Luton and Dunstable University Hospital NHS Foundation Trust

Evidence appendix
Lewsey Road
Luton
Bedfordshire
LU4 0DZ
Tel: 01582491166
www.ldh.nhs.uk

Date of inspection visit:
7 August to 13 September 2018

Date of publication:
7 December 2018

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute hospital sites at the trust

Services at the trust are operated from one main site, details of which are provided below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
</table>
| Luton and Dunstable University Hospital NHS Foundation Trust | Lewsey Road, Luton, LU4 0DZ | • Critical care  
• Diagnostic imaging  
• End of life care  
• Gynaecology  
• Maternity  
• Medical care  
• Outpatients  
• Surgery  
• Services for children and young people  
• Urgent and emergency care | Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire |

The trust also has an additional site at The Orthopaedic Centre based at Dunstable Road, Luton, LU4 8RQ, where all outpatient orthopaedic work is carried out.

(Source: Routine Provider Information Request (RPIR) P2 – Sites; trust quality account 2017/18)

Luton and Dunstable University Hospital NHS Foundation Trust has approximately 742 inpatient beds and 40-day case beds located at Luton and Dunstable University Hospital. The trust serves a
population of approximately 210,000 people in Luton, and neighbouring populations in Bedfordshire, Hertfordshire and parts of Buckinghamshire.

The number of staff employed by the trust as of April 2018 was 4,189.

The trust’s services are commissioned mainly by Luton Clinical Commissioning Group and Bedfordshire Clinical Commissioning Group.

(Sources: Routine Provider Information Request (RPIR) – Beds and Total staffing tabs; trust website)

Background to the trust

Luton and Dunstable University Hospital NHS Foundation Trust provides secondary care services for a population of around 400,000 people within the local catchment area covering Luton, South Bedfordshire and parts of Hertfordshire and Buckinghamshire. The hospital is situated between Luton and Dunstable and was opened in 1939. The hospital became a foundation trust in 2006.

Luton and Dunstable University Hospital NHS Foundation Trust has one main hospital, Luton and Dunstable Hospital which is a medium sized acute hospital. The trust also has an Orthopaedic Centre which is close to the hospital and was opened in November 2015 and offers orthopaedic outpatient appointments, x-rays and physiotherapy. The Arndale House which is an outpatient facility in Luton town centre opened in June 2018 and offers a variety of outpatient services including phlebotomy and dermatology services. The Cobham Clinic, a private surgical service which is also located at the hospital. The Cobham Clinic has 13 beds.

The trust was last inspected by the Care Quality Commission (CQC) in January 2016. Following this comprehensive inspection, we rated the hospital as good overall.

Facts and data about the trust

There are approximately 742 beds of which 82 are maternity and 18 are critical care beds and high dependency beds with 18 contingency beds over 27 wards. The trust has 12 operating theatres, as well as a laser and plastics unit and oral surgery treatment unit, providing elective (planned) and emergency surgical facilities for general surgery, trauma and orthopaedics, vascular, breast, urology, oral maxillofacial and plastic surgery. The trust holds around 442,000 outpatient attendances annually across most specialities, such as trauma and orthopaedics, cardiology, dermatology, diabetes, and obstetrics.

There are two wards designated for emergency assessment units for medical admissions, and 12 general medical and care of the elderly wards including specialist stroke, cardiology, respiratory and haematology wards. The surgical teams have a surgical assessment unit for emergency admissions, and three general surgical wards including a fractured neck of femur ward. The trust also has a private inpatient unit with 13 beds.

The trust has three adult critical care wards including a high dependency unit, an intensive care unit, and a coronary care unit (heart). For women and children, the hospital has level 3 neonatal intensive care unit and special care baby unit, alongside two maternity wards and one gynaecology ward (women). There are three paediatric wards (children) with a paediatric assessment unit.

As of April 2018, the trust employed 4,197 (headcount) staff, (3,772.37 Whole Time Equivalent or WTE), including 571 WTE medical and dental and 1,274.11 WTE nursing and midwifery staff.

Patient numbers

Trust activity (February 2017 to January 2018):
• 104,837 A&E attendances (increase of 4% compared to the same time 2016/17)
• 86,676 inpatient admissions (increase of 2% compared to the same time 2016/17)
• 442,113 outpatient attendances (increase of 1% compared to the same time 2016/17)
• 4,750 deliveries (decrease of 5% compared to the same time 2016/17)
• 1,248 (increase of 1% compared to the same time 2016/17)

Financial Position

We inspected the trust’s financial governance particularly its financial leadership, management and governance arrangements, information to support this was provided by NHS Improvements (NHSI).

