of the Board.

- Make recommendations to the Nomination Committee of the Council of Governors in respect of Non-Executive Director positions.

Membership of the Remuneration and Nominations Committee:

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

Charitable Funds Committee

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

Key responsibilities are to:

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

Membership of the Charitable Funds Committee:
The Charitable Funds Committee membership has been drawn from Board members and is chaired by and Independent Chair Mr Clifford Bygrave.

Council of Governors

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

1. The Membership;

2. The Council of Governors; and

3. The Board of Directors

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

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

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

In addition:

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

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

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

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

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

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

The Council of Governors met six times during 2018/19 and the attendance is recorded.

Register of Interests of the Council of Governors' Members

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

Elections

Our annual elections to the Council of Governors were held during May – August 2018. UK Engage were our independent scrutiniser to oversee the elections, which were held in accordance with the election rules as stated in our constitution.

The following constituency seats were filled by uncontested candidates

- Staff: Nursing and Midwifery
- Staff: Volunteers

The following constituency seats were filled by election

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

Analysis of Annual Election Turnout:

Date of election	Constituencies involved	Number of members in Constituency	Number of seats contested	Number of Candidates	Election turnout %
August 2018	Public: Luton	7014	3	13	14.06%
August 2018	Public: Bedfordshire	3191	3	9	17.71%
August 2018	Public: Hertfordshire	1514	2	3	18.36%

The Trust annual elections to the Council of Governors are held during May – July and the elected candidates initiate their terms from September. The average turnout is around 17%. For each election the Trust requests a voter profiling report to identify whether there are any issues with diversity. During 2018/19, the Trust continued to offer five languages on to the letter and envelope and members could request translated packs. However, there were no requests for these packs and voter turnout in the minority groups in Luton remained low.

GOVERNORS IN POST – April 2018 to March 2019

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Appointed Governors					
Luton CCG	Nicky Poulain	Appointed from February 2018	Start of 1st term	3 years	4/5
Bedfordshire CCG	Vacant				
Hertfordshire CCG	Vacant				
Central Bedfordshire Council	Cllr Brian Spurr	Appointed to May 2020		3 years	2/5
Luton Borough Council	Cllr Ayub Hussain	N/A	Resigned May 2018	3 years	0/0
	Cllr Waheed Akbar	Appointed from May 2018	To May 2021	3 years	1/3
University College London					
University of Bedfordshire	Bill Rammell	Appointed to 2021		3 years	0/5
Public Governors					
Hertfordshire	Mr Donald Atkinson	Elected to 2021	Start of 2nd term	3 years	3/5

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Hertfordshire	Ms Helen Lucas	Elected to 2021	Start of 2nd term	3 years	4/5
	Mr Malcolm Rainbow	Elected to 2020		3 years	4/5
Bedfordshire	Miss Dorothy Ferguson	Elected to 2021	Start of 3rd term	3 years	4/5
	Ms Jennifer Gallucci	Elected to 2018	Start of 2nd term	3 years	4/5
	Ms Linda Grant	Elected to 2020		3 years	4/5
	Mr Ray Gunning	Elected to 2018	End of 3rd term	3 years	1/1
	Mrs Sue Steffens	Elected to 2019			5/5
	Mr Mathew Towner	Elected to 2021	Start of 1st term		2/3
	Mr Jim Thakoordin	Elected to 2020		3 years	4/5
	Mr Roger Turner	Elected to 2020		3 years	5/5
Luton	Mr David Allen	Elected to 2021	Start of 1st term	3 years	3/3
	Mr Keith Barter	Elected to 2020		3 years	4/5
	Mrs Pam Brown	Elected to 2019		3 years	5/5
	Ms Marie-France Capon	Elected to 2018	End of 3rd term	3 years	2/2
	Mrs Susan Doherty	Elected to Sept 2020		3 years	2/5
	Mr Sean Driscoll	Elected to 2019		3 years	2/3
	Mrs Theresa Driscoll	Elected to 2021	Start of 1st term	3 years	3/3
	Mrs Judi Kingham	Elected to Sept 2020		3 years	4/5
	Mr Henri Laverdure	Elected to Sept 2019		3 years	4/5
	Mr Anthony Scroxton	Elected to 2019		3 years	4/5
	Mr Derek Brian Smith	Elected to 2021	Start of 3rd term	3 years	4/5
	Mr Mohammed Yasin	Elected to 2019		3 years	3/5
	Mr Shaobo Zhou	Elected to 2018	End of 1st term	3 years	0/2
Staff					
Admin, Clerical and Management	Mr Jim Machon	Elected to 2018	End of 3rd term	3 years	3/3
	Mrs Ros Bailey	Elected to 2019		3 years	2/2
Nursing and Midwifery (including Health Care Assistants)	Mrs Belinda Chik	Elected to 2021	Start of 2nd term	3 years	4/5
	Mrs Ann Williams	Elected to 2021	Start of 2nd term	3 years	5/5
	Mrs Marva Desir	Elected to 2019		3 years	2/5
Volunteers	Mrs Janet Graham	Elected to 2021	Start of 2nd term	3 years	4/5
Medical and Dental	Dr Ritwik Banerjee	Elected to 2020		3 years	2/5
Ancillary and Maintenance	Mr Gerald Tomlinson	Elected to 2019	Resigned May 2018	3 years	0/0
Professional and Technical	Ms Cathy O'Mahony	Elected to 2021	Start of 2nd term	3 years	5/5

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

Council of Governors Sub Committees

There are three sub-committees of the Council of Governors

Remuneration and Nomination Committee

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

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

During 2018/19 the committee met twice and has completed the following activities:

- Approved the remuneration and allowances for the Non-Executive Directors.
- Completed the process to be able to recommend to the Council of Governors Non-Executive Directors.
- Initiated a recruitment programme for Non-Executive Directors.
- The committee is chaired by Dorothy Ferguson.

Membership and Communication Committee

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

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

During 2018/19 the committee met three times and has completed the following activities:

- Issued two Ambassador newsletters.
- Reviewed the Membership Strategy.
- Supported the two Medical Lectures on Respiratory Care and Arthritis.
- Supported the Annual Member's Meeting.
- Visited locations across the catchment to increase membership.
- The committee is chaired by Pam Brown.

Constitutional Working Group

- The Constitutional Working Group assists the Council of Governors in carrying out the following functions:
- To ensure that the Constitution is up to date with new developments.
- To review the Constitution at least annually.
- Recommend amendments to the constitution to the Council of Governors;
- Liaise with Monitor and legal representatives when required.
- Report to the Annual Members Meeting to approve any Constitutional amendments.

During 2018/19 the committee did not need to make any amendments to the Constitution. The group is chaired by Roger Turner.

Foundation Trust Membership

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

i) Luton
ii) Bedfordshire
iii) Hertfordshire

The Trust currently has 19,574 members (14,028 public and 5,246 staff). The FT public membership numbers increase around 3% each year and the Governors set a target of 600 new members annually. The Governors agree a Membership Strategy through the Council of Governors and follows key objectives:

1. **To increase the membership -** The strategy outlines more focussed work on recruiting members in Bedfordshire with an engagement approach to the Luton and Hertfordshire membership. During 2018/19 we have focussed on outpatient areas for support and also linked with GP patient and public participation groups.

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

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

4. **To provide learning and development opportunities to the membership -** Two medical lectures were held for 2018/19 (respiratory care and arthritis) and two more are planned for 2018/19. Engagement events are also supported across the catchment area for the public and membership that provide the opportunity to learn about the L&D services and speak to medical teams.

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

Strategy for 2019/20

The strategy will be reviewed in May 2019 by the Membership and Communication Sub-Committee to identify the plans for 2019/20. The committee will consider the objectives to include:

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

During 2019/20, there are 11 vacancies; seven Public Governors (six Luton, one Bedfordshire) and four Staff Governors (one Nursing and Midwifery, two Admin and Clerical and one ancillary and maintenance). The Trust, in conjunction with the Council of Governors and the Board of Directors, is reviewing the Constitution in light of the ICS, potential mergers and consideration to the annual election taking place.

Table 1: Membership size and movement:

Public constituency	2018/19 (Plan)	2018/19 (Actual)	2019/20 (Plan)
At year start (April 1)	13,614	13,614	14,028
New members	600	1474	600
Members leaving	200	370	200
At year end (March 31)	14,014	14,028	14,428
Staff constituency *			
At year start (April 1)	5029	5029	5345
New members	975	1567	1610
Members leaving	747	1251	1368
At year end (March 31)	5257	5345	5587
Total Members	**19,271**	**19,373**	**20,015**
Patient constituency			
Not applicable			

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

Table 2: Analysis of current membership:

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

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

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

Notes:

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

The figures for Ethnicity and Socio-economic do not add up to 1,669,823.
The reasons provided by Membership Engagement Services are listed below:

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

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

Governor Training, Membership Recruitment and Engagement

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

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

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

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

- **Membership recruitment –** all Governors are involved with recruiting members. This ranges from visiting GP practices, attending events such as at the Chamber of Commerce and linking with local groups like the Women's Institute. A sub-committee of the Governors oversee this programme to ensure there is diversity of approach and this year we achieved our target of 600 new members.

- Ambassador Magazine – The Trust issued two 20 page magazines – August 2018 and March 2019 and provides the opportunity for the Governors to report back to the members about Trust progress, Governor involvement and how the Governors are holding the Non-Executive Directors to account.

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

- Governor training – Training is accessible to all Governors through NHS Providers GovernWell programmes. Governors also attend the

Contact Details

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

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

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

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

*Full list of Governors available on:
www.ldh.nhs.uk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Position: 1/20
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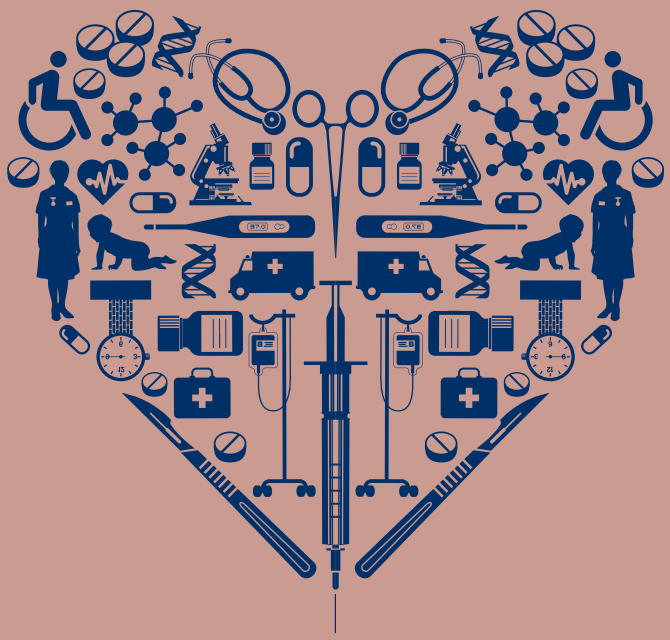
Financial Performance Report



Review of Financial Performance

A financial surplus for the 20th successive year was achieved with a 2018/19 surplus of £22.6m. Whilst the Trust delivered the Control Total, delivering it relied on non-recurrent items to offset the additional costs of temporary staffing that are very much part of the challenging environment in which the Trust operates. It should be noted that the £22.6m surplus includes a £18.4m performance bonus (known as Sustainability Provider Funding) which recognised the achievement of agreed performance and financial targets.

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

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

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

Year	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Turnover	153.2	169.1	189.3	204.9	211.6	220.8	230.6	244.3	259.2	271.2	308.8	334.1	354.6
Surplus	2	2.9	4.3	3.1	2.6	2.5	0.9	0.4	0.1	0.1	12.9	15.4	22.6
Cash	18.8	35.4	45.4	43.7	50.9	47.6	37.5	24.8	11.7	9.1	28.2	36.4	34.8

All figures £m

Cash balances continued to be monitored closely, with the FT ending the 2018/19 financial year with a balance of £34.8m. This was a reduction from 2017/18 and reflects the significant investment in the Trust site.

The FT has spent nearly £24m on capital in 2018/19 to deliver modern NHS services. Notable developments include a new MRI machine, new Theatres (due to go live in 2019/20), a new outpatient facility in the Arndale Centre, nearly £3m on medical equipment, an Endoscopy Decontamination Unit and nearly £3m on the Trust's Global Digital Excellence programme.

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

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

Going Concern

In 2019/20 the FT will continue to face, along with all other providers, a challenging financial environment. Despite this the FT has submitted a surplus plan for 2019/20 to NHS Improvement, albeit one that contains substantial risk and requires collaboration with NHS leadership organisations to deliver it. After due consideration, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

Key Variances from the Plan in 2018/19

In 2018/19 the Trust struggled to constrain costs in the face of growing demand. Significant overperformance on emergency activity led to pressures on both the Medical and Nursing pay bills. Much of the pressure manifested itself in Agency spend, leading to the Trust breaching the NHSI Agency Ceiling. Agency spend and controls were assessed and amended in order to assure the Board that performance and costs continue to remain appropriately balanced.

The Board of Directors continued to review the position of the hospital site developments in 2018/19 in order to achieve increased value for money, operational efficiency and effectiveness. The Trust continues to pursue the funding for an Acute Services Block, and is hopeful this will be approved in 2019/20.

Principal Risks and Uncertainties facing the Trust

Looking forward, our main commissioners benefit from both growth per capita and overall growth on their CCG allocations for 2019/20. Nevertheless this position is impacted by an expectation that our two main commissioners repay historic debts.

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

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

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

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

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

Remuneration report

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

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

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

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

The Remuneration and Nomination Committee approved the national flat rate pay uplift to all Executives in post as at April 2018.

Assurance on Very Senior Managers (VSM) Pay

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

During 2018/19 the Committee sought assurance by:

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

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

David Carter
Chief Executive
22nd May 2019

Fundraising and Charitable Donations

During the 2018/19 financial year the Luton and Dunstable Hospital Charitable Fund received £1,640,000 from 1371 donations from grant-giving trusts, companies, individuals, community groups and legacies.

Of the £1.6 m income, 75% of income was from Charitable Trusts, 11% was from individuals, 6% from events, 4% from legacy and IMO donations and 2% was from companies. The charitable trust figures are higher than usual, as £500k was received from The County Air Ambulance Trust, as part of their £2m pledge towards the new Helipad appeal.

Legacy donations received totalled £246,395 from four separate legacies gifted to benefit the hospital's general fund, Cancer, Stroke and Cardiac. We also received £31,400 in In Memory donations. Legacies play a key part in shaping the Hospital for future generations. We are held our first legacy event on 21st June 2018. We are currently aware of two legacies going through legal release.

The League of Friends have continued their kind support towards the hospital and donated £32,688. This has been used to buy medical equipment for various wards and departments.

This year we have worked hard to secure community links and promote the charity to schools, community groups, and small local companies. So far they have been engaged with 21 schools, 18 community groups and attended 24 community events with a promotional stand. This has also involved the appointment of Charity Ambassadors, who have been a key component in extending our reach and support. Companies we have partnered with include: Sainsbury's Dunstable, Dominos, Luton Sixth Form College, Luton Town Football Club, Foxley Kingham and The Luton Mayor.

The Child Oncology room's appeal was concluded raising over £220,000 to support the major transformation of two medical side rooms for young patients with cancer. We also had great success securing the funding for a new spinal table, that will support all spinal procedures to be carried out at the hospital and funding for a new CT beam cone scanner for oral maxillofacial patients. The NICU (Neonatal Intensive Care Unit) still continues to be one of the most supported funds from the local community, current and past patients. It has received 495 donations during 2018 / 2019 totalling £77,243. All of the 2018 Christmas campaigns fundraising income was allocated to the on-going costs of the Parents Facilities. Light up a Life raised £4,000. In January the Charity jointly purchased a property with the hospital for additional accommodation for the Neonatal families needing it. We put out a social media post and had 64 trades reply in support of the project which is currently underway, with the majority of the renovation being donated.

Social media continues to be a large source of contact with our supporters, with a knitting post reaching hundreds of thousands of supporters, some international. The appeal for the Helipad is the largest appeal that the Charity has supported. £5m target and The County Air Ambulance charity has offered to contribute £3m towards this project.

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

- NICU sound ears, equipment and refurbishment of the breast feeding room.
- Wheelchairs, with additional comfort and leg support
- Child cancer rooms
- Facilities for wards and surgical wards
- Engagement events for staff
- Scales, accuvein device, toys and bravery items for the Children's departments
- Cooling and hair loss mask for cancer patents
- Dementia equipment and specialist TV sets
- Murals for Maternity and the Delivery Suite
- Sleeping chairs for birthing partners
- Supported the retirement fellowship
- Diabetes equipment for paediatric patients

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

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

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

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

Property Plant and Equipment and Fair Value

As stated in note 1.7 to the accounts, Property Plant and Equipment are stated at Fair Value which is defined as the lower level of replacement cost and recoverable amount. A review is carried out each year for any potential impairment, with a formal revaluation every five years. A full property valuation as at 31 March 2018, was undertaken by Gerald Eve LLP. The Directors' opinion is that there are no fixed assets where the value is significantly different from the value included in the financial statements.

External Auditor

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

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

Private Finance Initiatives (PFI Schemes)

We have two capital schemes arranged under the PFI:

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

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

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

Better Payment Practice Code

We are continuing to maintain cash balances within the needs of our suppliers, settling 79% of non-NHS invoices within 30 days of receipt of a valid invoice.

2018/19	Number of invoices	Value £000s
Total Non-NHS trade Invoices paid in the year	82,829	£122,057
Total Non-NHS trade Invoices paid within target	65,458	£91,955
Percentage of Non-NHS trade Invoices paid within target	79%	75%

Off Payroll Engagements

NHS Foundation Trusts are required to disclose the information in the tables below about off-payroll engagements. The Trust requires contracts for services to be in place for all such engagements with a specific clause to allow the Trust to request assurance in relation to income tax and National Insurance obligations.

Table 1: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2019	1
Of which...	
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	1
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	1
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	0
Number for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	18

Counter Fraud

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

Data Loss and Incident Reporting.

The General Data Protection Regulation (GDPR) as implemented by the UK Data Protection Act 2018 became UK Law on 25 May 2018. It introduced a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority.

An organisation must notify a breach of personal data within 72 hours. If the breach is likely to result in a high risk to the rights and freedoms of individuals, organisations must also inform those individuals without undue delay.

Breach reporting is now mandatory for all organisations.

A breach is defined as; Article 4(12) "Personal data breach" means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.

Establish the likelihood that adverse effect has occurred

Summary of incidents reported to the information commissioners Office (ICO) via the DSP toolkit incident reporting tool in 2018/19

No.	Likelihood	Description
1	Not occurred	There is absolute certainty that there can be no adverse effect. This may involve a reputable audit trail or forensic evidence
2	Not likely or any incident involving vulnerable groups even if no adverse effect occurred	In cases where there is no evidence that can prove that no adverse effect has occurred this must be selected.
3	Likely	It is likely that there will be an occurrence of an adverse effect arising from the breach.
4	Highly likely	There is almost certainty that at some point in the future an adverse effect will happen.
5	Occurred	There is a reported occurrence of an adverse effect arising from the breach

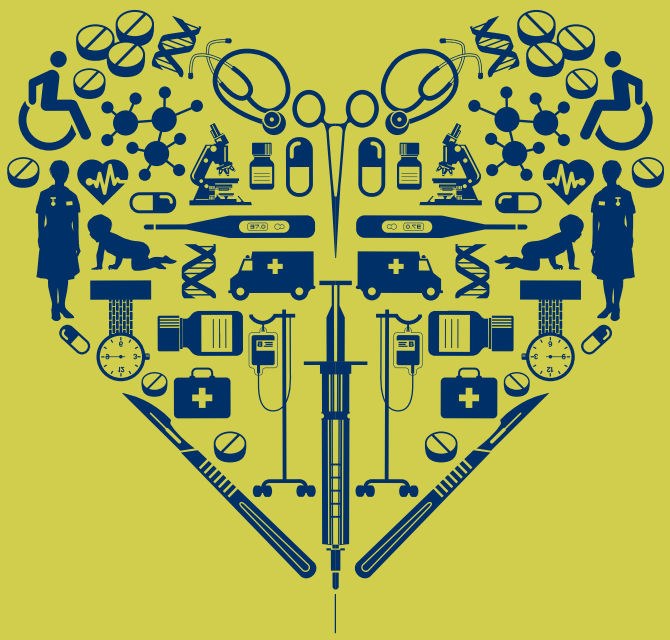
If the likelihood that an adverse effect has occurred is low and the incident is not reportable to the ICO, no further details will be required.

No	Effect	Description
1	No adverse effect	There is absolute certainty that no adverse effect can arise from the breach
2	Potentially some minor adverse effect or any incident involving vulnerable groups even if no adverse effect occurred	A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be the cancellation of a procedure but does not involve any additional suffering. It may also include possible inconvenience to those who need the data to do their job.
3	Potentially some adverse effect	An adverse effect may be release of confidential information into the public domain leading to embarrassment or it prevents someone from doing their job
4	Potentially Pain and suffering/ financial loss	There has been reported suffering and decline in health arising from the breach or there has been some financial detriment occurred. Loss of bank details leading to loss of funds. There is a loss of employment.
5	Death/ catastrophic event.	A person dies or suffers a catastrophic occurrence

Date of Incident (Month)	Nature of Incident	Nature of data involved	ICO Response:
June 2018	IG Manager/Data Protection Officer received an email from a patient explaining that she has reason to believe a member of staff (who she named in a subsequent telephone discussion) may have accessed her health record and disclosed.	Clinical information	Reported to ICO
June 2018	Community Midwife (CM) returned to car and placed bag on passenger seat. Car door opened and a mugger grabbed the bag containing diary and booking form.	Clinical Information	Not required to report
Jan 2019	Advised staff members had inappropriate access to shared folders within share drive that contained PID	Staff personnel files, clinical information	Not required to report
Mar 2019	Staff member allegedly accessing colleague's records and openly discussing it.	Clinical Information	Reported to ICO

Luton and Dunstable Incidents reported via the new incident tool

Annual Governance Statement and Accounts



Statement of the Chief Executive's Responsibilities

as the Accounting Officer of Luton and Dunstable University Hospital NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require [name] NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of [name] NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

David Carter
Chief Executive
Date: 22nd May 2019

Annual Governance Statement 2018/19

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Luton and Dunstable University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is accountable for managing risk and leads the Executive Board, attends each of the Sub-Committees of the Board and the Clinical Operational Board to ensure that the Trust has robust processes in place to manage risk.

The Board leads for Risk Management are the Chief Medical Advisor and the Chief Nurse. The Director of Re-Development is the Board lead for non-clinical (including Health and Safety) risk management. The Chief Medical Advisor leads on clinical risk management and chairs the Clinical Risk Management Committee where all aspects of clinical risk management are discussed. A report is provided to the Clinical Operational Board and assurance is then provided to the Clinical Outcome, Safety and Quality Committee and the Audit and Risk Committee. The Clinical Operational Board includes a high level Executive membership and includes the clinical medical consultant leadership though the Clinical Chairs and Divisional Directors. The Clinical Chairs and Divisional Directors are accountable for ensuring risk tolerance is embedded within their Divisional Boards.

All risks are reviewed by the Executive that demonstrates top level leadership to risks by considering and approving all new risks to the risk register.

At induction, new joiners to the organisation undergo basic training in risk management (clinical and non-clinical).

Risk management training sessions are provided to staff as required.

Liaison with Clinical Chairs and Divisional Directors ensures that when practice is changed as a result of integrated learning from the risk management process, this is cascaded to Divisions. This takes place through the Clinical Operational Board and the Divisional Board meetings.