The trust has achieved a financial surplus for the last 19 years. In 2017/18 the trust had a budget of £334m. The trust achieved a financial position of a £15m surplus, which was favourable to their control total which resulted in the trust obtaining additional Sustainability and Transformational Funding for over achievement of control total.

For 2018/19, the trust has accepted its control total of a £3.92m surplus.

The trust was working towards a possible merger with another NHS trust, whilst legally this would be an acquisition of that trust by Luton and Dunstable NHS Foundation Trust, both trusts referred to it as a merger. This was a positive decision by the boards as they wished to promote the culture of a merger rather than a takeover. In support of this it is referred to as a merger throughout this document.

What people who use the trust’s services say

From July 2017 to June 2018, 94% of inpatients said they would recommend the trust to family and friends. This was similar to the England average of 96%.

People who were discharged from an NHS acute hospital in July 2017 were invited to share their experience of the care they received in the CQC Adult Inpatient Survey 2017. The survey consisted of 71 questions, which covered all aspects of service provision such as privacy and dignity, the hospital and ward, doctors, care and treatment, leaving hospital and overall experience. Each question was scored out of 10 (the higher the score the better). The trust also received a rating, which showed whether their performance was ‘better’, ‘about the same’ or ‘worse’ than most other trusts that took part in the survey. The results showed the trust performed about the same as other trusts for 59 questions asked. The trust performed worse than other trusts for having been offered help from staff to eat meals. The following six areas had improved.

- Being offered a choice of food.
- Patients liking hospital food.
- Being told how to take medication.
- Getting understandable answers from nurses.
- Length of discharge delay.
- Discharge delay due to wait for medicines/to see doctor/for ambulance.

The trust’s Patient-Led Assessment of the Care Environment (PLACE) audit for 2017, showed the trust generally scored similar of slightly worse than the England average for all PLACE standards:

- Cleanliness of environment 96% (England average 98.4%)
• Food and hydration 84.9% (England average 89.7%)
• Privacy, dignity and wellbeing 73% (England average 83.7%)
• Facilities 93.4% (England average 94%)
• Dementia 79.9% (England average 76.7%)

PLACE assessments are an annual appraisal of the non-clinical aspects of healthcare settings, undertaken by teams made up of staff and members of the public. They provide a framework for assessing quality against standards in order to measure the environment’s cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

To write the well-led evidence appendix and rate the organisation, we interviewed the members of the board and a range of senior staff across the trust. This included clinical and non-clinical service and specialty directors. We met and talked with a range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and papers to the board, investigation reports, and feedback from patients, local people and stakeholders.
Is this organisation well-led?

Leadership

The trust has a stable executive board. Leaders had the experience, capacity, capability and integrity to identify the challenges and took actions to address these. Leaders at every level were visible and approachable.

The trust was a NHS foundation trust. NHS foundation trusts are independent legal entities and have unique governance arrangements. They are also accountable to local people, who can become members and governors.

Luton and Dunstable University Hospital NHS Foundation Trust board comprised of 14 individuals with a wide range of experience, knowledge and skills appropriate to their roles, although two were relatively new to their posts. There were seven executive directors and seven non-executive directors (NEDs). An executive director is a member of the board who also has managerial responsibilities. A NED is a board member without responsibilities for the daily management or operations of the organisation.

The trust board was led by the chairman and chief executive. The chairman was an executive director and joined the trust in September 2014. The chief executive officer (CEO) was appointed as acting chief executive from May 2017, then appointed as chief executive in February 2018 having previously held the role of managing director in the trust. The deputy chief executive was appointed in March 2018 having been acting deputy chief executive from May 2017. Her previous post was as director of service development and joined the Luton and Dunstable University Hospital NHS Foundation Trust in 2007. The chief medical advisor was appointed to the trust in 1985 as a Consultant Chemical Pathologist & Associate Physician in Clinical Endocrinology and Metabolism. She took on the role of Chief Medical Advisor in 2015 and was also the director of pathology. She was supported in the chief medical officer role by three medical directors, covering operations and performance, operations and transformation and serious incidents and mortality.

The chief nurse was the newest member of the board, having been appointed in June 2018. She had also been appointed as interim director of nursing at a local NHS trust, in anticipation of the proposed merger of the two trusts. She divided her time between the two trusts’, spending three days per week at Luton and Dunstable University Hospital NHS Foundation Trust. An interim deputy, an assistant director and an associated director of patient and quality were in post to support this role.

In addition to these positions, the executive team also comprised of a director of finance and performance (in post since September 2000) and director of human resources (in post since October 2011). There was also a company secretary (in post since November 2010). The trust had recently appointed to a new role of director of quality who was due to start in October 2018.

The seven non-executive directors (NEDs) had joined the trust at a variety of dates from 2002 to 2018. The NEDs brought an appropriate range of skills, experience and knowledge to the board. There were no executive and non-executive vacancies at the time of our inspection (September 2018).

Of the executive board members reported to be working at the trust as at March 2018, none were black and minority ethnic (BME) and 67% were female.

Of the non-executive board members 14% were BME and 29% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Executive directors</td>
<td>Non-executive directors</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>29%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Executive board members were capable, they have been both open and responsive to challenges and have strived for improvement throughout the organisation. The trust’s NED members of the board were able to challenge and, hold the executive team to account and challenged improving the performance of the trust.

As an NHS foundation trust, the trust was required to have a council of governors. We met with 15 governors. They had a wide range of experience as governors, some for many years with other newly appointed. They were clear about their role and felt supported to undertake it, they were a committed and well-motivated group.

The trust’s organisational structure comprised of four clinical divisions; surgery, medicine, women and children and diagnostics, therapeutics and outpatients. Within each division there were sub specialities, for example within the surgical division there was a general surgery, colorectal surgery, obesity, urology, trauma and orthopaedics, vascular, ophthalmology, maxillofacial and breast care division. This was described by managers as being critical to the trust’s vision of clinical leadership of individual services. At the time of the inspection each of the divisions had different leadership structures in place. The medicine division had a clinical chair for governance with each of the directorates generally led by a clinical director, general or service manager and a matron. In the surgery division the clinical chair post was currently vacant with an associate director and a matron across the division supported by clinical directors and general managers in the directorates. Diagnostics, therapeutics and outpatients was led by a senior consultant in the role of divisional director and a divisional general manager. Women and children’s division was led by a senior consultant in the role of divisional director, a divisional general manager, two lead matrons and the head of midwifery.

Prior to the inspection we carried out staff in focus groups, which drew mostly positive comments from staff about the trust leadership. Almost all staff were able to tell us about the trust’s executive team and most had seen, met or talked with them. Although some staff had not met the newly appointed chief nurse, but were aware she had commenced working at the trust.

Our interviews held with the trust leadership team demonstrated a level of awareness of the priorities and challenges facing the trust and how these were being addressed. Executive leaders spoke with insight about these challenges, which included the potential merger with a local NHS trust and recruitment and retention of staff.

We attended the public board meeting on 25 July 2018. We observed challenges to ascertain the level of assurance within the trust. For example, staffing levels were discussed and reassurance was provided that daily safer staffing meetings were held, delays in patients appointments for oncology services was raised and reassurance was provided that discussion with the NHS provider for oncology services was ongoing.

**Fit and Proper Persons**

All the employment files had been well maintained to provide assurance of checks to ensure that directors met the Fit and Proper Persons Requirement.
NHS trusts are required to carry out checks to ensure directors have the qualifications, competence, skills, experience and character required to carry out their role (Health and Social Act 2008 (Regulated Activities) Regulations 2014; Regulation 5 Fit and proper persons: directors). This regulation ensures that directors of NHS providers are of good character and have the right qualifications and experience to carry out this important role.

The trust held fit and proper persons records on all directors and NEDs in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We examined 14 files of the directors and NEDs to check whether the information had been obtained and was in order. The trust had developed a checklist at the front of each file to demonstrate the information required was present. The trust provided additional data to show that all DBS check were in date apart from two. An annual declaration was completed for each file we reviewed. Following the inspection, the trust informed us that they would review the DBS policy and agreed a three year revision of DBS checks.

The trust had a conflict of interest declaration policy which was approved in June 2017. The policy detailed identification, declaration and review of interests (including gifts and hospitality), management of interests, what should be declared, shareholdings and donations. Executive and non-executive directors (NED) were required to declare their interests both pre-employment and annually. Of the 14 personnel files we reviewed, all declaration forms were completed and in date.