The Trust Risk Register is developed from risks identified at the Board of Directors and its sub committees and at divisional and department level plus from those identified from other sources e.g. external reports. The Board ensures action is taken to mitigate any risks to quality. Risks and benefits to quality and safety are assessed for all reviews of efficiency related initiatives. The Board receives the Board Assurance Framework every three months and reviews a summary of the risk register every three months in order to be able to maintain understanding of the current and future risks. The Board has participated in seminars which help in the identification of future external risks to quality such as new national guidance, new technologies business continuity and health and safety.

The risk and control framework

Risk continues to be managed at all levels of the Trust and is co-ordinated through an integrated governance framework consisting of performance and assurance processes. The Executive Board and the Clinical Operational Board lead the review of risk through the Clinical Risk Management, Divisional Boards, Information Governance and Equality and Diversity sub Boards. The Board of Directors lead the review of board level strategic risk seeking assurance from the Audit and Risk, Clinical Outcome, Safety and Quality, Finance, Investment and Performance Committees and the Hospital Re-Development Board.

The Risk Management Strategy continues to provide an integrated framework for the identification and

management of risks of all kinds, whether clinical, organisational or financial and whether the impact is internal or external. This is supported by a Board Assurance Framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management.

There is a Risk Review process under the leadership of the Executive Directors, who are consulted to approve any new risks that have been identified through the Divisions, Corporate Services or Committees and reported through the central risk register database (Datix). The relevant Executive Director agrees whether the risk is a Strategic Board Level Risk that has implication to the achievement of the Trust Objectives, review the assessment score and also allocate the risk to the relevant Sub-Committee for assurance and operational board for performance monitoring. The closed risks are also monitored to ensure the Executive Team is aware of risk amendments. The Trust has in place a weekly Senior Staff Committee that overseas operational risk.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the Risk Management Framework across a range of domains; the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. The Trust risk tolerance is set by considering all risks through the Risk Review by the relevant Executive Director and identifying those risks that have implications to the achievement of the Trust Objectives. Any of these Board Level Risks that are rated as a high risk are reported to the Board of Directors every two months. Actions and timescale for resolution are agreed by the risk leads and monitored by the Board of Directors and relevant sub-committee. Through this process, the Board are informed of any risks that would require acceptance as being within the Trust's risk tolerance.

The organisations major risks are detailed on the Trust Risk Register and Assurance Framework. Through the annual planning, the risks are formulated into five elements and the risks linked to those and their mitigating actions are documented below. The Risk Register is reviewed by the Board of Directors, Audit and Risk Committee, Clinical Outcome, Safety and Quality Committee, FIP, and Executive Board, it contains in year and future risks.

L&D Top 5 Risks (Summary)

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Clinical Operational	1. Workforce Pressures 2. Capacity pressures and responding to demand 3. Implementation of integrated care 4. The need for robust and whole system working	High	High	Workforce plans in place. Board approved action plans with Trust partners where appropriate. Length of Stay, Discharge Project and Needs Based Care initiative. Ongoing collaborative work with BLMK ICS and Local Health system, in particular Bedford Hospital.	Weekly Senior Team and Executive meetings. Monthly Clinical Outcomes, Safety & Quality Committee and ongoing reporting to the Board. Board of Directors strategic oversight.

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Finance	Delivering the financial challenge in 2019/20 including Commissioner plans, agency spend and CQUIN	High	High	Monthly review of key income, expenditure, capex, cash, balance sheet and quality performance metrics. Monthly performance review meeting with Divisions led by Executive Directors. CQUIN forms part of the Quality Account.	Monthly reports of cumulative financial performance incorporating clear forecasting and an alert mechanism to identify issues that allow corrective action. Monthly Finance, Investment & Performance committee review. Monthly review of the Quality Account priorities at the Clinical Outcome, Safety and Quality Committee. Introduction of Monthly Service Line Executive Review Framework .
Present Hospital Campus	Going forward the Trust site will not be consistent for capacity or clinical requirements for good patient care. Backlog Maintenance	High	High	Robust management and governance arrangements in place to manage ongoing risks and hospital re-development project. Finance, Investment and Performance Committee (FIP) oversight of backlog maintenance plans and strategy. DH involvement.	Board oversight of developments with DH and NHSI. Board review of Full Business Case and approval of actions. Finance, Investment & Performance committee review.
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legislation	High	Moderate	Board approved action plans in place.	Regular monitoring / Assurance from Board Sub-Committees.
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event	High	Low	Ensure that the Emergency and Business Continuity plans are frequently reviewed, communicated and understood by key staff. Ensuring Brexit plans are fully developed.	Ongoing review and testing of Business Continuity plan relevant adaptation of plans. Oversight by Board Sub group.

Incident reporting is actively promoted and encouraged across all directorates as part of the culture of the organisation. The Trust actively promotes a culture of 'fair blame' or 'just blame', to encourage staff to report incidents. Incidents that have a significant impact on the Trust, its business or an individual are immediately and thoroughly investigated and the lessons learnt are shared across the Divisions.

Risks to data security are managed through a security risk register and through incident reporting. Mitigating actions are reviewed through the Information Governance Steering Group and reports to the Executive Board. Duty of Candour is also complied with for all incidents and above that result in moderate or severe harm.

Risk Management is an embedded activity of the organisation and can be demonstrated through a number of examples:

- Each Divisional Board reviews reported incidents and are required to report to the Clinical Operational Board and reflect on the issues raised, develop any further controls to manage the principal risks and to minimise, as far as reasonably practical, the incident occurring again. If there is a persistent risk issue identified from the incident, the issue is evaluated through the Risk Register and also subjected to independent scrutiny (for example: internal audit, external accreditation)

- Risk management is integrated into core Trust business in relation to equality impact assessments. All policies and procedures when created or reviewed have to include an Equality Analysis Form. If there are any negative impacts on a particular group of people/ equality group following the completion of this form, the Trust will record any changes to the service and/ or policy. Any actions will be integrated into existing service planning and performance management frameworks along with monitoring and review processes.

- Business cases include a risk analysis both financially and clinically.

- During the coming year the Trust will continue to embed a culture of external review and engagement of independent expertise to facilitate greater objectivity and learning;

- During the year in addition to using the services of internal and external audit, a number of specific reviews were commissioned.

- The Trust received an external CQC visit and the report received in June 2016 identified the Trust as 'good' with the Well-Led element of the assessment as 'Outstanding'.

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

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

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

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

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

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

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

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

A programme of communication to all staff was undertaken and action plans put in place across the domains. The action plans are monitored by the Clinical Outcome, Safety and Quality Committee on a quarterly basis.

The Trust promotes the involvement of patient representatives to ensure the quality of performance data and to triangulate feedback and reviews in many aspects of its activities. Patients and Governors are represented on the following committees:

- Equality and Diversity Committee
- Clinical Audit and Effectiveness Committee
- Patient and Public Participation Group

- PLACE (Patient Led Assessment of the Care Environment)
- Ethics Committee
- Outpatients
- Hospital Re-Development Board
- Car Parking Working Group
- Safeguarding Adults
- Carbon Management

Healthwatch monitor the services provided by the Trust and report directly to the Chief Executive and issues are then referred to appropriate Directorate for consideration and action. Representatives from Luton Healthwatch are members of the Trusts Patient and Public Participation Group. The National Patient Survey action plan is also progressed and monitored through this group. Healthwatch have been involved in the development and assurance of the Quality Accounts.

Since becoming a Foundation Trust the organisation has extended the involvement of staff and the public by creating a Council of Governors. The Council of Governors is responsible for a wide range of duties including, but not exclusively, being consulted on health service changes, meeting with members in their constituency, appointing and holding to account the Chair and Non-Executive Directors and attending Council of Governors' meetings. The Governors include representatives from other key stakeholders such as the CCGs, Local Government Councils and Universities.

The Trust ensures that it reviews its short, medium and long term workforce issues. This is completed by: Executive Performance speciality and divisional meetings outlined in the Scheme of Delegation

- Triangulation of information from the Shelford Safer Nursing Care tool, CHPPD, Nurse Sensitive Metrics along with professional judgements to determine the number of staff and range of skills required to meet the needs of patients. Additional analysis and recommendations will be presented for ED Nursing and children's services in addition to midwifery staffing
- Twice daily workforce meetings to assess and redeploy sufficient suitably qualified, competent, skilled and experienced staff to meet the care and treatment needs safely and effectively.
- Monthly Formal Executive meetings oversee the vacancy rate, agency rate and workforce pressures to agree business cases and assess risks and controls in place
- Executive Director review of agency is completed monthly to ensure that decisions are made at a high level
- Board approved workforce action plan reporting to NHSI with particular attention to agency use is reported to FIP monthly
- Assurance on the impact of vacancy and agency use is provided to COSQ and the Board including nursing safe staffing requirements triangulated with patient quality measures
- Assurance on the impact on finance and performance is provided to FIP and the Board

The Board agreed in April 2019 to formalise a Workforce Sub-Committee of the Board. This committee will receive assurance across nursing and midwifery, medical and other clinical staffing to triangulate issues and concerns and review new ways of working. It will also receive assurance that the recommendation from the Workforce Safeguards Review have been considered and implemented.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS'22 guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and *has a sustainable development management plan* in place which takes account of *UK Climate Projections 2018 (UKCP18). The trust ensures that its* obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

In addition to the financial review of resources within the quarterly monitoring returns to NHS Improvement and the monthly financial information provided to all

budget holders, the processes that have been applied to ensure resources are used economically, efficiently and effectively include Clinical Audit and Effectiveness, Medical Equipment and Medicines Management. The Trust has governance arrangements for the Finance, Investment and Performance Committee with Divisions presenting directly to the committee on a range of financial and operational matters.

A Clinical Audit and Effectiveness Department is also maintained to:

- Oversee the implementation of National Institute of Clinical Effectiveness (NICE) guidance.
- Monitor the introduction of new techniques ensuring clinical and cost effectiveness of new treatments, as well as the appropriate training of clinicians.
- Support clinical audit work within the Trust, ensuring clinicians work in the most effective way, adopting good practice uniformly across the Trust through protocols and guidelines.

The use of management groups charged with monitoring efficiency and effectiveness as part of their terms of reference:

- The Executive Team review the capital bids.
- The Medical Equipment Group advises on the replacement and purchase of new medical equipment.
- The Medicines Management Group oversees the maintenance and development of the drug formulary to ensure clinically appropriate and cost effective use of medicines.

The Trust's efficiency is quantified annually through the national reference costs exercise. The latest published index for the Trust is 89 (based on 2015-17 accounts and activity) compared to a national average index of 100.

The Trust is also engaging in a range of benchmarking exercises to determine best practice and assess the means of implementing it at the L&D for example the Carter Review.

Information Governance

The Trust has had four grade 2 information governance incidents in relation to a confidentiality breach and two were reported to the Information Commission Officer (ICO). Both events have been closed with no further action.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Account is the responsibility of the Director Quality and Safety Governance supported by all of the Executive Team and is written following guidance issued by NHS Improvement. Processes put in place via the Information Governance Toolkit, led by the Director of Information Technology, as Senior Information Risk Owner (SIRO),provides assurance that the Trust's Data Quality is reviewed and monitored.

Following development and launch of a Quality Strategy last year the Trust has confirmed its commitment to that strategy through the appointment of an Executive Director of Quality and Safety Governance to provide leadership to our quality improvement plans, with specific objectives around maintaining the Trust's Care Quality Commission's (CQC) rating of good together with developing a programme of work to support the organisation on its journey to outstanding.

A delivery plan is now in place which aims to enhance and support an organisational culture where quality improvement is part of our day to day business and to encourage an environment where our staff feel empowered to identify improvement need and then create the change with sustained improvement.

This programme of work will be overseen by a steering Board with a membership that includes the Medical Director, Chief Nurse and is chaired by the Director of Quality and Safety Governance. The group will provide regular updates to the Clinical Outcomes, Safety and Quality subcommittee of the Trust Board.

Through the Information Governance Toolkit, the Trust has a number of key information policies in place including data quality that sets out the roles and responsibilities.

The Trust has three reports that feed data into the Board of Directors; the Quality and Performance Report, Finance Report and Workforce Report. Each of these contains data that is tracked over months and years to identify variances.

The Trust monitors CHKS alerts through the Mortality Board, Clinical Operational Board and Clinical Audit and Effectiveness Committee. Clinical Audit forward plans detail the work undertaken to review the data quality of these alerts. Annually the Trust has an external audit of clinical coding that demonstrated excellent practice and an external peer review of Information Governance

that demonstrates assurance against the Information Governance Toolkit that includes Data Quality.

The Trust reviews directorate dashboards e.g. maternity to collect data at source and monitors the effectiveness of central data through the SUS (Secondary Uses Service) reports. The Trust monitors key performance indicators in relation to data quality that demonstrates improving practice across the Trust.

18 week data is generated by the Information Department on a weekly and monthly basis and then actively used by key departments to manage the patients' pathways so that patients receive treatment within 18 weeks of referral. Although initial checks are made by the Information Department, this data is further validated by our separate 18 week team who interrogate the files and physically track the patients' pathway on our current IT systems and record comments regarding the progress of the pathway. Inputting of the 18 week data is restricted to a core team to reduce the risk of inaccurate data entry and the further weekly validation allows for any errors to be rectified immediately. Weekly graphs are produced which are cascaded to a wider senior team both specifically around waiting list demand and 18 week performance, both which are able to highlight data discrepancies should they arise. A fortnightly meeting also interrogates the Flash report which details the 18 week patients at specialty level.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Clinical Outcome, Safety and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control during 2018/19 was monitored by the following:

- The Board of Directors – The Board places reliance upon the Audit and Risk Committee for assurances that the system of internal control is sound. They require the quality and financial sub-committees to oversee the actions and outcomes from the Internal Audits.

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

- The structure of the Board of Directors meetings allows the appropriate time to ensure matters regarding Performance and Quality would be managed through the whole Board

- The Clinical Outcome, Safety and Quality Committee focus on assurance issues relating to clinical and corporate governance, risk management and assurance framework and report monthly to the Board. This committee is supported by the Clinical Operational Board that ensures divisional clinical leadership. The COSQ committee also receive assurance against the Care Quality Commission Quality Outcomes on a monthly basis.

- The Clinical Audit and Effectiveness Committee reports to the Clinical Operational Board. The committee ensures clinical leadership through the divisions, monitors the implementation of NICE guidance and reviews the Dr Foster benchmarking data sets to review trends. This process is reported to the Executive Board and assurance provided to the Clinical Outcome, Safety and Quality Committee.

- The Finance, Investment and Performance Committee takes an overview of operational activity and performance against national and local targets.

- Internal Audit – Internal Audit review the system of internal control during the course of the financial year and report accordingly to the Audit and Risk Committee.

- A Provider Licence Assurance Framework was reviewed by the Audit and Risk Committee. The Trust has reviewed Governance arrangements through the assessment of the Healthy Board 2013 and the Monitor Code of Governance. These assessments have been cross referenced against the Licence

requirements laid out in condition 4 of the FT Governance. The CQC Assessment in December 2018 also provides assurance that the Trust is well led with appropriate governance in place.

Compliance with the NHS Foundation Trust Code of Governance

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

In relation to the more detailed provisions of the Code of Governance, the Trust were compliant with the provision with the exception of section B.1.2 from October 2018 to March 2019 the Board did not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

My review is also informed by:

Internal Audit which has completed reviews of the Scheme of Delegation, Preparation ahead of Well-Led governance review and E Rostering and Employment of agency staff. Unrated reviews were also carried out on the Trust progress towards the GDPR regulations, Clinical Coding and the Urgent GP Centre. Follow up work was also completed on Cyber Security and Medical Devices. This work has supported the Audit and Risk Committee's understanding and review of the key issues facing the Trust. Internal Audit reviews are conducted using a risk-based approach covering areas agreed as being the priority for review based on a risk assessment agreed between the Audit and Risk Committee, Management and the auditors.

The Head of Internal Audit reports that they have completed the programme of internal audit work for the year ended 31 March 2019. Their work identified low and medium rated findings but there were no high or critical risk rated reports in 2018/19, nor any individual findings rated high or critical. Three of the reviews undertaken in the year were performed as advisory to assist management in enhance processes and controls, and therefore the findings were not formally prioritised. The total number of findings / recommended or suggested actions is similar though to previous years, evidencing that there remain opportunities to strengthen governance, risk management and control although no major weaknesses have been identified.

Although there were no significant issues, some improvements are required in some areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

- For erostering and agency staff to review the strategic balance between clinical quality, safety and finance ensuring that decision-making processes are aligned to the intended balance and that financial plans allow for the consequent level risk of overspending.
- For the Scheme of Delegation to track the way decisions are made in alignment with the Scheme of Delegation document.
- For Clinical Coding to consider the scope for possible improved coding along with the potential adoption of encoder software to support coding accuracy. There were also some process elements that could be improved.
- For GDPR to continue to take action to achieve compliance with the requirements.

All recommendations arising from Internal Audit's work are considered by managers and an action plan agreed. The report, action plan and subsequent progress in implementing those actions are reviewed and monitored by the Audit and Risk Committee, and where relevant also by the Clinical Outcome, Safety and Quality Committee and the Finance Investment and Performance Committee.

The Trust has taken action throughout the year to address issues raised through the internal audit process. We:

- Strengthened the testing of cyber security and updated key policies and procedures
- Continued to monitor the implementation of the GDPR standards
- Further improved the Executive review of capital spend on medical devices
- Implemented further coding training and developed a position for ongoing auditing, training and mentoring.

Conclusion

No significant internal control issues were identified and this is supported by a robust governance structure that reviewed any identified any weaknesses regularly. Some areas for action were identified during the year and immediate action taken to mitigate and resolve the concerns.

David Carter
Chief Executive
Date: 22nd May 2019

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Independent auditor's report

to the Council of Governors of Luton and Dunstable University Hospital NHS FoundationTrust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Luton and Dunstable University Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Group Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2019 and of the Group and Trust's income and expenditure for the year then ended; and
- the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group and Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: Group financial statements as a whole*	£6.5m (2018:£5.9m) 1.8% (2018: 1.9%) of Group operating income	
Coverage	100% (2018:100%) of Group operating income	
Risks of material misstatement		**vs 2018**
Recurring risks	Valuation of land and buildings	◄►
	NHS and Non-NHS Income	◄►
Event Driven	NEW: Accrued expenditure recognition	▲

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Valuation of Land and Building Assets (£96m; 2018: £91m) *Refer to page C39 (Audit Committee Report) and page C21 (accounting policy)*	**Subjective Valuation** Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgement involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation, such as the condition of the asset. The Trust's accounting policy requires revaluations of property, plant and equipment to be performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. The Group operates from one site of which it holds land assets with a value of £12.27 million and buildings (excluding dwellings) with a value of £83.3 million as at 31 March 2019. The last full revaluation took place as at 31 March 2018. Therefore in line with its accounting policy the Trust has not engaged an external valuer during 2018/19. The significant movements in values therefore relate to the depreciation charge of £3 million, additions of £4.2 million and re-classifications totalling £3.6 million. Valuations are inherently judgmental. There is a risk that the methodology, assumptions and underlying data, are not appropriate or correctly applied.	Our procedures included: — **Assessing transparency:** We considered the adequacy of the disclosures in relation to the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities with reference to the Department of Health's Group Accounting Manual 2018/19; — **Management assumption:** We assessed the adequacy of the valuation used by the Trust in comparison to market trend and available indices. We also considered how management had assessed the need for any impairments across its asset base either due to loss of value or reduction in future benefits that would be achieved; — **Tests of details:** for a sample of assets that were reclassified in year we reviewed the transfer from assets under construction and confirmed that the value transferred was appropriate; and — **Tests of details:** For a sample of the assets recorded in the accounts as under construction we tested the status to assess the values recorded in the financial statements. — **Test of detail:** For a sample of assets purchased during the year, we considered whether the valuation basis used was consistent with the use of the assets. **Our findings** — We found the resulting valuation of land and buildings to be balanced.

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2. Key audit matters: our assessment of risks of material misstatement (cntd.)

	The risk	Our response
NHS and Non-NHS Income (£363.9m; 2018: £334.5m) *Refer to page C30 (Audit Committee Report) and page C19 (accounting policy)*	**2018/19 Income** The main source of income for the Group is the provision of health care services to the public under contracts with NHS commissioners, which make up 95.32% of income from activities (2017/18: 94.75%). Income from NHS England and CCGs is captured through the Agreement of Balances (AOB) exercises performed at months 6, 9 and 12 to confirm amounts received and owed. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes In 2018/19, the Trust secured £18.4m of Provider Sustainability Funding (PSF), representing achievement of all four quarterly targets and a bonus element. In addition to this patient care income the Group reported total income of £36 million (2017/18: £31 million) from non-NHS bodies. Much of this income is generated by contracts with Local Authorities and from overseas or private patients. Consequently there is a risk that income will be recognised on a cash rather than an accruals basis. We do not consider NHS and non-NHS income to be at high risk of significant misstatement, or to be subject to a significant judgement. However, due to its materiality in the context of the financial statements as a whole, NHS and non-NHS income is considered to be one of the areas that had the greatest effect on our overall audit strategy and allocations of resources in planning and completing our audit.	Our procedures included: **Tests of detail:** — We agreed a sample of the NHS income recorded in the financial statements to the signed contracts in place with key commissioners; — We agreed a sample of invoices to confirm they had been issued in line with the contracts signed with four of the Trust's key commissioners; — We obtained third party confirmations from commissioners through the AoB exercise and compared the values they are disclosing within their financial statements to the value of income and receivables captured in these financial statements; — We sample tested non-NHS income by agreeing to invoices and subsequent receipt of funds; — We agreed receivables to post year-end cash receipts, supporting invoices and other documentation. This included testing the assumptions made by the Group in respect of income due that was based on meeting agreed performance targets or KPIs with commissioners and ensuring any fines or deductions have been taken into account; — We confirmed that the approach to impairing receivables was in line with the Trust's accounting policies, and that the Group's judgement for the level of provision is appropriate; and — We reviewed the Trust's calculation of performance against the financial and operational targets used in determining receipt of PSF to determine the amount the Trust qualified to receive. **Our findings** — We found the resulting income recognition made by the Trust in relation to NHS and non-NHS income to be balanced.

2. Key audit matters: our assessment of risks of material misstatement (cntd.)

	The risk	Our response
Accrued expenditure recognition Trade and other payables - £30.8m (2017/18: £26.8m) *Refer to page C32 (Audit Committee Report) and page C20 (accounting policy)*	**Effects of irregularities** As most public bodies are not spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions.	Our procedures included: **Tests of detail:** — We inspected all material items of expenditure in the March and April 2019 bank statements and cashbooks to agree these have been accounted for correctly; — We considered year-end processes to assess that expenditure has been reflected in the correct period; — We vouched a sample of accrual balances to supporting documentation and post year-end cash payments to agree the correct treatment as a accrual at year-end — We performed a year-on-year comparison of payables to evaluate the completeness of the payable balance, as well as agreeing a sample to supporting documentation; and — We inspected confirmations of balances provided by the Department of Health as part of the Agreement of Balances exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of Commissioners or other providers. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure to Commissioners or other Providers. — We assessed the pressure upon the Trust to achieve a particular year end outturn position and it is normal for expenditure to exceed income for the year; — We reviewed the Trust's calculation of performance against the financial and operational targets used in determining receipt of PSF to determine the amount the Trust qualified to receive. As part of our work at month 9 and 12 we reconciled the expenditure figures reported in NHSI return with the source records. **Our findings** — We found the resulting estimates made by the Trust in relation to accrued expenditure to be balanced.