**Vision and strategy**

The vision, values and strategy had been developed through a structured planning process in collaboration with people who use the service, staff and external partners.

The trust organisational strategy was developed by the board in consultation with staff and stakeholders. The trust has two staff engagement events a year that helps shape the board direction in terms of strategies. The trusts organisational strategy was consulted on in July 2017 and the vision was consulted on in December 2017.

The Organisational Strategy March 2018 focuses on the following key areas:

- **Our staff** - our staff are central to our strategic vision. We are focusing on recruitment and retention and putting the staff and supporting our staff as central to the trust vision emphasizes this commitment.

- **Our patients** - we have launched our quality strategy setting out the trust's path to outstanding and have created a director of quality to give board leadership to its delivery. We also want communication with patients to be better and through the Global Digital Exemplar (GDE) programme we will deliver a patient portal allowing patients to better manage their own care.

- **Our services** - our service portfolio meets the needs of our population and we will continue with our more specialist services e.g. hyper acute stroke, bariatric surgery, NICU level 3 and head and neck cancer.

- **Our future** - we are aiming to create critical mass in the provision of services by merging with a local NHS trust. We have committed to maintaining the core services of A&E, pediatrics and maternity on the other NHS site. We already provide some joint clinical services such as vascular surgery, head and neck cancer services, cervical cancer screening services, neonatal intensive care, and stroke services.

- **Our approach** – the trust will continue to be dynamic and innovative
- **Our community** - The trust fully supports the objectives of the community and primary care programme of the integrated care system (ICS).

- **Our Estate** – We are committed to developing the hospital estate to ensure that it is fit for purpose.

There was a strong emphasis on values across the trust, these had been reviewed with the inclusion of staff. The trust’s vision was ‘To attract the best people, value our staff and develop high performing teams that deliver outstanding care to our patients’. The vision statement was based on the idea that the trust would deliver outstanding care through a chain of events. This included:

- Recruiting the best people
- Advising them when they are here
- Supporting them to create high performing teams.
- Outstanding care will not be delivered without this sequence of events.

Some strategies were coming to the end of their planned period. However, we noted engagement was taking place to develop future strategies and we understand the need to develop these considering the potential merger with a local NHS trust. An IT shadow strategy had been drafted ready for implementation.

Over 2000 staff attended the trust’s seventh ‘Tent Event’ held in July 2018. Staff were asked to select the words that they identified with the trust’s values. Staff had provided feedback on the trust’s values and had participated in the formation of the strategy. The five words which were the most important were ‘Teamwork (76%), helping others (56%), supportive (45%), learning (34%) and compassion (31%).

The pharmacy leadership team were visible and took steps to ensure that the vision and strategy of the department was shared with all team members. Medicines optimisation was integrated into all levels of the trust structure. The clinical operations board had representation from pharmacy.

Medicines optimisation progress on strategy was monitored regularly, and any issues were reported to the trust board.

The trust had an operational plan dated April 2018 for 2017-2019 which set out how the trust would achieve further progress against their strategic plan and was underpinned by five corporate objectives. The objectives included:

- Deliver the quality priorities outlined in the quality account.
- Deliver national quality and performance targets.
- Implement strategic plan
- Secure and develop a workforce to meet the needs of patients.
- Optimise the financial plan.

The executive board was accountable for the management of delivery of the operational plan. Performance was monitored by the board of directors and reported to the council of governors. Performance against deliveries was reported in the trust’s annual report.
Culture

The executive team and managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were committed to improving the quality of care and patient experience.

Staff were positive about the culture of the trust stating the leadership team were visible and approachable. Staff we spoke with during the core service inspection and the staff focus groups, felt respected, supported and valued. Staff comments included, ‘feeling proud to work for the trust’ and ‘we are like a family’. The executive team members and the non-executive directors spoken with during the inspection reported feeling very proud of all their colleagues and staff.

Staff we spoke with during our focus groups had attended the trust’s engagement event (Tent Event) and provided positive feedback about the event.

Freedom to Speak Up Guardian

Following Sir Robert Francis's Freedom to Speak Up review in 2015, NHS England and NHS Improvement expected all NHS organisations in England to adopt the Freedom to Speak Up: Raising Concerns policy for the NHS (April 2016), as a minimum standard. In response, the trust had appointed a freedom to speak up guardian (FTSUG). The FTSUG had a dedicated e-mail and telephone number that staff could access confidentially. However, most staff spoken with were unaware of who the freedom to speak up guardian was, but knew of their role and said they would go on the trust intranet to obtain their contact details.

The FTSUG was the head of communication and felt they had enough time allocated for the related activities in carrying out this role. Terms of reference for the role were in place and an associated policy. The FTSUG had open access to any member of the board and met regularly with the chief executive and with the director of human resources and was supported in all training and to attend the national and regional meetings.

The trust had a ‘raising concerns’ policy, any whistle-blowers could remain anonymous throughout the process and be supported by the guardian if they chose this option. The recommendations and outcomes following the investigation were shared with the staff member and they would identify and offer counselling.

There were eight concerns raised from staff for the period April to June 2018 of which six referred to attitudes and behaviours, one around patient experience and one other concern. Each of these were under investigation.

Summary of concerns received by the freedom to speak up guardian

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of concerns</th>
<th>Attitudes and behaviours</th>
<th>Equipment and maintenance</th>
<th>Staffing levels</th>
<th>Policies, procedures and processes</th>
<th>Quality and safety</th>
<th>Patient experience</th>
<th>Performance capability</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-2017</td>
<td>10</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2017-2018</td>
<td>20</td>
<td>5</td>
<td>0</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2018-2019</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total concerns raised</td>
<td>37</td>
<td>14</td>
<td>0</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

(Source: P111 summary of concerns raised)
Reports were made to the board of directors and an oversight of the process was reviewed by the audit and risk committee. The board was looking to how it could further leverage the success of this role by appointing ambassadors to support this role across the organisation.

The trust had dedicated staff with a culture of mutual respect and trust. All the staff we spoke with talked about an open and transparent culture within the hospital. Quotes from staff included, “everyone is friendly” “we work well as a team and support each other.” Staff also confirmed they enjoyed caring for their patients and we observed good interaction during the inspection.

Staff from the pharmacy department provided training to junior doctors with regards to medicine errors. Medicine errors were also discussed at the grand round with all medical staff. The trust medication safety officer (MSO) attended regional meetings with MSOs from other trusts.

Patients could access written information about their medicines. An interpretation service was also available for patients who spoke other languages. The pharmacy team were keen to extend this by providing bilingual dispensing labels for patients for whom English was not a first language. The trust was still considering whether to fund this service at the time of the inspection.

**Staff Diversity**

As of March 2017, the trust employed 3,950 people, of whom 38.9% were BME. It should be noted that 1.5% of staff chose not to disclose their ethnicity.


The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group:

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>28.0%</td>
<td>55.6%</td>
</tr>
<tr>
<td>Mixed</td>
<td>2.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>44.6%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Black</td>
<td>6.0%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2.2%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>4.0%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Not stated</td>
<td>12.7%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Staff diversity tab)

Luton and Dunstable University Hospital NHS Foundation Trust had an equality, diversity and human rights (EDHR) committee which provided leadership and set the strategic direction for EDHR across the trust. Committee members helped to ensure that the EDHR agenda was identified within the EDHR Strategy, action plan and the annual equality work plan was delivered by relevant staff across the trust. Members received reports to ensure that the trust remained compliant with the requirements outlined within equality and human rights legislation.

Following data reports shared during the EDHR committee meeting held in August 2017, it was determined that there was a need to have a focused task and finish sub-committee to deliver improvements and progress on key diversity areas where data showed low performance. This EDPR strategy and action plan (2015-2010) was due for next review in 2020 and provided a framework for all areas of the trust to own and develop further. It described:

- The trust’s duties and requirements under EDHR inequalities legislation including the equal treatment of people of nine different protected characteristics such as race, disability, gender, and age.
The need for fairness, respect, dignity, autonomy in the treatment of others and the encouragement of inclusion and access to services or employment.

The principles, goals and aims for the trust’s strategy.

The NHS equality delivery system which has four goals and 18 expected outcomes that inform the trust’s equality objectives and four-year action plan for 2015 -2019.

The equality delivery system also gives stakeholders a grading system to help evaluate the trust’s progress, supported by the annual equality and diversity progress report.

How the trust necessarily uses equality Information to help inform its progress reports, and to provide data for analysis to better inform decisions about policy or service changes.