3. Our application of materiality and an overview of the scope of our audit

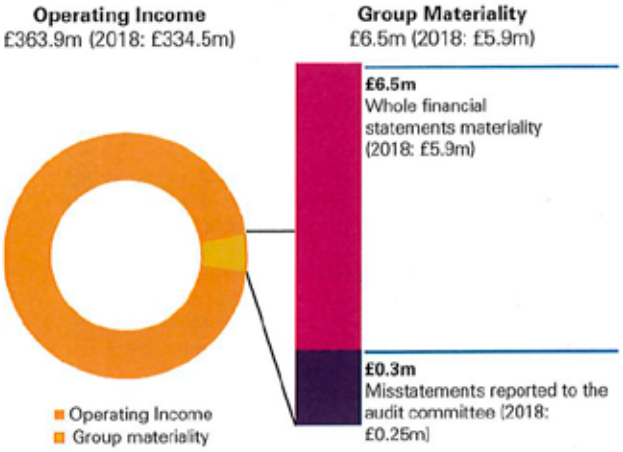
Materiality for the Group financial statements as a whole was set at £6.5 million (2018: £5.9million), determined with reference to a benchmark of operating income (of which it represents approximately 1.8%). We consider operating income to be more stable than a surplus or deficit-related benchmark.

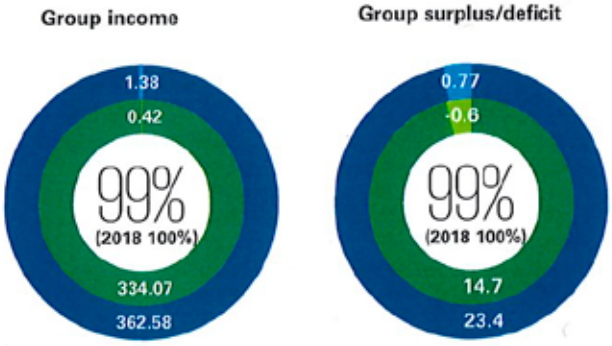
We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2018:(£0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

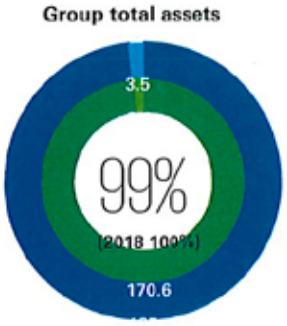
Of the Group's 2 (2018: 2) reporting components, we subjected 1 (2018: 1) to full scope audits for group purposes and 1 (2018: 1) to specified risk-focused audit procedures. The latter were not individually financially significant enough to require a full scope audit for group purposes, but did present specific individual risks that needed to be addressed. The components within the scope of our work accounted for the percentages illustrated opposite.

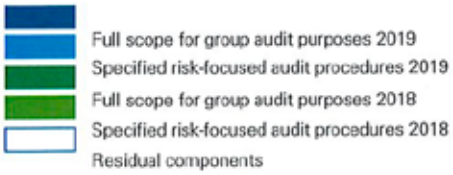
The remaining 1% of total Group revenue, 1% of Group profit before tax and 1% of total Group assets is represented by 1 reporting components, which does not individually represent more than 1% of any of total group revenue or total group assets.

The Group audit team visited all (2018: all) component locations to assess the audit risk and strategy.









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4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group or the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group or the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Group's and Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement on Page 132 on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Group and Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 132, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

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REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

We did not identify any significant risks during our risk assessment.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Luton and Dunstable University Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Fleur Nieboer
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
15 Canada Square, Canary Wharf, London, E14 5GL

24 May 2019

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Foreword to the Accounts

These accounts for the year ended 31 March 2019 have been prepared by the Luton and Dunstable University Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

David Carter

Chief Executive
Date: 22nd May 2019

Statement of comprehensive income

		Parent (L&D NHSFT)		Group (L&D NHSFT & NHS Charitable Funds)	
		2018/19	2017/18	2018/19	2017/18
	note	£000	£000	£000	£000
Operating Income from continuing operations	2.5	**362,582**	334,074	**363,965**	334,497
Operating Expenses of continuing operations	3	**(335,580)**	(314,437)	**(336,357)**	(315,565)
OPERATING SURPLUS		**27,002**	**19,637**	**27,608**	**18,932**
Finance Costs					
Finance income	6.1	**222**	63	**282**	137
Finance expense - financial liabilities	6.2	**(1,052)**	(1,115)	**(1,052)**	(1,115)
Finance expense - unwinding of discount on provisions		**(1)**	(2)	**(1)**	(2)
PDC Dividends payable		**(3,523)**	(3,214)	**(3,523)**	(3,214)
NET FINANCE COSTS		**(4,354)**	**(4,268)**	**(4,294)**	**(4,194)**
Gains/(losses) of disposal of assets		**(17)**	(1)	**85**	32
Surplus / (deficit) from continuing operations		**22,631**	15,368	**23,399**	14,770
SURPLUS / (DEFICIT) FOR THE YEAR		**22,631**	**15,368**	**23,399**	**14,770**
SURPLUS/ (DEFICIT) FOR THE YEAR		**22,631**	15,368	**23,399**	14,770
Other comprehensive income					
Revaluation Impact	23	**0**	3,597	**0**	3,597
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**22,631**	**18,965**	**23,399**	**18,367**

Note: Allocation of profits for the period: This surplus is wholly attributable to the owner of the parent.

Statement of financial position

	note	Parent 31 March 2019 £000	Parent 31 March 2018 £000	Group 31 March 2019 £000	Group 31 March 2018 £000
Non-current assets					
Intangible assets	7	**61**	124	61	124
Property, plant and equipment	8	**136,443**	120,722	136,443	120,722
Other investments	11	**0**	0	1,620	2,216
Trade and other receivables	14	**2,927**	1,886	2,927	1,886
Other assets	15	**2,287**	2,432	2,287	2,432
Total non-current assets		**141,718**	**125,164**	**143,338**	**127,380**
Current assets					
Inventories	13	**3,733**	3,421	3,733	3,421
Trade and other receivables	14	**44,957**	32,701	44,967	32,656
Cash and cash equivalents	24	**34,767**	36,400	37,324	37,716
Total current assets		**83,457**	**72,522**	**86,024**	**73,793**
Current liabilities					
Trade and other payables	16	**(30,804)**	(26,673)	(30,852)	(26,810)
Borrowings	18	**(1,668)**	(1,485)	(1,668)	(1,485)
Provisions	21	**(252)**	(267)	(837)	(685)
Other liabilities	17	**(597)**	(1,608)	(597)	(1,608)
Total current liabilities		**(33,321)**	**(30,033)**	**(33,954)**	**(30,588)**
Total assets less current liabilities		**191,854**	**167,653**	**195,408**	**170,585**
Non-current liabilities					
Borrowings	18	**(27,198)**	(28,126)	(27,198)	(28,126)
Provisions	21	**(559)**	(630)	(559)	(776)
Total non-current liabilities		**(27,757)**	**(28,756)**	**(27,757)**	**(28,902)**
Total assets employed		**164,097**	**138,897**	**167,651**	**141,683**
Financed by					
Taxpayers Equity					
Public Dividend Capital		**68,616**	66,047	68,616	66,047
Revaluation reserve	22	**11,914**	11,914	11,914	11,914
Income and expenditure reserve		**83,567**	60,936	83,567	60,936
Others' Equity					
Charitable Fund Reserves	23	**0**	0	3,554	2,786
Total taxpayers & others' equity		**164,097**	**138,897**	**167,651**	**141,683**

Signed:

D Carter
Date: 22 May 2019

Statement of changes in equity

	Parent - Pre Consolidated				Group Consolidated				
	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Charitable Funds Reserves £000	Total £000
Taxpayers' and Others' Equity at 1 April 2018 - as previously stated	66,047	11,914	60,936	**138,897**	66,047	11,914	60,936	2,786	**141,683**
Surplus/(deficit) for the year	0	0	22,631	**22,631**	0	0	22,148	1,251	**23,399**
Revaluation Impact	0	0	0	**0**	0	0	0	0	**0**
Public Dividend Capital received	2,569	0	0	**2,569**	2,569	0	0	0	**2,569**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	483	(483)	**0**
Taxpayers' and Others' Equity at 31 March 2019	**68,616**	**11,914**	**83,567**	**164,097**	**68,616**	**11,914**	**83,567**	**3,554**	**167,651**
Taxpayers' and Others' Equity at 1 April 2017 - as previously stated	**61,512**	**8,317**	**45,568**	**115,397**	**61,512**	**8,317**	**45,568**	**3,384**	**118,781**
Surplus/(deficit) for the year	0	0	15,368	**15,368**	0	0	14,760	10	**14,770**
Revaluation Impact	0	3,597	0	**3,597**	0	3,597	0	0	**3,597**
Public Dividend Capital received	4,535	0	0	**4,535**	4,535	0	0	0	**4,535**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	608	(608)	**0**
Taxpayers' and Others' Equity at 31 March 2018	**66,047**	**11,914**	**60,936**	**138,897**	**66,047**	**11,914**	**60,936**	**2,786**	**141,683**

Statement of cash flows

	Group	
	2018/19 £000	2017/18 £000
Cash flows from operating activities		
Operating surplus from continuing operations	**27,608**	18,932
Operating surplus	**27,608**	**18,932**
Non-cash income and expense:		
Depreciation and amortisation	**8,602**	8,719
(Increase)/Decrease in Trade and Other Receivables	**(13,313)**	(9,002)
(Increase)/decrease in other assets	**145**	0
(Increase)/Decrease in Inventories	**(312)**	(130)
Increase/(Decrease) in Trade and Other Payables	**146**	3,322
Increase/(Decrease) in Other Liabilities	**(1,011)**	(42)
Increase/(Decrease) in Provisions	**(87)**	(244)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**(120)**	240
Other movements in operating cash flows	**(12)**	10
NET CASH GENERATED FROM OPERATIONS	**21,646**	**21,805**
Cash flows from investing activities		
Interest received	**222**	63
Purchase of Property, Plant and Equipment	**(19,671)**	(12,954)
Sale of Property, Plant and Equipment	**0**	0
NHS Charitable funds - net cash flows from investing activities	**773**	967
Net cash generated used in investing activities	**(18,676)**	**(11,924)**
Cash flows from financing activities		
Public Dividend Capital received	**2,569**	4535
Movement in loans from the Department of Health and Social Care	**(835)**	(835)
Other loans repaid	**(8)**	(8)
Capital element of Private Finance Initiative obligations	**(645)**	(580)
Interest paid	**(398)**	(408)
Interest element of Private Finance Initiative obligations	**(673)**	(707)
PDC Dividend paid	**(3,372)**	(3,148)
Net cash used in financing activities	**(3,362)**	**(1,151)**
Increase/(decrease) in cash and cash equivalents	**(392)**	8,730
Cash and Cash equivalents at 1 April 2018	**37,716**	28,986
Cash and Cash equivalents at 31 March 2019	**37,324**	**37,716**

1. Accounting policies and other information

1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow IFRS to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Body. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going concern

These accounts have been prepared on a going concern basis.

The FT is facing, along with all other providers, a challenging financial environment. The FT has, however, submitted a surplus plan for 2019/20 to NHS Improvement, albeit one that contains risk and requires collaboration with NHS leadership organisations to deliver the plan. After due consideration, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

1.3 Consolidation

The Trust is the corporate trustee to Luton & Dunstable Hospital NHS Foundation Trust Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

* recognise and measure them in accordance with the foundation trust's accounting policies; and
* eliminate intra-group transactions, balances, gains and losses.

The Trust does not have any other subsidiaries, associates, joint ventures or joint operations as defined under International Financial Reporting Standards.

Unless otherwise stated the notes to the accounts disclose the group position.

1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period the income is deferred and recognised as a contract liability.

Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of healthcare is generally satisfied over time as healthcare is received

and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the trust accrued income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld the Trust reflects this in the transaction price and derecognises the relevant portion of income.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right, instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

NHS Injury Cost Recovery Scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4.2 Revenue Grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income to the point at receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4.3 Other Income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale of contract.

1.5 Expenditure on Employee Benefits
Short-term Employee Benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust also has employees who are members of the NEST pension scheme. This is a defined contribution scheme and employers pension cost contributions are charged to operating expenses as and when they become due

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- • it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- • it is expected to be used for more than one financial year;
- • the cost of the item can be measured reliably; and
- • the item has an individual cost of at least £5,000; or
- • the item forms a group of assets which individually have a cost of more than £1,000, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates and are under single managerial control.
- • the item forms a group of assets which are the initial equipping costs of a new or reconfigured asset with a collective value of over £20,000 and the group of assets are under common managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plan and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

* Land and non-specialised buildings - market value for existing use
* Specialised buildings - depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued by professional valuers as part of the five or three-yearly valuation or when they are brought into use where the capital cost is greater than £5m and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component

of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7.4 Donated assets, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expenses as incurred. The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

The lifecycle costs i.e. those costs anticipated to be incurred to maintain the asset to a specified standard, within the scheme form part of the liability of the Trust and consequently have been recognised as a separate asset within the Statement of Financial Position. The asset is amortised each accounting period in accordance with the lifecycle costs incurred in respect of the PFI scheme asset.

1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	n/a	n/a
Buildings, excluding dwellings	0	80
Dwellings	0	80
Plant & machinery	0	15
Transport equipment	0	15
Information technology	0	8
Furniture & fittings	0	5

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciatetd replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as

for Property, Plant and Equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method and weighted average cost for drug inventory.

1.10 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.11 Carbon Reduction Commitment scheme (CRC)
The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation. Allowances acquired under the scheme are recognised as intangible assets.

1.12 Financial assets and financial liabilities

1.12.1 Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classifed as a tax by ONS. This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade/Settlement date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

1.12.2 Classification and Measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. Financial assets are classified as subsequently measured at amortised cost, or fair value through income and expenditure or fair value through other comprehensive income. Financial liabilities are classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses are determined by a review of outstanding contract receivables/ assets for known disputed items, items greater than one year, and cutstomers where there is a history of non-payment. Only in exceptional circumstances will the Trust recognise expected credit losses in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.12.3 De-recognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.13 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.13.1 The Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of

the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.13.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating lesases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. For charitable funds decisions made by the Charitable Fund Committee for which there is a constructive obligation to undertake activities are recognised at the point the decision is made.

The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the Trust is disclosed at note 22 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor

NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable (iv) any Provider Sustainability Fund (PSF) Incentive / Bonus.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation Tax

The majority of the Trust's activities are related to core healthcare and are therefore not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the corporation tax threshold, as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

1.19 Foreign exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM, see Note 24.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and special payments register which reports on a cash basis with the exception of provisions for future losses, see Note 32.

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- review of operating leases to determine whether the significant risks and rewards of ownership of the leased assets have transferred. To mitigate the risk of incorrect conclusions an external advisor's opinion was obtained.

1.23.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- allocation of lifes to acquired plant and equipment (excluding buildings for which a valuer's opinion is obtained) to calculate the depreciation charge. This is estimated based on the lives of similar assets and knowledge of the procurer.

- It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 8.

- income generated from partially completed spells and non contract income. These are estimated assuming that patterns of provision of service are consistent from year to year.

- accrued expenditure for annual leave is estimated by applying NHS employment contracts' terms and conditions and Trust policy to the average annual leave balance for a sample of departments.

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

The GAM does not require the following Standards and Interpretations to be applied in 2018/19.

- IFRS 14 Regulatory Deferral Accounts - Not EU endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2.1 Operating Income from patient care activities (by nature)

	2018/19 Total £000	2017/18 Total £000
Income from Activities		
Elective income	**43,250**	41,067
Non elective income	**113,430**	101,920
Outpatient income	**46,554**	43,979
A & E income	**16,115**	15,346
Other NHS clinical income	**89,939**	91,578
Additional income for delivery of healthcare services	**7,300**	4,500
Private patient income	**2,085**	2,071
AfC pay award central funding	**2,834**	0
Other clinical income	**1,108**	706
Total income from patient care activities	**322,615**	**301,167**

2.2 Commissioner Requested Services

The Trust's provider licence specifies the Commissioner Requested Services, for details see www.improvement.nhs.uk. This note analyses income from activities between Commissioner Requested Services and Non Commissioner Requested Services.

	2018/19 £000	2017/18 £000
Commissioner Requested Services	**309,289**	293,891
Non Commissioner Requested Services	**13,326**	7,276
	322,615	**301,167**

2.3 Operating lease income

	2018/19 Total £000	2017/18 Restated Total £000
Operating Lease Income		
Rents recognised as income in the period	**2,031**	755
TOTAL 2,031 755		
Future minimum lease payments due on leases of Buildings expiring		
- not later than one year;	**172**	99
- later than one year and not later than five years;	**628**	320
- later than five years.	**319**	224
TOTAL	**1,119**	**643**

2.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2018/19 £000	2017/18 £000
Income recognised this year	249	172
Cash payments received in-year	85	109
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	63	83

2.5 OPERATING INCOME (by type)

	Parent		Group	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Income from activities				
CCGs and NHS England	**300,376**	285,371	**300,376**	285,371
NHS Foundation Trusts	**557**	438	**557**	438
NHS Trusts	**1,418**	1,245	**1,418**	1,245
Local Authorities	**2,650**	2,573	**2,650**	2,573
NHS Other	**490**	469	**490**	469
Non NHS: Private patients	**2,085**	2,071	**2,085**	2,071
Non-NHS: Overseas patients (non-reciprocal)	**249**	172	**249**	172
NHS injury scheme (was RTA)	**1,108**	705	**1,108**	705
Non NHS: Other*	**3,548**	3,623	**3,548**	3,623
AfC pay award central funding	**2,834**	0	**2,834**	0
Additional income for delivery of healthcare services	**7,300**	4,500	**7,300**	4,500
Total income from activities	**322,615**	**301,167**	**322,615**	**301,167**

*Non NHS: Other relates to a contract with private sector provider, previously commissioned by NHS Bedfordshire

2.6 OTHER OPERATING INCOME

Other operating income from contracts with customers:				
Research and development	**1,073**	972	**1,073**	972
Education and training	**9,730**	9,298	**9,730**	9,298
Income in respect of staff costs where accounted on gross basis	**2,166**	1,421	**2,166**	1,421
Provider sustainability fund / Sustainability and transformation fund income (PSF / STF)[1]	**18,363**	13,313	**18,363**	13,313
Other[2]	**5,844**	6,466	**5,844**	6,466
Other non-contract operating income				
Education and training - notional income from apprenticeship fund	**277**	74	**277**	74
Charitable and other contributions to expenditure	**439**	566	**0**	0
Received from NHS charities: Other charitable and other contributions to expenditure	**44**	42	**0**	0
Rental revenue from operating leases	**2,031**	755	**2,031**	755
NHS Charitable Funds: Incoming Resources excluding investment income	**0**	0	**1,866**	1,031
Total other operating income	**39,967**	**32,907**	**41,350**	**33,330**
TOTAL OPERATING INCOME	**362,582**	**334,074**	**363,965**	**334,497**

1 NHS Performance bonus received for achieving financial and performance targets

2 This includes car parking income of £1,753k (2017/18 £1,738k). This is strictly an income generation activity whereby income exceeds cost and the surplus is invested in the provision of patient care. There are other Trust objectives delivered through this activity including a contribution to the patient and staff safety and experience agenda (additional security and maximising the availability of car parking spaces).

2.7 Additional Income on contract revenue (IFRS 15) recognised in the period

£1,382k was recognised in 2018/19 that was previously included in the contract liability balance.

2.8 Transaction price allocated to remaining performance obligations

The vast majority of contracts the trust holds align with financial periods with an adjustment made for partially completed patient care treatment as at the financial year end (£1,613k as at 31/03/2019). As at 31/03/2019 the revenue expected when performance obligations are met in future periods was £597k.

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

3.1 OPERATING EXPENSES (by type)

	Parent		Group	
	2018/19 £000	2017/18 Restated £000	2018/19 £000	2017/18 Restated £000
Employee Expenses - Non-executive directors	**133**	127	**133**	127
Employee Expenses - Staff & Executive directors	**219,431**	203,555	**219,431**	203,555
Supplies and services - clinical (excluding drug costs)	**31,539**	28,205	**31,539**	28,205
Supplies and services - general	**15,039**	5,626	**15,039**	5,626
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**29,295**	27,476	**29,295**	27,476
Consultancy costs	**609**	2,285	**609**	2,285
Establishment	**9,243**	7,066	**9,243**	7,066
Premises	**5,633**	16,139	**5,633**	16,139
Transport (including staff and patient travel)	**1,356**	582	**1,356**	582
Depreciation on property, plant and equipment	**8,539**	8,649	**8,539**	8,649
Amortisation on intangible assets	**63**	70	**63**	70
Movement in credit loss allowance	**(184)**	195	**(184)**	195
Provisions arising / released in year	**(10)**	0	**(10)**	0
Audit fees payable to the External Auditor				
audit services- statutory audit[1]	**51**	49	**51**	49
other services: audit-related assurance services'	**7**	7	**7**	7
other auditor remuneration (external auditor only)	**0**	18	**0**	18
Audit fees payable re charitable fund accounts	**0**	0	**3**	3
Internal Audit Costs - not included in employee expenses	**101**	61	**101**	61
Clinical negligence (Insurance Premiums)	**10,873**	10,277	**10,873**	10,277
Legal fees	**66**	165	**66**	165
Insurance	**94**	90	**94**	90
Education and training - staff costs	**235**	0	**235**	0
Education and training - non-staff	**847**	959	**847**	959
Education and training - notional expenditure funded from apprenticeship fund	**277**	74	**277**	74
Rentals under operating leases - minimum lease receipts	**1,046**	996	**1,046**	996
Charges to operating expenditure for on-SoFP IFRIC 12 schemes on IFRS basis	**596**	512	**596**	512
Redundancy - (not included in employee expenses)	**0**	14	**0**	14
Car parking & Security	**737**	754	**737**	754

	Parent		Group	
	2018/19 £000	2017/18 Restated £000	2018/19 £000	2017/18 Restated £000
Hospitality	**2**	6	**2**	6
Losses, ex gratia & special payments	**12**	96	**12**	96
Other services, eg external payroll	**247**	244	**247**	244
Grossing up consortium arrangements	**0**	61	**0**	61
NHS Charitable funds: Other resources expended	**0**	0	**774**	1,125
Other	**(297)**	79	**(297)**	79
TOTAL	**335,580**	**314,437**	**336,357**	**315,565**

*1 Excluding non-recoverable VAT.

4.1 Employee Expenses

(excluding non-executive directors)	2018/19 Permanent £000	2018/19 Other £000	2018/19 Total £000	2017/18 Permanent £000	2017/18 Other £000	2017/18 Total £000
Salaries and wages	143,367	25,859	**169,226**	134,871	22,563	**157,434**
Social security costs	14,588	2,820	**17,408**	14,319	1,933	**16,252**
Apprenticeship Levy	830	15	**845**	626	92	**718**
Pension costs - defined contribution plans Employers contributions to NHS Pensions	16,725	1,997	**18,722**	15,912	1,209	**17,121**
Pension cost - other	8	13	**21**	0	0	**0**
Agency/contract staff	0	16,323	**16,323**	0	14,838	**14,838**
Costs capitalised as part of assets	(2,155)	(724)	**(2,879)**	(2,203)	(591)	**(2,794)**
TOTAL (Employee expenses & Education & Training)	**173,363**	**46,303**	**219,666**	**163,525**	**40,044**	**203,569**

4.2 Average number of employees (WTE basis)

	2018/19 Permanent Number	2018/19 Other Number	2018/19 Total Number	2017/18 Permanent Number	2017/18 Other Number	2017/18 Total Number
Medical and dental	564	181	**745**	563	157	**720**
Administration and estates	804	98	**902**	761	94	**855**
Healthcare assistants and other support staff	560	281	**841**	558	254	**812**
Nursing, midwifery and health visiting staff	1,391	189	**1,580**	1,331	185	**1,516**
Nursing, midwifery and health visiting learners	7	0	**7**	7	0	**7**
Scientific, therapeutic and technical staff	400	13	**413**	368	14	**382**
Healthcare science staff	156	59	**215**	156	47	**203**
Other	3	0	**3**	3	0	**3**
Number of Employees (WTE) engaged on capital projects	(54)	(13)	**(67)**	(55)	(10)	**(65)**
TOTAL	**3,831**	**808**	**4,639**	**3,692**	**741**	**4,433**

4.3 Employee benefits

There were no employee benefits during either 2018/19 nor 2017/18.