The Governance, implementation, monitoring, and reporting measures in place - including the role of Care Quality Commission which all work to secure actions and evidence of real improvement and of the benefits and values of continuing to take into account the needs, and expectations of the local population.

The trust made necessary adjustments for staff with additional needs such as those with life limiting medical conditions. Staff we spoke with gave an example of a flexible working adjustment which had been made to a staff member diagnosed with a life limiting condition.

**NHS Staff Survey 2016** – results better than average of acute trusts.

The trust scored better than the England average for acute trusts for 19 of the 32 key findings in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 17: Percentage of staff feeling unwell due to work-related stress in last 12 months</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>Key finding 18: Percentage of staff attending work despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>51%</td>
<td>52%</td>
</tr>
<tr>
<td>Key finding 7: Percentage of staff able to contribute towards improvements at work</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>Key finding 6: Percentage of staff reporting good communication between senior management and staff</td>
<td>40%</td>
<td>33%</td>
</tr>
<tr>
<td>Key finding 3: Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Key finding 24. Percentage of staff reporting most recent experience of violence.</td>
<td>79%</td>
<td>66%</td>
</tr>
<tr>
<td>Key finding 27. Percentage of staff reporting most recent experience of harassment, bullying or abuse.</td>
<td>51%</td>
<td>45%</td>
</tr>
<tr>
<td>Key finding 12. Quality of appraisals.</td>
<td>3.33</td>
<td>3.11</td>
</tr>
<tr>
<td>Key finding 13. Quality of non-mandatory training, learning or development.</td>
<td>4.10</td>
<td>4.05</td>
</tr>
<tr>
<td>Key finding 30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.76</td>
<td>3.73</td>
</tr>
<tr>
<td>Key finding 19: Organisation and management interest in and action on health and wellbeing</td>
<td>3.71</td>
<td>3.62</td>
</tr>
<tr>
<td>Key finding 1: Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.84</td>
<td>3.75</td>
</tr>
<tr>
<td>Key finding 4: Staff motivation at work</td>
<td>3.99</td>
<td>3.92</td>
</tr>
<tr>
<td>Key finding 8: Staff satisfaction with level of responsibility and involvement</td>
<td>3.96</td>
<td>3.91</td>
</tr>
<tr>
<td>Key finding</td>
<td>Trust score</td>
<td>National average</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Key finding 11: Percentage of staff appraised in the last 12 months.</td>
<td>82%</td>
<td>86%</td>
</tr>
<tr>
<td>Key finding 20: Percentage of staff experiencing discrimination at work in the last 12 months.</td>
<td>17%</td>
<td>12%</td>
</tr>
<tr>
<td>Key finding 28: Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month.</td>
<td>33%</td>
<td>31%</td>
</tr>
<tr>
<td>Key finding 15: Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>Key finding 16: Percentage of staff working extra hours.</td>
<td>75%</td>
<td>72%</td>
</tr>
<tr>
<td>Key finding 22: Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months.</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Key finding 23: Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Key finding 25: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.</td>
<td>31%</td>
<td>28%</td>
</tr>
<tr>
<td>Key finding 32: Effective use of patient / service user feedback.</td>
<td>3.67</td>
<td>3.71</td>
</tr>
</tbody>
</table>

The trust scored similar to the England average for acute trusts for the remaining four key findings.

(Source: NHS Staff Survey 2017)

The NHS staff survey undertaken from September to December 2017 identified that the trust’s top strengths were for example, good communication between senior management and staff; staff motivation at work; quality of appraisals; percentage of staff reporting most recent experience of harassment, bullying or abuse. However, the hospital was in the worst 20% of trusts regarding staff experiencing discrimination at work in the last 12 months; staff experiencing physical violence, harassment, bullying or abuse from patients, relatives or the public in the last 12 months and staff satisfaction with the opportunities of flexible working. Based on the staff survey which identified physical violence, the trust had taken steps to reduce the abuse to staff with the introduction of the “action against abuse” notices. We saw these on display in public areas across the hospital. Staff confirmed this had been communicated to them in a recent e-mail. During the inspection, staff confirmed awareness of the survey result but had not been personally involved in any confrontation.
**Workforce race equality standard**

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>NHS Staff Survey Indicator</th>
<th>Proportion of respondents answering “Yes”</th>
<th>% difference between BME and white staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust: 30.9% England: 27.7%</td>
<td>-2.1%</td>
</tr>
<tr>
<td>KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months</td>
<td>Trust: 24.8% England: 28.6%</td>
<td>-3.8%</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust: 77.8% England: 71.6%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?</td>
<td>Trust: 12.7% England: 15.5%</td>
<td>-2.8%</td>
</tr>
</tbody>
</table>

Of the four questions above, two questions showed a statistically significant difference in score between white and BME staff:

- Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.
- In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

In both cases, the difference between the scores for white and BME staff was less pronounced for the trust’s staff than for staff across all NHS acute trusts.