4.4 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There were 3 (2017/18: 2) retirements, at an additional cost of £141k (2017/18: £82k). This information has been supplied by NHS Pensions.

4.5.1 Senior Managers Remuneration

		2018/19		
Name and Title		Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman				
Simon Linnett	Chairman	40 to 45	n/a	40 to 45
Non Executive Directors				
Alison Clarke	Non-Executive Director	15 to 20	n/a	15 to 20
Ninawatie Tiwari	Non-Executive Director	10 to 15	n/a	10 to 15
John Garner	Non-Executive Director (to October 2018)	5 to 10	n/a	5 to 10
Mark Versallion	Non-Executive Director	10 to 15	n/a	10 to 15
David Hendry	Non-Executive Director (to October 2018)	10 to 15	n/a	10 to 15
Denis Mellon	Non-Executive Director	10 to 15	n/a	10 to 15
Simon Barton	Non-Executive Director (from September 2018)	5 to 10	n/a	5 to 10
Mark Prior	Non-Executive Director (from October 2018)	5 to 10	n/a	5 to 10
Executive Directors				
David Carter	Chief Executive	180 to 185	75 to 77.5	255 to 260
Cathy Jones	Deputy Chief Executive	120 to 125	77.5 to 80	195 to 200
Andrew Harwood	Director of Finance (to January 2019)[1]	135 to 140	n/a	135 to 140
Matthew Gibbons	Director of Finance (Acting from January 2019)[1]	105 to 110	TBC	TBC
Danielle Freedman	Chief Medical Advisor	160 to 165	n/a	160 to 165
Angela Doak	Director of Human Resources	120 to 125	27.5 to 30	150 to 155
Sheran Oke	Director of Nursing (Acting to June 2018)	35 to 40	177.5 to 180	215 to 220
Liz Lees[2]	Chief Nurse (from June 2018)	95 to 100	20 to 22.5	115 to 120
Catherine Thorne	Director of Quality & Safety Governance (From Oct 2018)	55 to 60	82.5 to 85	135 to 140

Name and Title		2017/18 Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman				
Simon Linnett	Chairman	40 to 45	n/a	40 to 45
Non Executive Directors				
Alison Clarke	Non-Executive Director	15 to 20	n/a	15 to 20
Ninawatie Tiwari	Non-Executive Director	10 to 15	n/a	10 to 15
John Garner	Non-Executive Director	10 to 15	n/a	10 to 15
Mark Versallion	Non-Executive Director	10 to 15	n/a	10 to 15
David Hendry	Non-Executive Director	15 to 20	n/a	15 to 20
Jill Robinson	Non- Executive Director (to 10/11/17)	5 to 10	n/a	5 to 10
Clifford Bygrave	Non-Executive Director (to 31/03/18)	10 to 15	n/a	10 to 15
Denis Mellon	Non-Executive Director (from 11/11/17)	5 to 10	n/a	5 to 10
Executive Directors				
Pauline Philip	Chief Executive (Seconded from 8/5/17)[1]	205 to 210	n/a	205 to 210
David Carter	Chief Executive (Acting from 8/5/17 appointed 14/2/18)			
Managing Director (to 07/05/17)		175 to 180	105 to 107.5	280 to 285
Andrew Harwood	Director of Finance	130 to 135	85 to 87.5	220 to 225
Danielle Freedman	Chief Medical Advisor	160 to 165	n/a	160 to 165
Cathy Jones	Deputy Chief Executive (Acting from 8/5/17 appointed 7/3/18)[1]	105 to 110	117.5 to 120	220 to 225
Sheran Oke	Director of Nursing (Acting)	90 to 95	120 to 122.5	215 to 220
Marion Collict	Director of Transformation (to 31/03/18)	110 to 115	95 to 97.5	210 to 215
Angela Doak	Director of Human Resources	120 to 125	27.5 to 30	150 to 155

[1] Salary is for full year for all staff (including period when not voting Director)

[2] Shared post with Bedford Hospital. Value stated reflects full cost.

For the purpose of this note Senior Managers are defined as being the Chief Executive, Non Executive Directors and Executive Directors. I.e. Those individuals with voting rights.

Senior Managers have not received any taxable benefits, annual performance-related bonuses or long-term performance related bonuses in either 2018/19 or 2017/18.

Note 4.5.2 Pension Benefits

	2018/19				
Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2019 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2019 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real Increase in Cash Equivalent Transfer Value £000
David Carter Chief Executive	2.5 to 5	162.5 to 165	906	741	165
Cathy Jones Deputy Chief Executive	7.5 to 10	80 to 82.5	339	239	100
Andrew Harwood[1] Director of Finance (to January 2019)					
Matthew Gibbons Director of Finance (Acting from January 2019)	5 to 7.5	85 to 87.5	398	309	89
Danielle Freedman1 Chief Medical Advisor					
Angela Doak Director of Organisational Development	0 to 2.5	185 to 187.5	1,057	924	133
Sheran Oke Director of Nursing (Acting to June 2018)	30 to 32.5	185 to 187.5	1,038	779	259
Liz Lees Chief Nurse (from June 2018)	0 to 2.5	0 to 2.5	23	0	23
Catherine Thorne Director of Quality & Safety Governance (From Oct 2018)	7.5 to 10	160 to 162.5	921	762	159

[1] No longer contributing to pension scheme

	Restated 2017/18				
Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2018 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2018 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real Increase in Cash Equivalent Transfer Value £000
Pauline Philip[1] Chief Executive (Seconded from 8/5/17, left 17/1/18)					
David Carter Chief Executive (Acting from 8/5/17 appointed 14/2/18) Managing Director (to 07/05/17)	17.5 to 20	152.5 to 155	741	640	101
Andrew Harwood Director of Finance	17.5 to 20	210 to 212.5	1,079	930	149
Danielle Freedman[1] Chief Medical Advisor					
Cathy Jones Deputy Chief Executive (Acting from 8/5/17 appointed 7/3/18)	20 to 22.5	67.5 to 70	239	171	68
Sheran Oke Director of Nursing (Acting)	22.5 to 25	152.5 to 155	779	643	136
Marion Collict Director of Transformation (to 31/03/18)	17.5 to 20	152.5 to 155	838	711	127
Angela Doak Director of Organisational Development	0 to 2.5	182.5 to 185	924	848	76

4.5.3 Median Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

	2018/19	2017/18
Band of Highest Paid Director's Total Remuneration	180 to 185	205 to 210
Median Total*	**28,050**	**26,565**
Ratio	6.5	7.7

The highest paid director's remuneration decreased in 2018/19. Median pay increased.

* Excludes bank and agency staff

4.5.4 Staff Exit Packages

	2018/19		2017/18	
Exit package cost band (including any special payment element)	Total number of exit packages	Total cost of exit packages £'000	Total number of exit packages	Total cost of exit packages £'000
<£10,000	13	39	11	35
£10,001 - £25,000	2	23	2	24
£25,001 - 50,000	0	0	0	0
£50,001 - £100,000	0	0	0	0
£100,001 - £150,000	0	0	0	0
>£150,000	0	0	0	0
Total	**15**	**62**	**13**	**59**

	2018/19	2018/19	2017/18	2017/18
	Payments agreed	Total value	Payments agreed	Total Value
	Number	£'000	Number	£'000
Compulsory redundancies	0	0	1	14
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Contractual payments in lieu of notice	15	62	12	45
	15	**62**	**13**	**59**

4.5.5 Expenses of Governors and Directors

The Foundation Trust had a total of 33 (35 in 2017/18) governors in office in 2018/19. 10 (7 in 2017/18) of these governors received expenses in 2018/19, with aggregate expenses paid to governors of £1,185 (£1,100 in 2017/18).

The Foundation Trust had a total of 18 (17 in 2017/18) directors in office in 2018/19. 10 (11 in 2017/18) of these directors received expenses in 2018/19, with aggregate expenses paid to directors of £6,018 (£9,400 in 2017/18)

5.1 Operating leases

	2018/19 £000	2017/18 £000
Minimum lease payments	1,046	996
TOTAL	**1,046**	**996**

5.2 Arrangements containing an operating lease

Future minimum lease payments due:	2018/19 £000 Land	2018/19 £000 Buildings	2018/19 £000 Other	2018/19 £000 Total	2017/18 £000 Total
- not later than one year;	79	177	112	**368**	223
- later than one year and not later than five years;	317	554	223	**1,094**	782
- later than five years.	628	1,714	0	**2,342**	1,985
TOTAL	**1,024**	**2,445**	**335**	**3,804**	**2,990**

The Trust does not have any significant leasing arrangements.

Note 5.3 Limitation on auditor's liability

There is £1m limitation on the auditors liability.

5.4 The late payment of commercial debts (interest) Act 1998

£0k was paid in respect of the late payment of commercial debts (interest) Act 1998 (£0k in 2017/18)

5.5 Other Audit Remuneration

£0k expenditure was incurred with the external audit provider in respect of tax advice in 2018/19. (£18k 2017/18)

5.6 Impairment of assets (PPE & intangibles)

No impairments have been charged to expenditure in either 2017/18 nor 2018/19.

6.1 Finance income

	Parent		Group	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Interest on instant access bank accounts	222	63	222	63
Interest on held-to-maturity financial assets	0	0	0	0
NHS Charitable funds: investment income	0	0	60	74
TOTAL	**222**	**63**	**282**	**137**

6.2 Finance costs - interest expense

	Parent		Group	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Capital loans from the Department of Health	396	408	396	408
Interest on late payment of commercial debt	0	0	0	0
Finance Costs in PFI obligations				
Main Finance Costs	656	707	656	707
TOTAL	**1,052**	**1,115**	**1,052**	**1,115**

7.1 Intangible Assets 2018/19

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2018 as previously stated	536	**536**
Additions - purchased	0	**0**
Cost or valuation at 31 March 2019	536	**536**
Amortisation at 1 April 2018 as previously stated	412	**412**
Provided during the year	63	**63**
Amortisation at 31 March 2019	475	**475**
Net book value		
NBV - Owned at 31 March 2019	61	**61**
NBV total at 31 March 2019	61	61

7.2 Intangible Assets 2017/18

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2017 as previously stated	536	**536**
Additions - purchased	0	**0**
Cost or valuation at 31 March 2018	536	**536**
Amortisation at 1 April 2017 as previously stated	342	**342**
Provided during the year	70	**70**
Amortisation at 31 March 2018	412	**412**
Net book value		
NBV - Owned at 31 March 2018	124	**124**
NBV total at 31 March 2018	124	124

8.1 Property, plant and equipment 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018 as previously stated	12,270	78,737	375	11,208	31,034	3,900	16,333	232	**154,089**
Additions - purchased (including donated)	0	3,966	258	12,476	6,910	206	467	0	**24,283**
Reclassifications	0	3,632	0	(6,141)	0	0	2,509	0	**0**
Disposals[1]	0	0	0	0	(82)	0	0	(1)	**(83)**
Cost or valuation at 31 March 2019	**12,270**	**86,335**	**633**	**17,543**	**37,862**	**4,106**	**19,309**	**231**	**178,289**
Accumulated depreciation at 1 April 2018 as previously stated	0	0	0	0	21,738	2,484	8,942	205	**33,369**
Provided during the year	0	3,008	11	0	2,449	384	2,683	4	**8,539**
Disposals[1]	0	0	0	0	(62)	0	0	0	**(62)**
Accumulated depreciation at 31 March 2019	0	3,008	11	0	24,125	2,868	11,625	209	**41,846**
Net book value									
NBV - Owned at 31 March 2019	12,270	69,376	611	17,543	12,114	1,238	7,677	22	**120,851**
NBV - PFI at 31 March 2019	0	12,029	0	0	751	0	0	0	**12,780**
NBV - Donated at 31 March 2019	0	1,922	11	0	872	0	7	0	**2,812**
NBV total at 31 March 2019	**12,270**	**83,327**	**622**	**17,543**	**13,737**	**1,238**	**7,684**	**22**	**136,443**

[1] No assets used in the provision of commissioner requested services were disposed of during the year.

8.2 Property, plant and equipment 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017 as previously stated	10,650	82,027	438	8,104	28,979	3,900	14,621	210	**148,929**
Additions - purchased (including donated)	0	1,912	0	6,798	2,907	0	598	22	**12,237**
Reclassifications	0	2,580	0	(3,694)	0	0	1,114	0	**0**
Revaluations	1,620	(7,782)	(63)	0	0	0	0	0	**(6,225)**
Disposals1	0	0	0	0	(852)	0	0	0	**(852)**
Cost or valuation at 31 March 2018	**12,270**	**78,737**	**375**	**11,208**	**31,034**	**3,900**	**16,333**	**232**	**154,089**
Accumulated depreciation at 1 April 2017 as previously stated	0	6,436	26	0	20,109	2,029	6,587	204	**35,391**
Provided during the year	0	3,347	13	0	2,477	454	2,355	3	**8,649**
Revaluations	0	(9,783)	(39)	0	0	0	0	0	**(9,822)**
Disposals[1]	0	0	0	0	(851)	0	0	0	**(851)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**0**	**21,735**	**2,483**	**8,942**	**207**	**33,367**
Net book value									
NBV - Purchased at 31 March 2018	12,270	64,977	355	11,208	8,423	1,417	7,391	17	**106,058**
NBV - PFI at 31 March 2018	0	11,962	0	0	0	0	0	0	**11,962**
NBV - Donated at 31 March 2018	0	1,798	20	0	876	0	0	8	2,702
NBV total at 31 March 2018	**12,270**	**78,737**	**375**	**11,208**	**9,299**	**1,417**	**7,391**	**25**	**120,722**

[1] No assets used in the provision of commissioner requested services were disposed of during the year.

8.3 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	n/a	n/a
Buildings excluding dwellings	0	124
Dwellings	0	112
Assets under Construction & POA	n/a	n/a
Plant & Machinery	0	15
Transport Equipment	0	7
Information Technology	0	8
Furniture & Fittings	0	10
Intangible Software Licenses	0	8

9 Other Property Plant & Equipment Disclosures

The Trust received £439k of donated property, plant and equipment from the charitable funds associated with the hospital.

The Trust entered into a 10 year contract for the provision of medical records in February 2013. Due to the length of the contract, the expected life of the equipment in question and, on the basis that the equipment is solely used by this Trust, the Trust has recognised this equipment as property plant and equipment. The value of this equipment as at 31 March 2019 was £1,047k.

In December 2018 the trust entered into a 10 year managed service bed contract. This arrangement included the replacement of beds which at the end of the contract transfer ownership to the trust. Given the length of the contract and the transfer of ownership the trust has recognised the beds delivered as at 31 March 2019 as property plant and equipment. The value of this equipment as at 31 March 2019 was £751k.

The Trust's estate, encompassing land and buildings was revalued as at 31 March 2018. This valuation was completed by Gerald Eve LLP, professional valuers in accordance with the RICS Valuation - Professional Standards published by the Royal Institution of Chartered Surveyors. The Directors' opinion is that there are no property plant or equipment where the value is significantly different from the value included in the financial statements.

Land was valued using existing use value methodology at £12,270k using the concept of economic substitution of the service utility of the asset.

Given the specialised nature of the buildings the majority of the estate has been valued using depreciated replacement cost based on modern equivalent assets at a value of £83,327k.

There are various small assets which are temporarily idle, although not for sale, where the period for which the asset is idle is uncertain these have had their depreciation accelerated and are held on the Statement of Financial Position at values reflecting their short remaining economic lives.

10.1 Non-current assets for sale and assets in disposal groups

The Trust held no non-current assets for sale nor assets in disposal groups in 2017/18 or 2018/19.

10.2 Liabilities in disposal groups

The Trust held no liabilities in disposal groups in 2017/18 nor 2018/19.

11 Investments

	Parent		Group	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
NHS Charitable funds: Other investments				
Carrying value at 1 April 2018	0	0	2,216	3,075
Acquisitions in year - other	0	0	950	258
Fair value gains (taken to I&E)	0	0	102	34
Disposals	0	0	(1,648)	(1,151)
Carrying value at 31 March 2019	0	0	1,620	2,216

12 Associates & Jointly Controlled Operations

The NHS foundation trust is the corporate trustee to Luton & Dunstable Hospital Charitable Funds. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The main financial statements disclose the NHS organisation's financial position alongside that of the group (which is the NHS organisation and the NHS charity). The NHS charity's accounts, which have been prepared in accordance with UK Financial Reporting Standard (FRS) 102, can be found on the Charity Commission website and are summarised in note 23 to these accounts.

As the accounting policies applicable to both the Trust and the Charitable Funds are consistent no adjustment other than intra-group transactions has been required.

The Trust had no other associates nor jointly controlled operations in 2017/18 nor 2018/19.

13.1 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	971	955
Consumables	2,762	2,466
TOTAL INVENTORIES	**3,733**	**3,421**

13.2 Inventories recognised in expenses

	2018/19 £000	2017/18 £000
Additions	50,164	47,828
Inventories recognised in expenses	(49,852)	(47,698)
MOVEMENT IN INVENTORIES	**312**	**130**

14.1 Trade receivables and other receivables

	Parent		Group	
	31 March 2019 £000	31 March 2018 restated* £000	31 March 2019 £000	31 March 2018 restated* £000
Current				
Trade Receivables**	**0**	11,513	**0**	11,513
Contract receivables (IFRS 15): invoiced**	**20,011**	0	**20,011**	0
Contract receivables (IFRS 15): not yet invoiced / non-invoiced**	**20,524**	0	**20,524**	0
Accrued income**	**0**	13,214	**0**	13,214
Allowance for impaired contract receivables / assets	**(71)**	0	**(71)**	0
Allowance for impaired other receivables	**(457)**	(852)	**(457)**	(852)
Prepayments	**3,821**	4,192	**3,821**	4,192
Prepayments - Lifecycle replacements	**44**	44	**44**	44
VAT receivable	**878**	1,341	**878**	1,341
Other receivables	**207**	3,249	**170**	3,195
NHS Charitable funds: Trade and other receivables	**0**	0	**47**	9
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**44,957**	**32,701**	**44,967**	**32,656**
Non-Current				
Contract receivables (IFRS 15): not yet invoiced / non-invoiced**	**1,106**	0	**1,106**	0
Accrued income**	**0**	1,012	**0**	1,012
Prepayments	**1,558**	568	**1,558**	568
Prepayments - PFI related	**263**	306	**263**	306
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**2,927**	**1,886**	**2,927**	**1,886**

* Restated to consolidate prior year trade receivables (previously disclosed as NHS receivables, Other Related Party receivables and Other Trade Receivables)

** Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

14.2 Allowances for credit losses (doubtful debts) 2018/19

	Contract receivables and contract assets £000	All other receivables £000	Total £000
At 1 April 2018	0	852	852
Impact of IFRS 9 (and IFRS 15) implementation on 1 April 2018 balance	437	(437)	0
Changes in the calculation of existing allowances	(116)	42	(74)
Reversals of allowances (where receivable is collected in-year)	(110)	0	(110)
Utilisation of allowances (where receivable is written off)	(140)	0	(140)
At 31 March 2019	**71**	**457**	**528**

14.3 Allowances for credit losses (doubtful debts) 2017/18

	All Receivables
	£000
At 1 April 2017	943
Increase/(Decrease) in provision	195
Amounts utilised	-286
At 31 March 2018	852

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

14.4 Finance lease receivables

During 2018/19 the Trust did not have any finance lease receivables.

15 Other assets (Non Current)

	31 March 2019 £000	31 March 2018 £000
PFI Scheme - lifecycle costs	**2,287**	2,432
Total	**2,287**	**2,432**

16.1 Trade and other payables

	Parent		Group	
	31 March 2019 £000	31 March 2018 restated £000	31 March 2019 £000	31 March 2018 restated £000
Current				
Trade payables	**12,228**	11,353	**12,228**	11,353
Trade payables - capital	**5,247**	1,370	**5,247**	1,370
Accruals	**7,063**	8,342	**7,063**	8,342
Receipts in advance	**3**	57	**3**	57
Social Security costs	**5,171**	4,668	**5,171**	4,668
Other payables	**777**	719	**777**	719
PDC Dividend Payable	**315**	164	**315**	164
NHS Charitable funds: Trade and other payables	**0**	0	**48**	137
TOTAL CURRENT TRADE & OTHER PAYABLES	**30,804**	**26,673**	**30,852**	**26,810**

There were no non current trade or other payables at either 31 March 2018 or 31 March 2019.

Trade and other payables do not include any outstanding pension contributions due to NHS Pensions Agency as at 31 March 2019.

17 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred Income	**597**	1,608
TOTAL OTHER CURRENT LIABILITIES	**597**	**1,608**

There are no non current other liabilities in 2017/18 nor 2018/19.

18 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Capital loans from Department of Health	878	835
Other loans	4	11
Obligations under Private Finance Initiative contracts/ service concessions	786	639
TOTAL CURRENT BORROWINGS	**1,668**	**1,485**
Non-current		
Capital loans from Department of Health	17,134	17,970
Other loans	0	0
Obligations under Private Finance Initiative contracts/ service concessions	10,064	10,156
TOTAL OTHER NON CURRENT LIABILITIES	**27,198**	**28,126**

19. Finance lease obligations

The Trust had no finance lease obligations during 2018/19 other than the PFI scheme arrangement and the service concession disclosed in Note 20.1.

20.1 PFI and Service Concession obligations (on SoFP)

	31 March 2019 £000	31 March 2018 £000
Gross PFI liabilities of which liabilities are due	**15,121**	15,744
- not later than one year;	**1,422**	1,318
- later than one year and not later than five years;	**5,812**	5,587
- later than five years.	**7,887**	8,839
Finance charges allocated to future periods	**(4,271)**	(4,949)
Net PFI liabilities	**10,850**	**10,795**
- not later than one year;	**786**	639
- later than one year and not later than five years;	**3,729**	3,311
- later than five years.	**6,335**	6,845

20.2 The Trust is committed to make the following payments for on-SoFP PFIs and Service Concession obligations during the next year in which the commitment expires:

	31 March 2019 Total £000	31 March 2018 Total £000
Within one year	**2,226**	1,829
2nd to 5th years (inclusive)	**9,285**	7,688
Later than 5 years	**13,490**	13,696
Total	**25,001**	**23,213**

The Trust incurred £527k expenditure in respect of the service charge under the PFI contract (£512k in 2017/18) and £69k was incurred in relation to the service concession (bed contract). These were separately disclosed as 'Charges to operating expenditure for on-SoFP IFRIC 12 schemes on IFRS basis' in Note 3.1 .

21 Provisions for liabilities and charges

Parent	**Current**		**Non-current**	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Pensions relating to other staff	**63**	65	**559**	630
Other legal claims	**179**	177	**0**	0
Other	**10**	25	**0**	0
Total	**252**	**267**	**559**	**630**

Group	**Current**		**Non-current**	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Pensions relating to other staff	**63**	65	**559**	630
Other legal claims	**179**	177	**0**	0
Redundancy	**0**	0	**0**	0
Other	**10**	25	**0**	0
NHS charitable fund provisions	**585**	418	**0**	146
Total	**837**	**685**	**559**	**776**

	Pensions - other staff £000	Other legal claims £000	Redundancy £000	Other £000	NHS charitable fund provisions £000	Total £000
At 1 April 2018	**695**	**178**	**0**	**25**	**563**	**1,461**
Arising during the year	0	156	0	0	0	156
Utilised during the year	(65)	(104)	0	(15)	0	(184)
Reversed unused	(9)	(51)	0	0	0	(60)
Unwinding of discount	1	0	0	0	0	1
NHS charitable funds: movement in provisions	0	0	0	0	22	22

	Pensions - other staff	Other legal claims	Redundancy	Other	NHS charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000
At 31 March 2019	622	179	0	10	585	1,396
Expected timing of cashflows:						
- not later than one year;	63	179	0	10	585	837
- later than one year and not later than five years;	257	0	0	0	0	257
- later than five years.	302	0	0	0	0	302
TOTAL	622	179	0	10	585	1,396

Provisions for legal claims represents the gross estimated liability from employer and public liability cases. These cases are managed by NHS Litigation Authority through the LTPS scheme, the amount of the provision recoverable from NHS Litigation Authority is included within debtors.

£165,159k is included in the provisions of the NHS Litigation Authority at 31/03/2019 in respect of clinical negligence liabilities of the Trust (31/03/2018 £163,330k).

Other provisions relate to various provisions for trading and employment contractual issues (all less than £1m).

22 Revaluation reserve

	Revaluation Reserve -property, plant and equipment £000	Total Revaluation Reserve* £000
Revaluation reserve at 1 April 2018	11,914	**11,914**
Revaluation Impact	0	**0**
Other Movements	0	**0**
Revaluation reserve at 31 March 2019	**11,914**	**11,914**
Revaluation reserve at 1 April 2017	8,317	**8,317**
Revaluation Impact	3,597	**3,597**
Other Movements	0	**0**
Revaluation reserve at 31 March 2018	**11,914**	**11,914**

* The Trust held no revaluation reserve in respect of intangible assets.

23 Charitable Funds Summary Statements

As per Note 12, below summarises the NHS Charity's accounts which have been consolidated within the Group's accounts in accordance with IAS 27.

	Subsidary	
	2018/19 £000	2017/18 £000
Statement of Financial Activities/ Comprehensive Income		
Incoming resources	**1,866**	1,031
Resources expended	**(1,260)**	(1,736)
Net resources expended	**606**	(705)
Incoming Resources: investment income	**60**	74
Fair value movements on investments	**102**	34
Net movement in funds	**768**	(597)

	31 March 2019 £000	31 March 2018 £000
Statement of Financial Position		
Non-current assets	**1,620**	2,216
Current assets	**2,605**	1,324
Current liabilities	**(671)**	(609)
Non-current liabilities	**0**	(145)
Net assets	**3,554**	**2,786**
Funds of the charity		
Endowment funds	**0**	1
Other Restricted income funds	**2,374**	871
Unrestricted income funds	**1,180**	1,914
Total Charitable Funds	**3,554**	**2,786**

24 Cash and cash equivalents

	Parent		Group	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
At 1 April (as previously stated)	**36,400**	28,176	**37,716**	28,986
Net change in year	**(1,633)**	8,224	**(392)**	8,730
At 31 March	**34,767**	36,400	**37,324**	37,716
Broken down into:				
Cash at commercial banks and in hand	**99**	83	**99**	83
NHS charitable funds: cash held at commercial bank	**0**	0	**2,557**	1,315
Cash with the Government Banking Service	**34,668**	36,318	**34,668**	36,318
Cash and cash equivalents as in SoFP	**34,767**	36,400	**37,324**	37,716
Cash and cash equivalents as in SoCF	**34,767**	36,400	**37,324**	37,716

The Trust held £0.03k cash at bank and in hand at 31/03/19 which relates to monies held by the Trust on behalf of patients.

25.1 Contractual Capital Commitments

The Trust had contractual capital commitments totalling £7.1m at 31 March 2019.

25.2 Events after the reporting period

There have been no events after the reporting period end requiring disclosure.

The Director of Finance authorised the financial statements for issue on x May 2019.

26. Contingent (Liabilities) / Assets

	31 March 2019 £000	31 March 2018 £000
Gross value of contingent liabilities	66	29
Net value of contingent liabilities	66	29
Net value of contingent assets	0	0

Contingent liabilities relate to claims that the NHS Litigation Authority (NHS Resolution) is aware of and has requested that we disclose.

27 Related Party Transactions

The Luton & Dunstable Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the NHS Foundation Trust.

All bodies deemed to be within the remit of the United Kingdom 'Whole of Government' are regarded as related parties. During the year the Trust has had significant transactions with the bodies disclosed in this note.

The Trust is the Corporate Trustee for the Charitable Funds, the transactions for which have been consolidated within these financial statements in accordance with IAS 27.

	Income 2018/19 £000	Expenditure 2018/19 £000	Income 2017/18 £000	Expenditure 2017/18 £000
NHS and DH				
Bedfordshire CCG	**79,684**	**0**	72,979	0
Buckinghamshire CCG	**3,680**	**0**	3,118	0
Department of Health	**10,152**	**3,523**	4,532	3,597
Health Education England	**9,583**	**3**	9,242	0
Herts Valleys CCG	**24,510**	**0**	24,427	0
Luton CCG	**140,053**	**0**	130,225	0
NHS England: East Commissioning Hub	**34,282**	**0**	34,565	0
NHS England: Central Midlands Local Office	**10,399**	**0**	9,627	0
NHS England: Core	**18,556**	**0**	14,997	0
NHS Resolution (Previously NHS Litigation Authority)	**0**	**10,873**	0	10,304
Central Government				
HM Revenue and Customs	**0**	**18,799**	0	17,738
National Health Service Pension Scheme	**0**	**18,722**	0	17,595

Payables	Payables 31 March 2019 £000	Receivables 31 March 2019 £000	Payables 31 March 2018 £000	Receivables 31 March 2018 £000
Related Party Balances				
NHS and DH				
Bedfordshire CCG	4,693	0	3,551	0
Buckinghamshire CCG	478	0	819	0
Department of Health	7,300	0	1	0
Health Education England	2,588	0	793	0
Herts Valleys CCG	0	0	47	0
Luton CCG	2,856	0	2,240	0
NHS England: East Commissioning Hub	839	0	1,006	0
NHS England: Central Midlands Local Office	303	0	45	0
NHS England: Core	11,485	0	8,445	0
NHS Resolution (Previously NHS Litigation Authority)	0	4	0	0
Central Government				
HM Revenue and Customs	878	5,171	1,341	4,668
National Health Service Pension Scheme	0	2,635	0	2,574

28.1 For PFI schemes deemed to be off-SoFP

The Trust ended the off SoFP PFI scheme relating to the provision of the electronic patient record system in 2011/12. There are no transactions within either 2017/18 or 2018/19 relating to an off-SoFP PFI scheme.

28.2 Further narrative on PFI schemes/ Service Concession Arrangements

The Trust had two capital schemes arranged under PFI arrangements, one of these ended in 2011/12.

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 11 years remaining. The operator is responsible for maintaining the building during this period and ownership reverts to the Trust at the end of the contract. There are no break clauses nor re-pricing dates (On-SoFP)

2. The contract for the electronic patient record scheme has now finished. This contract was for 10 years.

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

During 2018/19 the Trust entered into a 10 year bed contract (service concession). As the beds provided under the contract revert to the Trust's ownership at the end of the contract the beds have been recognised under IFRIC 12.

29.1 Financial assets by category

	Parent		Group	
	Loans and receivables £000	Total £000	Loans and receivables £000	Total £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets (at 31 March 2019)	33,561	**33,561**	33,561	**33,561**
Cash and cash equivalents (at bank and in hand (at 31 March 2019))	34,767	**34,767**	34,767	**34,767**
NHS Charitable funds: financial assets (at 31 March 2019)	0	**0**	4,224	**4,224**
Total at 31 March 2019	**68,328**	**68,328**	**72,552**	**72,552**
Carrying values of financial assets as at 31 March 2018 under IAS 39				
Trade and other receivables excluding non financial assets (at 31 March 2018)	23,126	**23,126**	23,126	**23,126**
Cash and cash equivalents (at bank and in hand (at 31 March 2018))	36,400	**36,400**	36,400	**36,400**
NHS Charitable funds: financial assets (at 31 March 2018)	0	**0**	3,539	**3,539**
Total at 31 March 2018	**59,526**	**59,526**	**63,065**	**63,065**

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Financial Assets risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS receivables	Low	Low	Low
Accrued income	Low	Low	Medium
Other debtors	Low	Low	Medium
Cash at bank and in hand	Low	Medium	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

The Trust has a robust, audited, debt management policy that mitigates against the debtor liquidity risk. The Trust mitigates the cash credit risk by investing only in line with the NHS Improvement compliant Treasury Management Policy.

29.2 Financial liabilities by category

	Parent		Group	
	Other financial liabilities £000	Total £000	Other financial liabilities £000	Total £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9				
Borrowings excluding finance lease and PFI liabilities (at 31 March 2019)	18,016	**18,016**	18,016	18,016
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2019)	10,850	**10,850**	10,850	10,850
Trade and other payables excluding non financial liabilities (at 31 March 2019)	25,227	**25,227**	25,227	25,227
IAS 37 provisions which are financial liabilities	811	**811**	811	811
NHS Charitable funds: financial liabilities (at 31 March 2019)	0	**0**	634	634
Total at 31 March 2019	**54,904**	**54,904**	**55,538**	**55,538**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39				
Borrowings excluding finance lease and PFI liabilities (at 31 March 2018)	18,816	**18,816**	18,816	18,816
Obligations under Private Finance Initiative contracts (31 March 2018)	10,795	**10,795**	10,795	10,795
Trade and other payables excluding non financial liabilities (31 March 2018)	26,674	**26,674**	26,674	26,674
NHS Charitable funds: financial liabilities (31 March 2018)	0	**0**	191	191
Total at 31 March 2018	**56,285**	**56,285**	**56,476**	**56,476**

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Financial Liabilities risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS creditors	Low	Low	Low
Other creditors	Low	Low	Low
Accruals	Low	Low	Low
Capital creditors	Low	Low	Low
Provisions under contract	Low	Low	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

All major contractors are credit checked prior to the awarding of the contract, thus limiting credit risk.

The Trust mitigates the liquidity risk via 12 month forward cash planning.

29.3 Maturity of Financial Liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	28,340	28,345
In more than one year but not more than two years	1,756	1,548
In more than two years but not more than five years	5,485	5,103
In more than five years	19,957	21,481
Total	**55,538**	**56,477**

29.4 Fair values of financial assets at 31 March 2019

The fair value of the Trust's financial assets were the same as the book value as at 31 March 2019 (and 31 March 2018).

29.5 Fair values of financial liabilities at 31 March 2019

The fair value of the Trust's financial liabilities were the same as the book value as at 31 March 2019 (and 31 March 2018).

30.1 On-Statement of Financial Position pension schemes.

The Trust has no on Statement of Financial Position Pension Scheme transactions.

30.2 Off-Statement of Financial Position pension schemes.

NHS Pension Scheme

See Note 1.3 for details of the accounting treatment of the NHS Pension Scheme.

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

30.3 Off-Statement of Financial Position pension schemes.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government

announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

National Employment Savings Trust (NEST)
The Trust offers employees an alternative pension scheme, NEST. This is a defined contribution, off statement of financial position scheme and the number of employees opting in and the value of contributions have been negligible (£21k employers contribution costs in year.)

31 Losses and Special Payments

	2018/19 Total number of cases Number	2018/19 Total value of cases £000's	2017/18 Total number of cases Number	2017/18 Total value of cases £000's
LOSSES:				
1. a. Losses of cash due to theft, fraud etc	1	0	0	0
3.a. Bad debts and claims abandoned in relation to private patients	73	14	25	4
3.b. Bad debts and claims abandoned in relation to overseas visitors	45	63	28	83
3.c. Bad debts and claims abandoned in relation to other	93	3	21	117
4.b Damage to buildings, property etc. due to stores losses	0	0	1	65
4.c Damage to buildings, property etc. due to other	0	0	1	17
TOTAL LOSSES	**212**	**80**	**76**	**286**
SPECIAL PAYMENTS:				
7.a Ex gratia payments in respect of loss of personal effects	24	11	22	14
7.g Ex gratia payments in respect of other	7	1	7	0
TOTAL SPECIAL PAYMENTS	**31**	**12**	**29**	**14**
TOTAL LOSSES	**243**	**92**	**105**	**300**

There were no compensation payments received.

32 Discontinued operations

There were no discontinued operations in 2018/19.

33 Corporation Tax

Corporation Tax is not due as the Trust is below the de minimis threshold as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

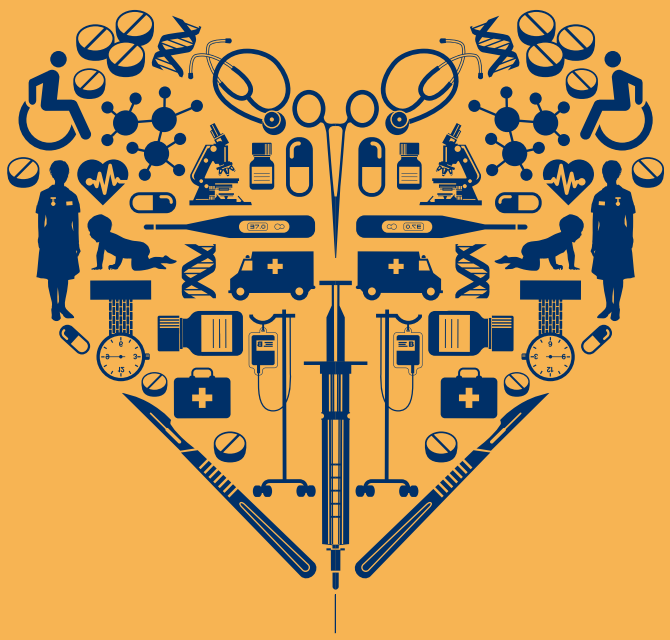
34 Segmented Operations

The Trust operates in one segment, that of the provision of healthcare, as reported to the Chief Operating Decision Maker, the Board.

35 Foundation Trust Income Statement and Statement of Comprehensive Income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's surplus for the period was £22,631k (2017/18: £15,368k). The trust's total comprehensive income for the period was £22,631k (2017/18 comprehensive income: £18,965k).

Appendix 1 Quality Account



What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an **annual Quality Account**. This is a report that informs the public about the quality of the services that we deliver. They are published annually and are available to the public.
Quality Accounts aim to increase public accountability and drive quality improvement. They do this by requiring organisations to review their performance over the previous year, publish their performance and identify areas for improvement. Quality accounts will also inform you about how an organisation will make those improvements and how they will be measured.
A review of our quality of services for 2017/18 is included in this account alongside our priorities and goals for quality improvement in 2018/19 and how we intend to achieve them.

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

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

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

About our Quality Account

This report is divided into sections.

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

About Our Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 90,000 admitted patients, nearly 400,000 outpatients and Emergency Department attendees and we delivered over 5,300 babies.

We serve a diverse population most of whom are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile.

There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 Luton Annual Public Health reports states that in many cases, Black and Minority Ethnic (BME) communities have poorer health outcomes when compared to the overall population and these are linked to infant mortality, access to services due to awareness, language and cultural barriers, early onset dementia and diabetes. The Index of Multiple Deprivation 2010 also indicates that Luton is becoming more deprived. The Luton Annual Public Health Report 2015/16 focussed on school aged children and identified particular issues in relation to language, poverty, obesity and activity, looked after children and mental health.

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

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

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

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

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

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

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

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

A Statement on Quality from the Chief Executive

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

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

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

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

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

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

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

David Carter
Chief Executive Officer
22nd May 2019

Corporate Objectives 2018/19

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

1. Deliver the Quality Priorities outlined in the Quality Account

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

2. Deliver National Quality and Performance Targets

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

3. Implement our Strategic Plan

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

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

- Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention and reducing our agency use.
- Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes.
- Deliver excellent in teaching and research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

5. Optimise our Financial Plan

- Deliver our financial plan

The updated plan sets out:

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

Achievements in Quality Improvement Priorities 2018/19

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

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

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

The outputs from this work are listed below.

Priority 1: Improving Patient Experience

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

Why was this priority?

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

What did we do?

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

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

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

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

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

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

How did we perform?

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

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

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

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

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

Why was this priority?

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

What did we do?

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

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

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

How did we perform?

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

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

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

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

Why was this priority?

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

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

What did we do?

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

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

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

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

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

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

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

How did we perform?

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

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

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

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

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

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

Priority 4 – Involvement in decision making

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

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

- Families to be asked regarding their specific needs.

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

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

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

Priority 2: Improve Patient Safety

2.1 Improve continuity through the delivery of Needs Based Care

Why was this priority?

The delivery of 7 day consultant led services and early senior review and decision making for patients admitted to hospital as an emergency has always been a focus for quality improvement for the Trust, with significant increases in consultant presence out of hours and at the 'front-door' of the hospital over the last few years. However, as our model for emergency care has gradually evolved, an unintended consequence has been an increase to the number of consultants that have sequential input into a patient's care and it is not unusual for a patient admitted to a medical specialty as an emergency to receive care from a number of different consultants during their hospital stay.

This can lead to confusion for the patient and their family as to what is happening, difficulties in co-ordinating the plan where the owning consultant is not following it through, and does not make it easy for senior medical staff to closely monitor a patient's progress and assess the effectiveness of treatment. By improving the continuity of consultant care for an individual patient, we will improve patient experience, reduce length of stay and minimise potential clinical risk as a result of patient management plans being handed over between senior clinical staff multiple times.

Within the range of emergency admissions to hospital, there will be some patients who will benefit from being cared for by physicians with a particular specialist interest, such as stroke, cardiology or respiratory. There are other patients who may be admitted with a straightforward medical issue, such as an infection or after a fall, but have very complex needs perhaps because of underlying long term conditions, poly-pharmacy, or extensive social or support needs. These patients require care from a senior general medical physician, with support from a wide range of professionals, and carefully managed transitions between hospital and usual place of residence.

Getting the patient to the right specialty team as early in their admission as possible is really important to avoid unnecessary investigations, support the patient to be managed at home wherever possible and to enable rapid and targeted treatment and intervention without having to wait for advice from another specialist.

What did we do?

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

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

The key service improvements delivered by the respiratory team are:

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

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

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

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

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

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

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

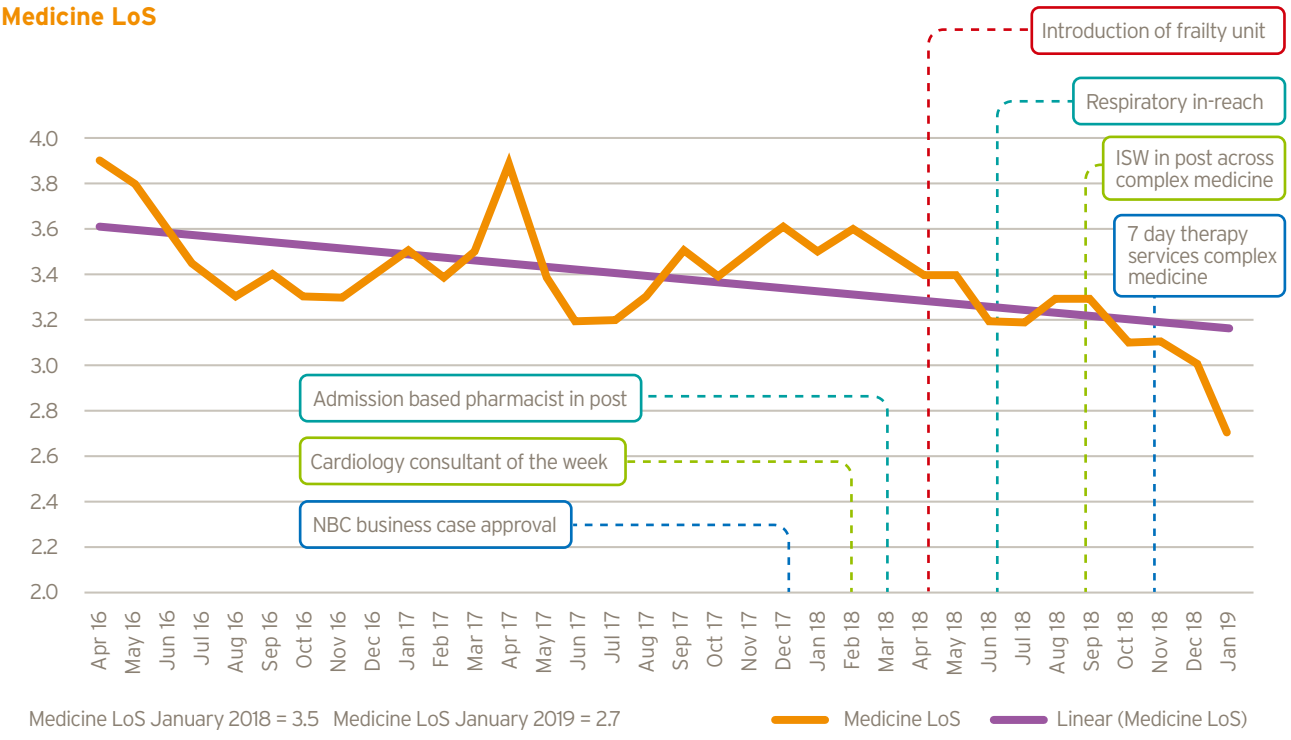
Finally, the model for use of our Therapy staff has also been reviewed leading to significant improvements. This staff optimisation was not to simply an increase in staffing numbers but was the use of more experienced "decision makers" from the therapy team in addition to extending the scope of their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

How did we perform?

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

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

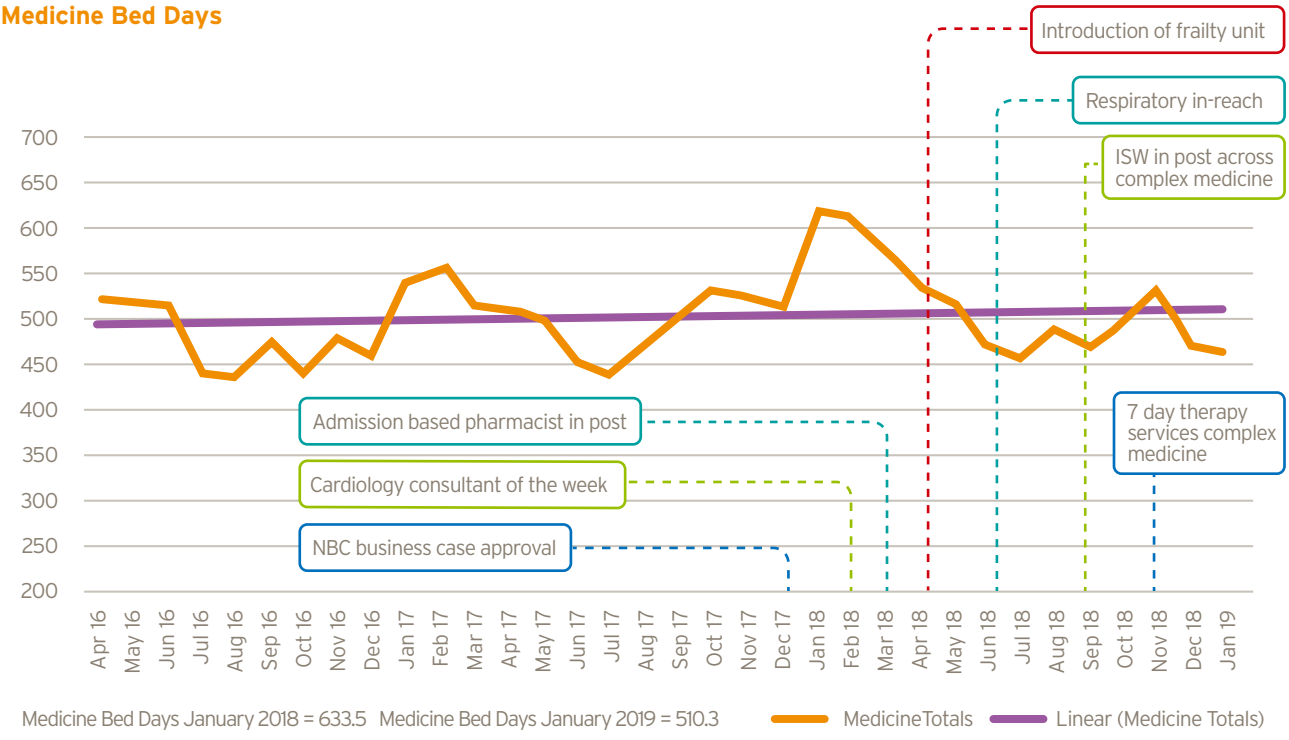
Medicine LoS



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

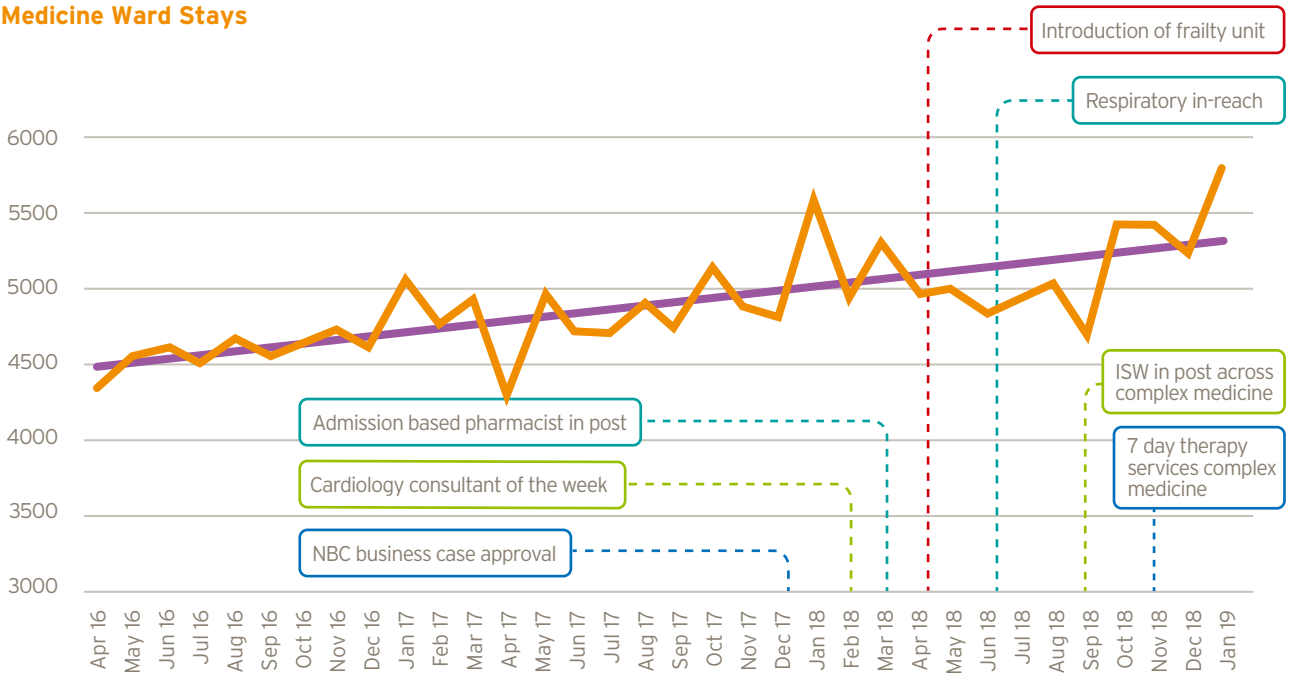
This can only be made possible by the more efficient delivery of care and treatment resulting from the cumulative effect of a range of best practice initiatives and patient pathways

Medicine Bed Days



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

Medicine Ward Stays



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

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

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

Why was this priority?

Over the past five years, the Trust has shown a year on year improvement in the prevalence of falls with harm but the incidence of falls (rate per 1000 bed days) has remained relatively static.

Whilst the Trust continues to have a lower incidence of falls than the national average, we remain committed to continuing to focus on reducing our rate of inpatient falls as when a patient does fall in hospital, the effect can be both physically and psychologically detrimental and may lead to an increase in their length of stay. Not only does this impact negatively on the patient themselves, but on the efficient delivery of services to patients by less effective use of beds.

Research has shown that when staff such as doctors, nurses and therapists work more closely together, they may prevent 20-30% of falls (NICE 2013). Whilst we have shown an improvement in our audit results, the Trust wanted to continue to build upon the work already undertaken to strengthen our approach to the prevention of falls.

What did we do?

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

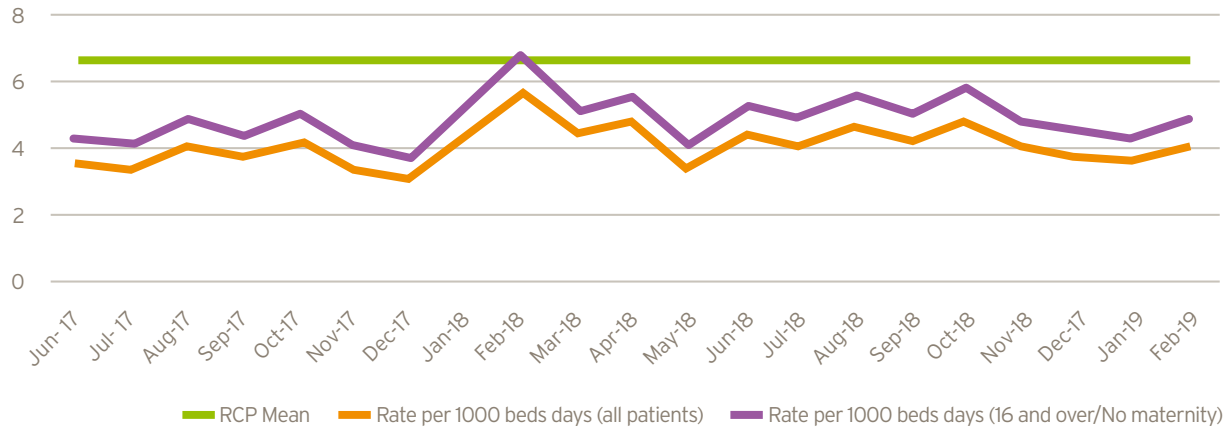
The improvement work plan included several key actions which have been undertaken, for example.

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

How did we perform?

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

Falls Rate per 1000 Bed Days



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

2.3 Improve the management of deteriorating patients

Why was this priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2017-18 highlighted some areas for improvement. This included earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. Furthermore, this linked with the need to continue in our improvements in delivering more sensitive, appropriate care at the end of a person's life. In particular, it is key that those nearing the end of their life, receive care based on appropriate decisions for compassionate and dignified care where aggressive treatment or resuscitation are not indicated.

What did we do?

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

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

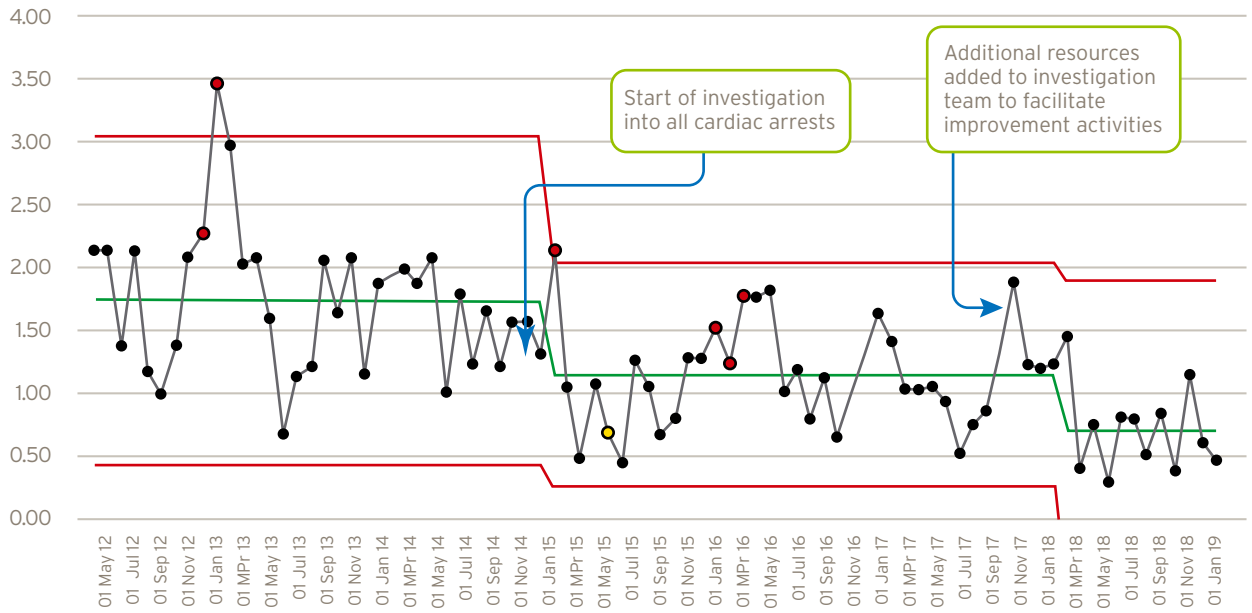
In addition to further improve expertise around treatment and resuscitation of patients at end of life specialist palliative care team implemented extra training around having difficult conversations aimed at improving skills enabling clinicians to develop the confidence to facilitate these discussions.

How did we perform?

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

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

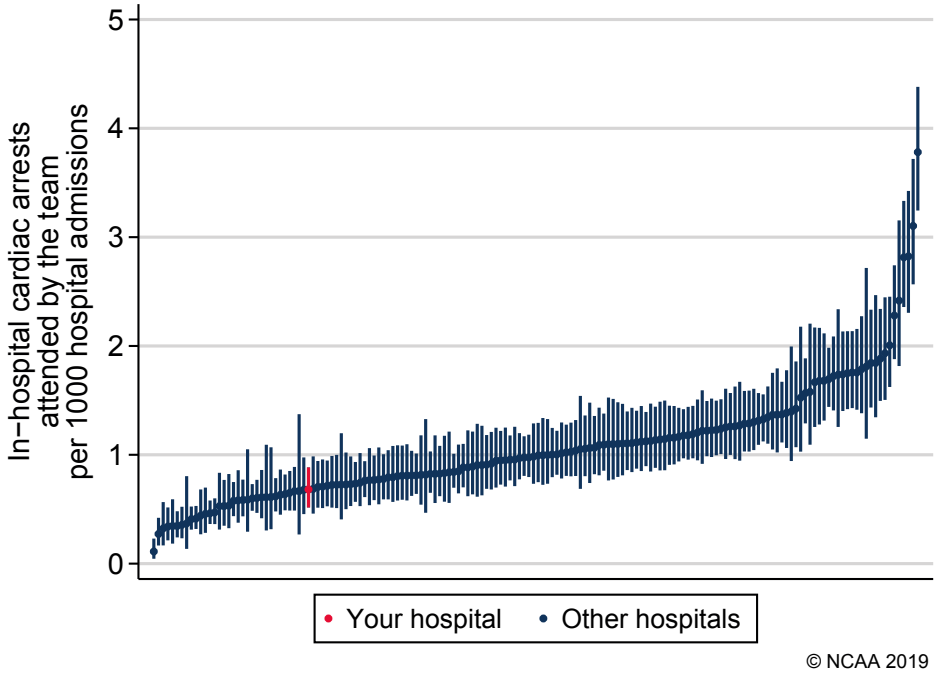
Chart 1 SPC Chart of of cardiac Arrests 2012-18



BaseLine 1.31 09

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

Chart 2 Rate of in-hospital cardiac arrests



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

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

Why was this priority?

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

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

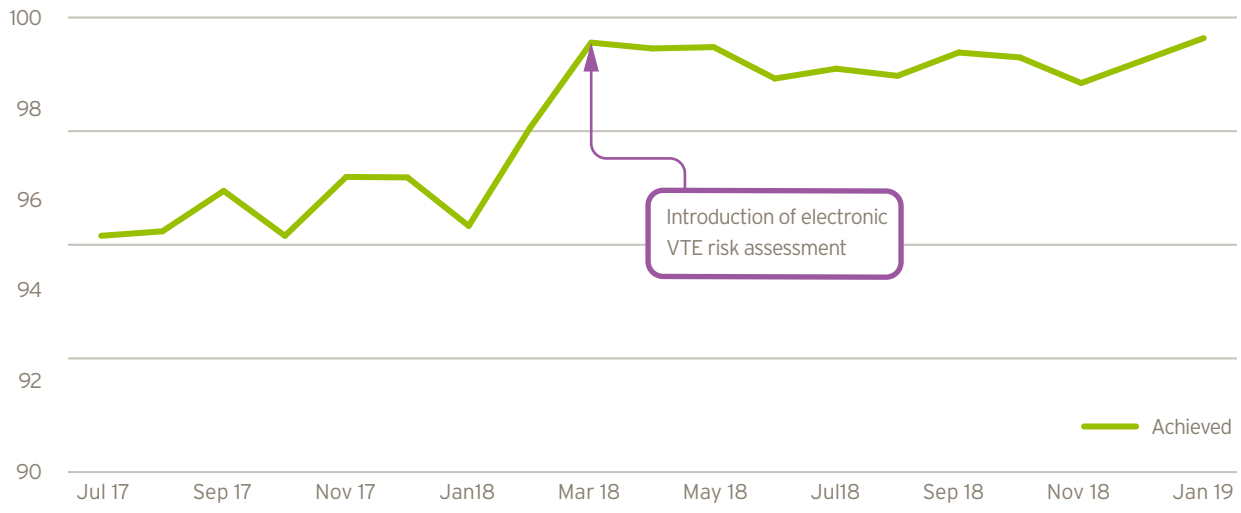
What did we do?

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

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

How did we perform?

% VTE Risk Assessment compliance



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

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

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

2.5 To reduce the incidence of medication errors for inpatients

Why is this priority?

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

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

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

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

What did we do?

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

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

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

How did we perform?

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

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

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

Priority 3: Deliver Excellent Clinical Outcomes

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

Why was this priority?

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

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

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

What did we do?

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

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

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

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

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

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

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

How did we perform?

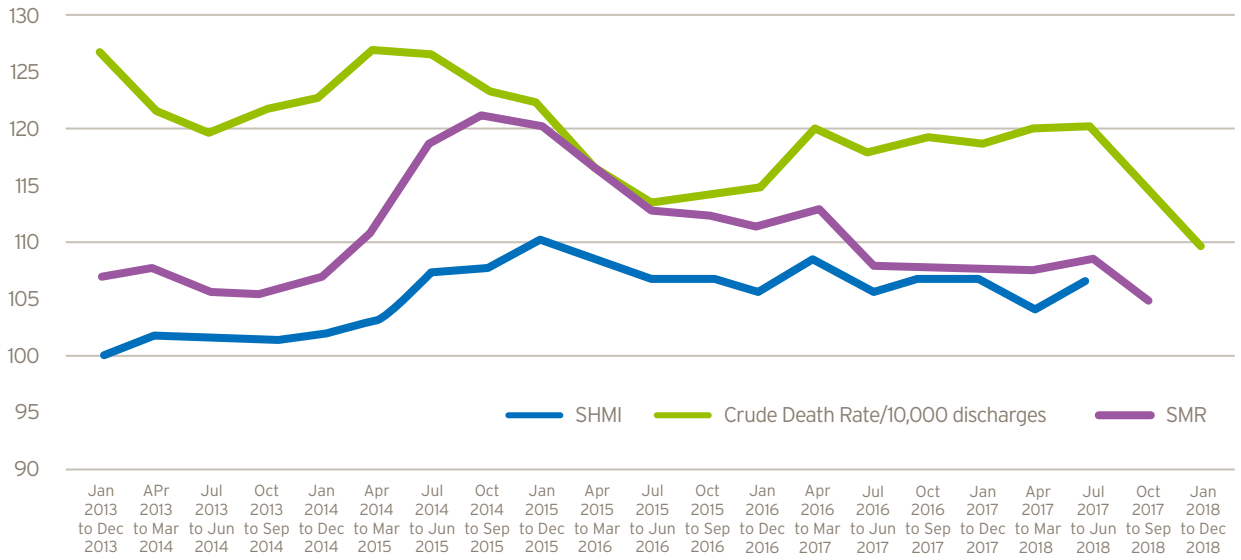
The Trust is very encouraged by the improvements made throughout the year and during 2018 we saw the lowest crude mortality rate seen at the Trust for some years, as demonstrated by the green line on the chart below. Despite a particularly high number of deaths in January and February and a 5% increase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

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

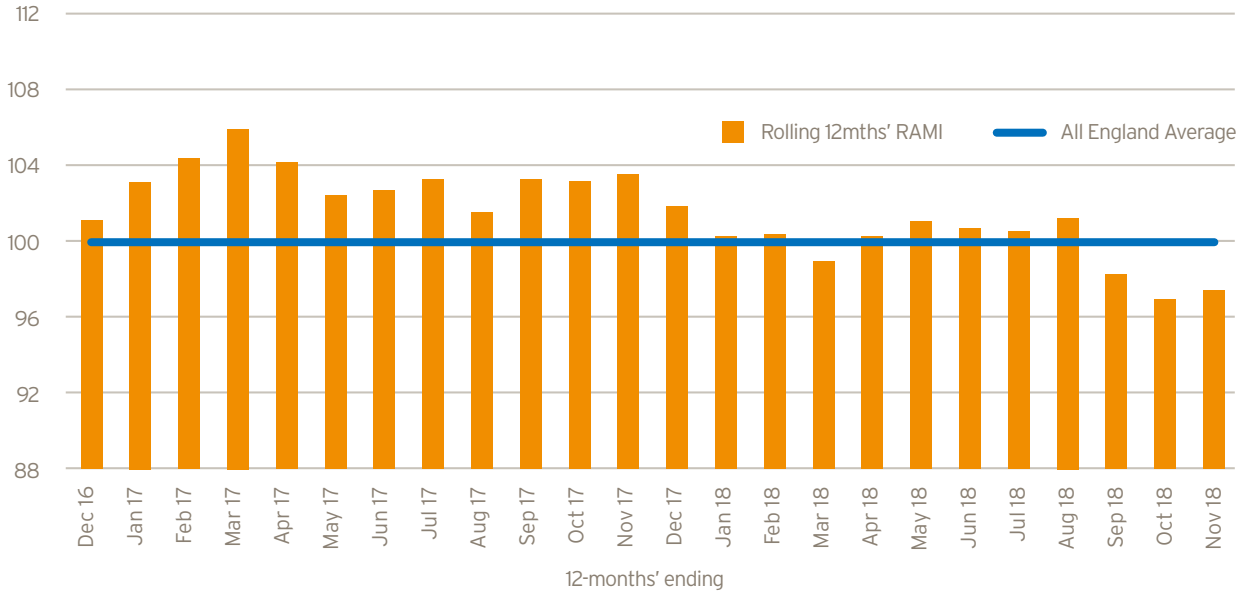
Whilst the latest data to October 2018 shows our Standard Mortality Ratios (SMR) and Summary Hospital-

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

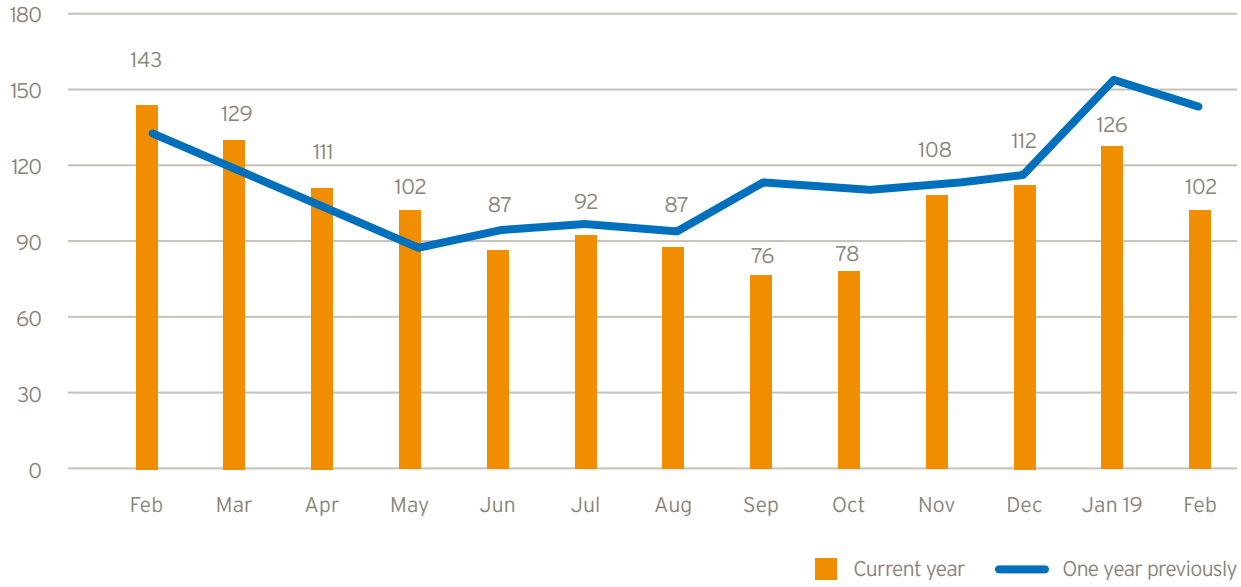
Crude Death Rate, SMR and SHMI - rolling 12 month updated quarterly



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



Monthly deaths for the last two years



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

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

Why is this priority?

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these, it is estimated that 11,000 could have been prevented.

In response to this our quality improvement initiative, is aimed at embedding NICE guidance to improve sepsis management we aimed to combine a responsive approach to the detection and treatment of sepsis balanced with a rigorous approach to the stewardship of antibiotics. Antimicrobial resistance has increased in recent years and the Chief Medical Officer believes that it is a major risk for healthcare. Without a reversal of the trend, we may find we have no drugs to treat serious infections in the future.

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

What did we do?

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

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

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

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

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

How did we perform?

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

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

Why is this priority?

Nationally, more than 1 million presentations are currently recorded as being directly related to mental ill health. Furthermore, evidence has shown that people with mental ill health have 3.6 times more potentially preventable emergency admissions than those without mental ill health and that the high levels of emergency care use by people with mental ill health indicate that there are opportunities for planned care to do more.
A large majority of the people who attend A&E more frequently are likely to have significant health needs including physical and mental comorbidities and may benefit from assessment and review of care plans with specialist mental health staff and further interventions from a range of health and social services. Tin recognition of these issues this is a national priority and included in our commissioning for quality and innovation (CQUIN) scheme and therefore a Trust priority with specific requirements to support cross-provider working to deliver improvements in care through provision of enhanced packages of care from the most appropriate services.

What did we do?

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

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

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

How did we perform?

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

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

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

Why was this a priority?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years.

Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this quality improvement initiative was to implement best practice guidance to enable us to take action to prevent these adverse outcomes as well as support people with frailty to live as well as possible. It was hoped that appropriate services, delivered effectively to this group of patients would support a reduction in length of stay, reduced morbidity

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

What did we do?

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

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

How did we perform?

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

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

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

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

Why was it a priority?

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

What did we do?

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

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

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

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

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

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

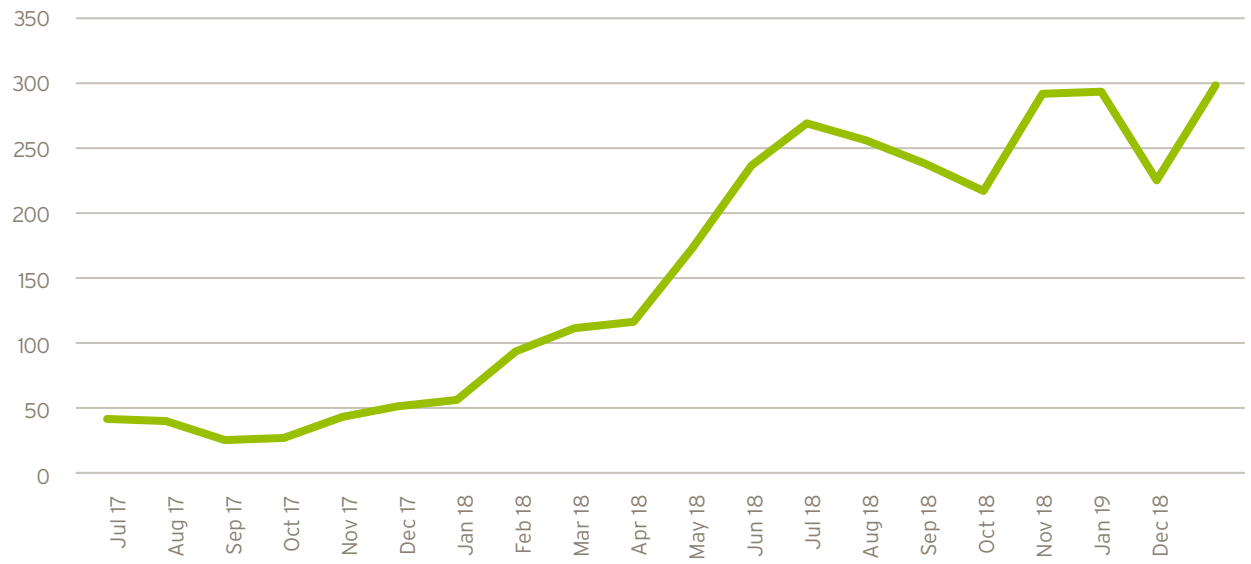
- **Specialties that cover 75% of referrals received (year 2):**

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

How did we perform?

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

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



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

CQUIN compliance April 17- December 2018

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

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

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

Priority 4: Prevention of Ill Health

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

Why was this priority?

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

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

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

What did we do?

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

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

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

How did we perform?

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

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

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

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

Why was this a priority?

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

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

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

What did we do?

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

How did we perform?

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

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

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

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

Why was this a priority?

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

What did we do?

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

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

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

How did we perform?

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

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

Why was this priority?

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

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

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

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

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

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

What did we do?

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

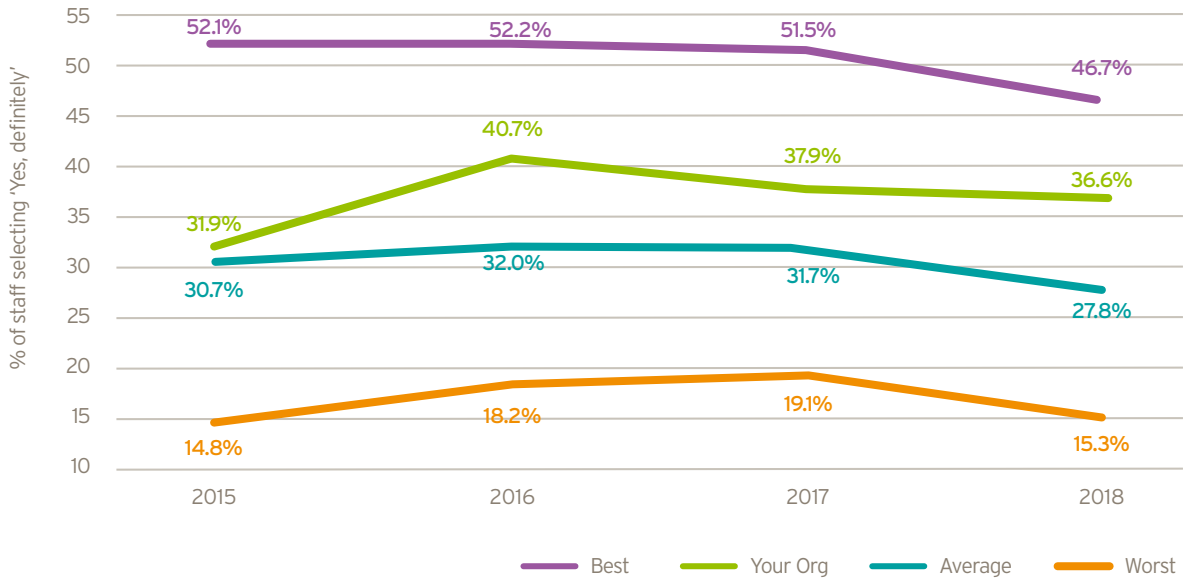
- An annual health and well-being day offering activities such as laughter yoga, chair based exercises, smoothie bikes, healthy eating demos and table tennis,
- Monthly campaign of "Apples & Pears to take the Stairs" which encourages staff to use the stairs rather than ten lift to increase activity and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

How did we do?

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

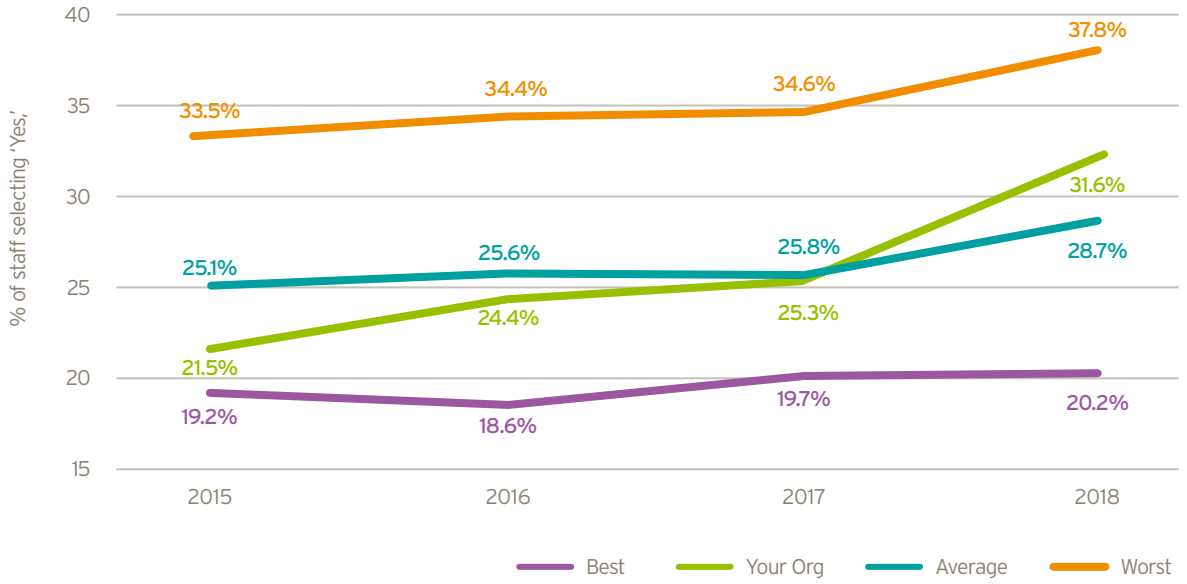
- 37% of staff reported that they believe our organisation takes positive action on health and wellbeing. Whilst this is a small reduction on last year's result, it was noted the Trust performance is 9% above the average for NHS Trusts in England.

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

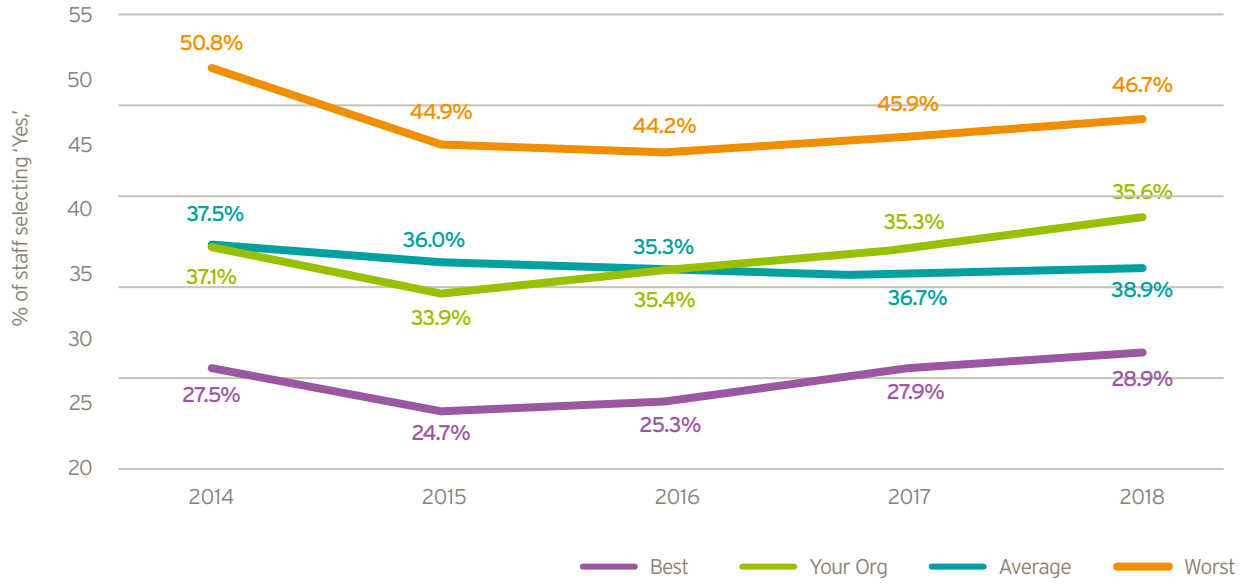


- In the last 12 months, 31.6% of staff reported that they have experienced musculoskeletal problems as a result of work activities. The result is 6% worse for the Trust than last year and for the first time, the Trust response is worse than the England average.

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



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



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

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

Quality Improvement Priorities 2019/20

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

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

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

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

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

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

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

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

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

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

Statements of Assurance from the Board

3.1 Review of services

During 2018/19 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services.

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

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

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

3.2 Participation in Clinical Audits and National Confidential Enquiries

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

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

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

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

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

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

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

National Audit of Breast Cancer in Older People

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

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

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

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

National Emergency Laparotomy Audit (NELA)

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

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

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

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

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

National Prostate Cancer Audit

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

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

Learning Disability Mortality Review Programme (LeDeR)

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

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

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

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

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

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

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

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

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

National Audit of Cardiac Rehabilitation (NACR)

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

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

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

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

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

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

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

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

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

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

National Audit of Percutaneous Coronary

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

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

More cath lab capacity is needed. This has been escalated

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

National Cardiac Arrest Audit (NCAA)

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

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

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

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

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

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

BTS Paediatric Pneumonia Audit

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

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

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

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

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

National audit of Dementia – spotlight audit on Delirium

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

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

National Pulmonary Rehabilitation audit

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

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

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

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

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

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

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

National Confidential Enquiries

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

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

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

3.3 Participation in Research

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

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

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

3.4 Commissioning for Quality and Innovation payment framework (CQuIN)

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

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

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

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

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

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

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

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

3.5 Care Quality Commission Registration (CQC)

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

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

The Luton and Dunstable University Hospital NHS Foundation Trust is required to register with the CQC and its current registration status is GOOD and is current registration is **Registration without Conditions.**

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

3.6 Data Quality

The accuracy and completeness of the data we use to support the delivery of high quality care is of the utmost importance to the Trust. The Trust has been making progress with data quality during the year 2018/19 and there are many processes carried out by the Information Team, which identify data quality issues.

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

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

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

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

Action Plan for Data Quality Improvement for 2019/20

Information Governance

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

CCGs Challenges

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

Outpatients

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

Inpatients

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

Waiting List

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

Theatres

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

Referrals

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

Patient Demographics

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

A&E

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

SUS+ dashboards

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

3.7 NHS Number and General Medical Practice Code Validity

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

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

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

3.8 Clinical Coding Error rate

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

3.9 Information Governance Toolkit Attainment levels

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

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

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

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

3.10 Learning from Deaths

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

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

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

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

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

In relation to each quarter, this consisted of:

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

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

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

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

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

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

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

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

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

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

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

Other key learning from reviews throughout the year has included:

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

3.11 Seven Day Services Board Assurance Framework

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

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

3.12 Freedom to Speak Up (F2SU) and Guardian

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

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

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

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

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

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

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

3.13 Guardian of Safer Working Hours Report Statement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Review of Quality Performance

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

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

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

Performance Indicator	Type of Indicator and Source of data	2015* or 2015/16	2016* or 2016/17	2017* or 2017/18	2018* 2018/19	National Average	What does this mean?
% of fractured neck of femur to theatre in 36hrs	Clinical Effectiveness Dr Foster	78%	62%	76%	71.3%	69%	The Trust is in line with the national average.
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	69.7*	70.79*	50.8*	63.16*	100	This is demonstrating the Trust as a positive outlier.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	112.8*	89.56*	100.3*	76.5*	100	This is demonstrating the Trust as a positive outlier.
Readmission rates*: Knee Replacements Trauma and Orthopaedics	Clinical Effectiveness Dr Foster	7.2%	7.09%*	7.00%*	3.7%	N/A	This shows an improving position for the Trust
% Caesarean Section rates	Patient Experience Obstetric dashboard	28.3%	32.9%	31.2%	31.3%%	25%	The Trust shows a higher rate than average and continues to monitor rates.
Patients who felt that they were treated with respect and dignity**	Patient Experience National in patient survey response	9.0	8.8	9.0	Not available until May 2019	Range 8.5 - 9.7	Demonstrating an improving position.
Complaints rate per 1000 discharges	Patient Experience Complaints database and Dr Foster number of spells for the year	6.29	6.64	5.50	4.70	N/A	The Trust continues to encourage patients to complain to enable learning but has seen a reduction in formal complaints.
Patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	7.4	7.6	8.1	Not available until May 2019	Range 7.1 - 9.1	Demonstrating a slightly poorer position but still within range.
Venous thromboembolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95%	Achieved >95%	Achieved >95%	Achieved >95%	N/A	Maintaining a good performance consistently due to the introduction of an electronic solution

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

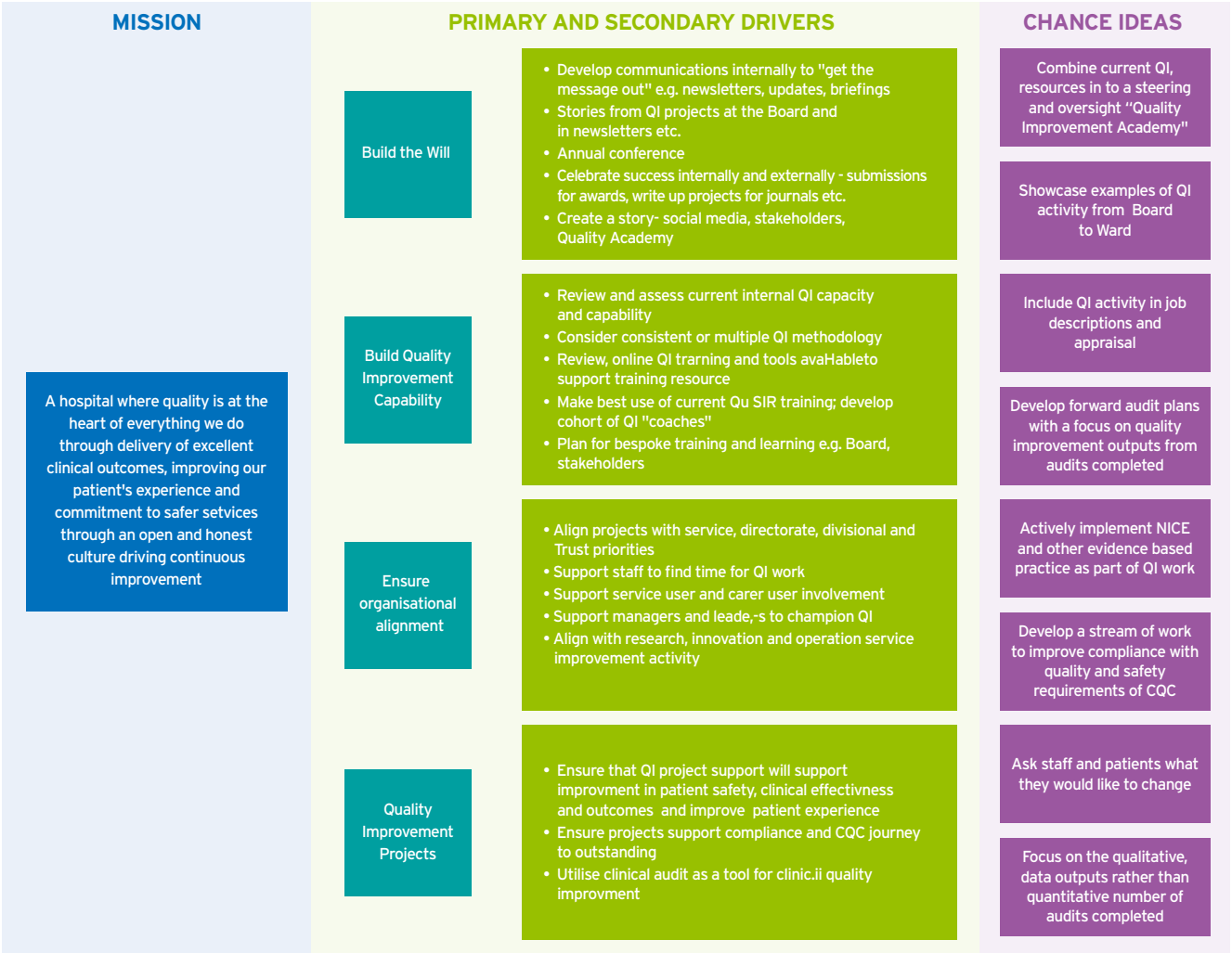
3.15 Quality Improvement

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

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

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

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



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

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

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

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

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

Capacity, Capability & Sustainability of Quality Improvement

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

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

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

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

The programme covers the following topics,

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

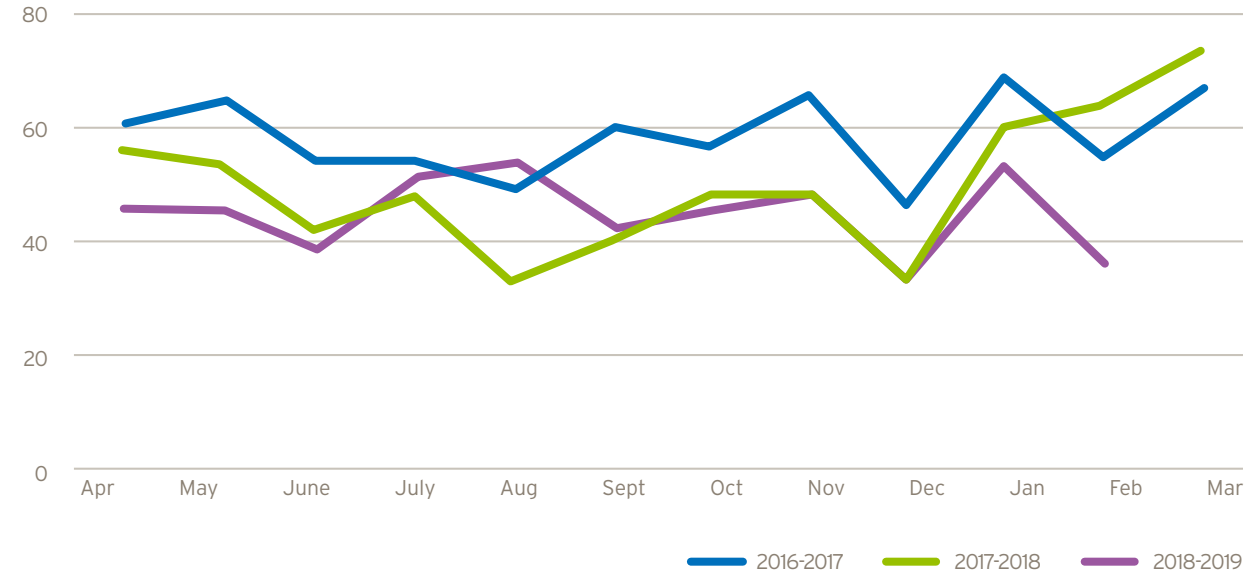
3.18 Complaints

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

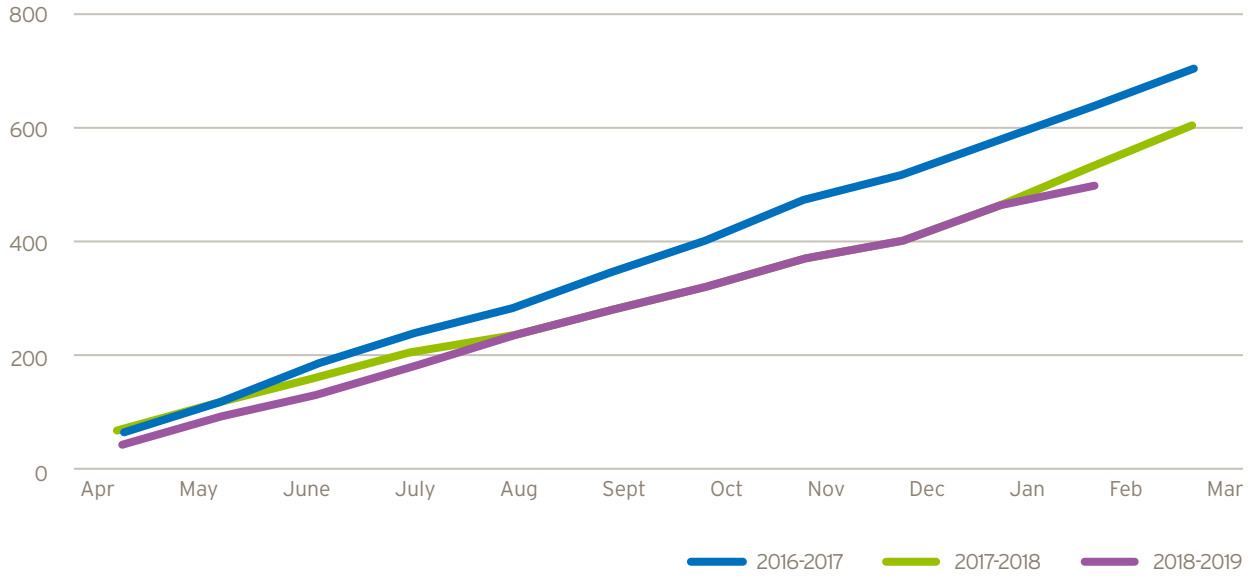
The Patient Advice and Liaison Team (PALS) have maintained a crucial front of house presence in the last year, in order to resolve issues raised with them to prevent escalation to formal complaints. Service Managers have been pro-active in contacting complainants to help resolve their complaints informally,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

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

Formal Complaints - 2016/17 to 2018/19



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



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

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

Learning from Complaints

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

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

Listening to Patient Concerns

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

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

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

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

Compliments

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

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

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

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

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

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

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

3.17 Friends and Family Test

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

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

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

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

We continue to collect information from the following clinical areas;

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

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

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

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

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

Table One: Trust Comparisons to National Inpatient Recommend FFT Results

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

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

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

Table 3: Inpatients Percentage Recommend Scores 2018/19

% of Inpatients who would recommend 2018/19

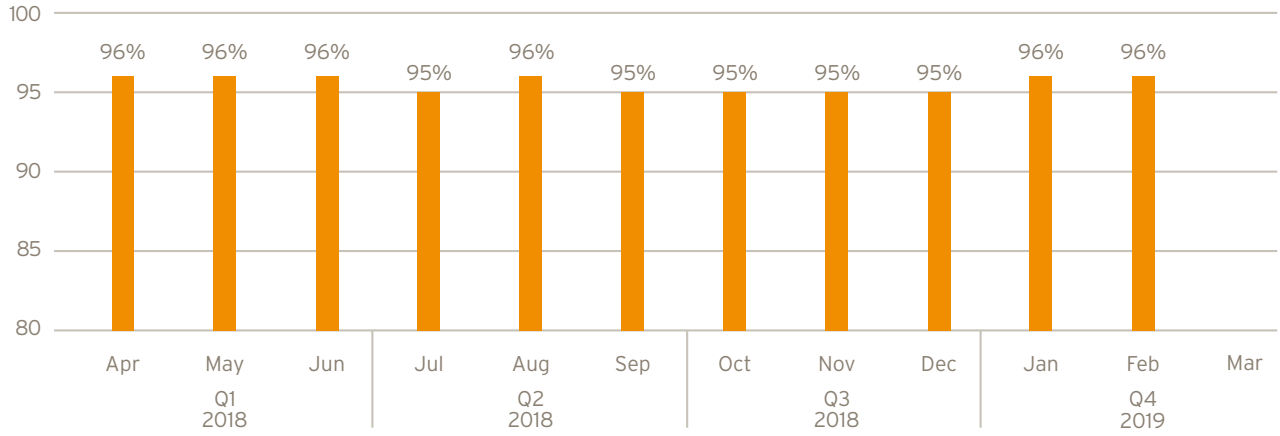


Table 4: Accident and Emergency Percentage Recommend Scores 2018/19

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

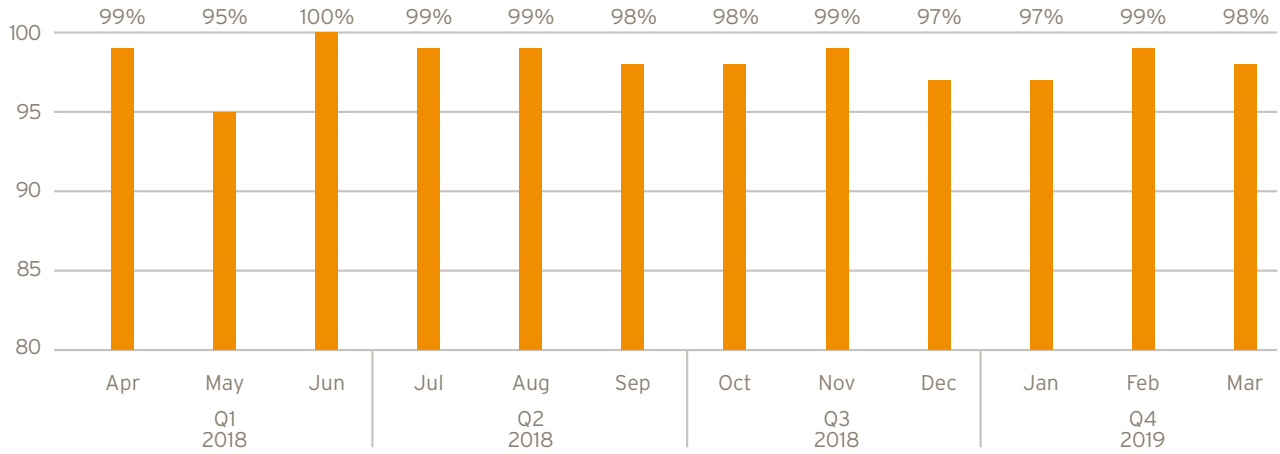


Table 5: Maternity Percentage Recommend Scores 2018/19

% of Maternity Patients who would recommend 2018/19

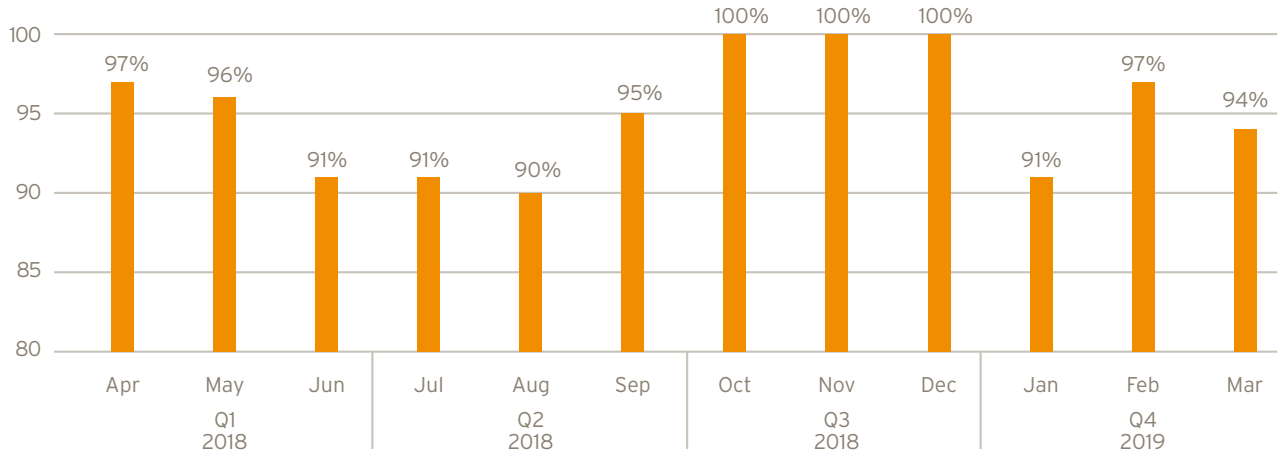
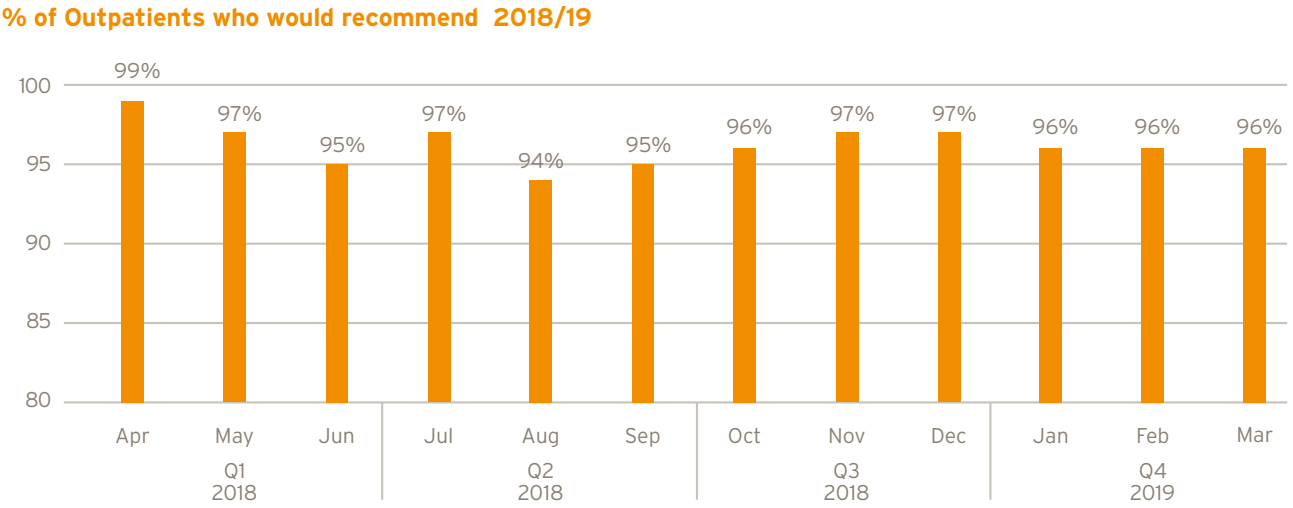


Table 6: Outpatients Percentage Recommend Scores 2017/18



Patient Stories and Improvements following patient feedback.

STORY ONE

Sharing Documentation and Information

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

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

Lesson learned;

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

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

STORY TWO

Early Onset Dementia

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

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

Lessons Learned:

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

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

3.18 National Inpatient Survey 2018

(At time of writing contemporary data remains embargoed)

The report of the L&D inpatient survey was received in June 2019 and the results detailed in the table below are published by the Care Quality Commission. Detailed management reports are shared internally and a programme of work will be developed and monitored at Clinical Outcomes, Safety and Quality meetings. Patients who were treated in July 2018 were surveyed. The Trust had a response rate of 40% against a national average of 45%, compared to 38% and 41 % respectively from 2017

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

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

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

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

3.19 NATIONAL STAFF SURVEY 2018

NHS staff survey

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

The response rate to the 2018 survey among trust staff was 52 % (2017: 54

%). Scores for each indicator together with that of the survey benchmarking

Group 'Acute Trusts' are presented below.

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

Commentary

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

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

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

Areas for improvement

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

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

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

Future priorities

The Trust is implementing a suite of improvement priorities for our staff and these include:

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

Health and Wellbeing / Occupational Health

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

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

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

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

Annual Health and wellbeing event

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

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

Employee Assistance Programme

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

Health Checks for staff

The NHS promotes health checks for those over the age of 40 years, and the Trust has actively engaged with this initiative. A company commissioned by Luton Borough Council provides free health checks to those over the age of 40 and up to the age of 74. Whilst this is national scheme we have been able to continue to secure dates for this service to be brought on site to our staff. Since October 2013 sessions have been available on a monthly basis with over 580 members of staff seen. Each check includes height, weight, BMI, blood pressure, cholesterol levels and taking family history and life style analysis such as eating, smoking and drinking to discuss risk

factors. The results are shared with the individual and their GP, and where necessary onward referrals made.

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

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

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

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

3.21 Performance against Core Indicators 2018/19

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

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

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
Value and banding of the SHMI indicator	Published Apr 13 (Oct 11 -Sep 12)	As expected	As expected			2
	Published Jul 13 (Jan 12 - Dec 12)	As expected	As expected			2
	Published Oct 13 (Apr 12 -Mar 13)	As expected	As expected			2
	Published Jan 14 (Jul 12 - Jun 13)	As expected	As expected			2
	Published Oct 14 (Apr 13 -Mar 14)	As expected	As expected			2
	Published Jan 15 (Jul 13 - Jun 14)	As expected	As expected			2
	Published Mar 16 (Sep 14 -Sep 15)	As expected	As expected			2
	Published Mar 17 (Sep 15 -Sep 16)	As expected	As expected			2

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
	Published Mar 18 (Oct 16 – Sept 17)	As expected	As expected			2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level (The palliative care indicator is a contextual indicator)	Published Apr 13 (Oct 11 –Sep 12)	12.4%	19.2%	0.2%	43.3%	N/A
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 –Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 – Jun 13)	12.6%	20.6%	0%	44.1%	N/A
	Published Oct 14 (Apr 13 –Mar 14)	13.7%	23.9%	0%	48.5%	N/A
	Published Jan 15 (Jul 13 – Jun 14)	14.7%	24.8%	0%	49%	N/A
	Published Mar 16 (Sep 14 –Sep 15)	13.8%	26.7%	0%	53.5%	N/A
	Published Mar 17 (Sep 15 –Sep 16)	26.2%	29.6%	0.4%	56.3%	N/A
	Published Mar 18 (Sep 16 –Sep 17)	32.8%	31.6%	11.5%	59.8%	N/A
	Published Feb 19 (Oct 17 –Sep 18)	36.1%	33.6%	59.5%	14.3%	N/A

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

- This is based upon clinical coding and the Trust is audited annually.
- The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- On-going Use of "Structured Judgement" as a methodology for mortality reviews with these fed through to the regular morbidity and mortality learning meetings held within each of the organisational Divisions and services
- We have appointed a Board-level Executive lead for the Mortality Review Process, and we have a non-Executive lead charged with oversight and challenge.
- The outcomes from Mortality Reviews are shared quarterly through a Board level quality report as from September 2017.
- Membership of our Mortality Board has been broadened to include representation from external stakeholders; including our lead Clinical Commissioning Group this allows oversight to ensure that any deaths that require a community review are subject to a consistent process.

Readmission Rates
Indicator: Readmission rates

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

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 – 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*

	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2018/19	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2010/11	10.16	11.17	13.00	0.0%
	2011/12	10.64	11.26	13.50	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2016/17	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2017/18	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2018/19	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:
- This is based upon clinical coding and the Trust is audited annually.
- The Trust does not routinely gather data on 28 day readmission rates

The Luton and Dunstable University Hospital has taken the following actions to improve this percentage, and so the quality of its services, by:
- Continued work with our external partners to prevent unnecessary readmissions to hospital via admission avoidance services available for patients to access.

These include Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team, the Hospital at Home service, provider support in the Emergency Department and the integrated models of care

*The most recent available data on NHS Digital is 2011/12 uploaded in December 2013.

Patient Reported Outcomes Measures (Proms)
Indicator: Patient Reported Outcome Measures (PROMs) scores

PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Groin hernia surgery	2010/11	0.110	0.085	0.156	-0.020
	2011/12	0.12	0.087	0.143	-0.002
	2012/13	0.09	0.085	0.157	0.014
	2013/14	0.079	0.085	0.139	0.008
	2014/15	0.088	0.081	0.125	0.009
	2015/16	**	0.088	0.13	0.08
	2016/17*	0.078	0.08	0.14	0.06
Varicose vein surgery	2010/11	**	0.091	0.155	-0.007
	2011/12	**	0.095	0.167	0.049
	2012/13	**	0.093	0.175	0.023
	2013/14	**	0.093	0.15	0.023
	2014/15	**	0.1	0.142	0.054

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

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

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14	0.369	0.436	0.545	0.342
	2014/15	**	0.442	0.51	0.35
	2015/16	**	0.45	0.52	0.36
	2016/17	0.38	0.44	0.53	0.33
	2017/18*	0.43	0.46	0.55	0.36
Knee replacement surgery	2010/11	0.325	0.299	0.407	0.176
	2011/12	0.313	0.302	0.385	0.181
	2012/13	0.321	0.319	0.409	0.194
	2013/14	0.297	0.323	0.416	0.215
	2014/15	**	0.328	0.394	0.249
	2015/16	**	0.334	0.412	0.207
	2016/17	0.30	0.32	0.39	0.24
	2017/18*	0.31	0.34	0.41	0.25

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

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

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

Responsiveness To The Personal Needs Of Patients During The Reported Period
Indicator: Responsiveness to the personal needs of patients during the reporting period

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

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

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Responsiveness to the personal needs of patients.	2010/11	65.6	67.3	82.6	56.7
	2011/12	64	67.4	85	56.5
	2012/13	67.5	68.1	84.4	57.4
	2013/14	65.6	68.7	84.2	54.4
	2014/15	66	68.9	86.1	59.1
	2015/16	74.2	77.3	88	70.6
	2016/17	71.6	76.7	88	70.7
	2017/18	66.2	68.6	86.2	54.4
	2018/19	Not Avail	Not Avail	Not Avail	Not Avail

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- The source of the data is the National In-Patient Survey.
- The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- The PALs service continued to provide the first contact and support the collection of ongoing friends and family feedback.
- Improved access to interpreters.
- Implemented recommendations following Healthwatch visits including improved awareness of translation services.
- Reviewed the complaints process and have initiated recommendations to streamline the responses.
- Themes from complaints identified discharge from hospital as a concern. Therefore this was included as a Quality Account Priority for 2018/19.

Staff Recommendation
Indicator: Staff recommendation

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Percentage of staff who would recommend the Trust as a provider of care to family and friends when compared to other acute providers.	2010/11	57%	66%	95%	38%
	2011/12	57%	65%	96%	33%
	2012/13	61.5%	63%	94%	35%
	2013/14	67%	67%	89%	38%
	2014/15	67%	65%	89%	38%
	2015/16	72%	70%	*	*
	2016/17	77%	70%	95%	45%
	2017/18	72%	70%	87%	60%
	2018/19	70%	71.3%	87%	40%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- The source of the data is the National Staff Survey.
- The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:
- Engaged with staff about the vision, values and behaviours and have embedded them within the appraisal process.
- Provided information and training at the Staff Engagement Event in July 2018 to over 2500 staff, on how to deal with challenging situations.
- Supported fast track physiotherapy access to staff .

Risk Assessment For Venous Thromboembolism (VTE)

Indicator: Risk assessment for venous thromboembolism (VTE)
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Percentage of patients who were admitted to hospital and who were risk assessed for VTE.	2010/11 - Q4	90.3%	80.8%	100%	11.1%
	2011/12 - Q4	96.1%	92.5%	100%	69.8%
	2012/13 - Q4	95.3%	94.2%	100%	87.9%
	2013/14 - Q4	95.1%	96.1%	100%	74.6%
	2014/15 - Q4	95%	96%	100%	74%
	2015/16 - Q3	95.7%	95.5%	100%	94.1%
	2016/17 - Q3	95.74%	95.64%	100%	76.48%
	2017/18 - Q3	95.91%	95.3%	100%	76.08%
	2018/19 - Q1	99.34%	95.64%	100%	52.66%
	2018/19 - Q2	98.2%	95.7%	100%	74.8%
	2018/19 - Q3	99.17%	95.73%	100%	55.6%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- There is a robust process for capturing the evidence of completion

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

Clostridium Difficile Rate
Indicator: Clostridium difficile infection rate

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

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Rate for 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	5.1	15.1	62.2	0
	2015/16	5.4	14.9	66	0
	2016/17	3.6	13.2	82.7	0
	2017/18	4.0	14.0	91.0	0
	2018/19	2.1	Not Avail	Not Avail	Not Avail

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:
- The accuracy of the data is checked prior to submission. The data is also cross checked with laboratory data and verified before reporting to the Board.
- The Trust had 5 C.difficile for 2018/19

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by maintaining C.difficile high on the training agenda for all healthcare staff.

Patient Safety Incident Rate
Indicator: Patient safety incident rate

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Total number and rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute trusts	2010/11	**	**	**	**
	2011/12	**	**	**	**
	2012/13	**	**	**	**
	2013/14	**	**	**	**
	2014/15	37.52	35.1	17	72
	2015/16	32.2	39.6	14.8	75.9
	2016/17	23.3	41.1	23.1	69.0
	2017/18	32.2	42.6	24.2	124
	2018/19	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Total number and rate of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2010/11	0.03	0.04	0.17	0
	2011/12	0.03	0.05	0.31	0
	2012/13	0.03	0.05	0.26	0
	2013/14	0.03	0.05	0.38	0
	2014/15	0.25	0.19	1.53	0.02
	2015/16	0.09	0.16	0.97	0
	2016/17	0.06	0.2	0.53	0.01
	2017/18	0.13	0.16	0.55	0
	2018/19	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- The hospital reports incident data and level of harm monthly to the National Reporting and Learning System

Learning from incidents is shared through Divisional Governance, Grand Rounds and Safety Briefings. Patient Safety Newsletters are issued to all staff each quarter and include a focus on learning from Serious Incidents.

3.22 Performance Against National Priorities

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

Glossary

Term	Description
Acute Kidney Infection (AKI)	A painful and unpleasant illness caused by bacteria travelling from your bladder into one or both of your kidneys
Antimicrobial	An agent that kills microorganisms or stop their growth
BAUS	British Association of Urological Surgeons
BRA	Breast Reconstruction Evaluation
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
CCG	Clinical Commissioning Group.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
Continence	Ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.
CQUIN	Commissioning for Quality and Innovation – these are targets set by the CCG where the Trust receives a financial incentive if it achieves these quality targets.
Delirium	Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment.
DME	Division of Medicine for the Elderly
DNACPR	In the right circumstances, a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order helps ensure that a patient's death is dignified and peaceful.
Elective	Scheduled in advance (Planned)
EOL	End of Life
Epilepsy	Recurrent disorder characterised by seizures.
EPMA	Electronic Prescribing and Monitoring Administration system in place.
Grand Round	A lunch time weekly meeting with consultants and junior medical staff to communication key issues and learning.
Frailty	Frailty is a common geriatric syndrome that embodies an elevated risk of catastrophic declines in health and function among older adults
GIRFT	The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow.
HES	Hospital Episode Statistics

Term	Description
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
HSMR	Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate.
ICNARC	Intensive Care National Audit and Research Centre
Laparoscopic	Key hole surgery
Learning Disability	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
LIG	Local Implementation Group
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Needs Based Care	Inpatient adult wards are organised by patient need rather than age for example a cardiac ward, respiratory ward.
NELA	National Emergency Laparotomy Audit
Neonatal	New-born – includes the first six weeks after birth
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	Degenerative disorder of the central nervous system
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
Prevalence	The proportion of patients who have a specific characteristic in a given time period
Red and Green	The Red: Green Bed day is a visual management system to assist in the identification of wasted time in a patient's journey. If it is red, the patient has not progressed, green they have.
QSIR	Quality, Service Improvement and Redesign The QSIR programmes are delivered in a variety of formats to suit different levels of improvement experience and are supported by publications that guide participants in the use of tried and tested improvement tools, and featured approaches, as well as encouraging reflective learning.
Safety Thermometer/Harm Free Care	Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or their poisons in the blood stream.

Term	Description
SHMI	Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard
Somatosensory	The somatosensory system is a part of the sensory nervous system. The somatosensory system is a complex system of sensory neurons and pathways that responds to changes at the surface or inside the body.
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit.
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply A review methodology based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.
Structured Judgement Review	A review methodology based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.
Two week wait	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins
WHO	World Health Organisation

Research – Glossary of terms

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

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

Statement of Directors responsibilities for Quality Account

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018-19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to May 2019; papers relating to quality reported to the Board over the period April 2018 to May 2019;
  - feedback from commissioners dated [not received at time of signing];
  - feedback from governors dated 27 February 2019 ;
  - feedback from local Health watch organisations dated 16th May 2019 from Bedfordshire Healthwatch [Luton Healthwatch not received at time of signing]
  - feedback from Overview and Scrutiny Committee - Central Bedfordshire dated 20th May 2019
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21 May 2019;
  - the latest national patient survey [not received at time of signing];
  - the latest national staff survey dated March 2019;
  - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2019;
  - CQC inspection report dated 7 December 2018.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.
- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

22nd May 2019
Simon Linnett
Chair

22nd May 2019
David Carter
Chief Executive

Stakeholder Feedback

healthwatch Central Bedfordshire

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

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

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

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

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

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

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

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

Diana Blackmun
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https: //healthwatch-centralbedfordshire.org. uk

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

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

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

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

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

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

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

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

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

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

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

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

NHS
Bedfordshire
Clinical Commissioning Group

Statement from Luton Clinical Commissioning Group (LCCG) and Bedfordshire Clinical Commissioning Group (BCCG) to Luton & Dunstable University NHS Foundation Trust (LDUH) on Quality Account 2018- 2019

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

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

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

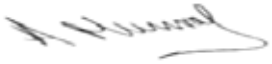
In the past year the Trust has made advances to the development of 7 day services across the organisation in line with NHSI guidance for Quality Accounts for 2018/19. Furthermore the CCG acknowledges the service redesign and Quality improvement initiatives regarding respiratory services, the development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

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

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

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

Anne Murray
Chief Nurse



Bedfordshire Luton & Milton Keynes
Commissioning Collaborative

Independent Auditor Assurance Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LUTON AND DUNSTABLE UNIVERSITY NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Luton and Dunstable University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

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

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

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* (the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

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

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the

Council of Governors as a body and Luton and Dunstable University Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) , 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board CISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting
- Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

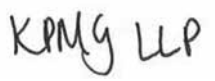
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual and supporting guidance*.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Luton and Dunstable University Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.



KPMG LLP
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24 May 2019


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