*(Source: NHS Staff Survey 2017)*
Sickness absence rates

The trust’s sickness absence level from April 2017 to March 2018 was lower than or similar to the England average.

(Source: NHS Digital)

Gender pay gap

From 6 April 2017, employers in Great Britain with more than 250 staff are required by law to publish their gender pay gap information, covering pay and bonuses, and are required to publish this information on their website and via the designated government website. In accordance with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), Luton and Dunstable University Hospital NHS Foundation Trust published their gender pay gap review in March 2018. The report was based on rates of pay as at 31 March 2017 and bonuses paid in the year 1 April 2016 to 31 March 2017. The headline findings from the review were:

- A higher ratio of female to male in the workforce. The ratio for the NHS is 78% to 22% and for this trust is 79.8% to 20.2% respectively.
- In the higher quartile of pay the ratio of female to male becomes 65% female to 35% male and females tend to be in the lower bands.
- There is a predominantly male workforce in the higher banded medical and dental professions where a bonus is applied.

The study included 4156 relevant staff of which 3316 (79.8%) were female and 840 (20.2%) were male. The greatest proportion of employees were nurses and nursing support staff such as healthcare assistants, the majority of which are female.

The trust will continue to review annually the gender split across all bands and staff groups including the board and look to see if there are barriers to female career progression. They will also consider the following:
• Review the leadership programmes and talent management initiatives to see if these are attractive to women and support them to progress.

• Take account of gender in the providing of leadership opportunities e.g. NHS Insight Improvement Programme, Shadow Board Programme, coaching, mentoring or opportunity for secondments or to lead important projects.

• Explore how we can attract more men into the profession at lower bands and within nursing and midwifery to get a better gender balance and equalities.


Guardian of safe working hours

The guardian of safe working was introduced in 2016, to protect patients and doctors by making sure doctors were not working unsafe hours. The trust has advertised and interviewed to the post of the guardian of safe working hours. The post holder explained that for the first year they had met regularly with the human resources team, the director of medical education, the unions and junior doctor’s representatives to clarify the role and what was to be done and achieved.

The guardian was allocated one programmed activity session dedicated to this work but there was no dedicated administrative support for the role. The guardian looked at the dashboard every morning to address immediate concerns and identified themes through this. Issues that had been identified included the intensity of work with the proposed solution of having floating person to help ease the pressure points. One report had been submitted to the board in February 2018 noting there had not been an excessive number of exception reports submitted. Workload issues and junior doctors being unable to attend all the training sessions due to service commitments were the main issues identified, although the later was mainly raised through other means with very few exception reports submitted on this topic. It was noted this report was presented to the private part of the board meeting rather than the public session.

The first annual report was due to be presented to the October board meeting.

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council National Training Scheme Survey the trust was a negative outlier for the educational supervision indicator. The trust was in the middle 50% of trusts for the remaining 17 indicators.

(Source: General Medical Council National Training Scheme Survey 2018)

The trust had implemented an action plan following this report which included a review of work schedules, ensuring all junior doctors had a named supervisor and support. The trust had also implemented a monthly trainee medical staff committee where junior doctors attended and could raise and discuss concerns. This committee was facilitated by the director of medical education and chaired by one of the junior doctors. The trust chair, CEO, deputy CEO and director of HR all attended this committee.

Action was taken to address behaviour and performance that was inconsistent with the vision and values. The trust told us about one service in which, whilst the outcomes for patients were not a concern, there was rising concerns relating to staff behaviour. To address this, they invited the Royal College of Surgeons to undertake a review. This took place in May 2018 with a report presented to the trust in July 2018, this included 21 recommendations which the trust was addressing and had some improvements had been noted.
Governance

The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.

Board meetings and public board meetings were held quarterly. We attended the public board meeting on 25 July 2018. The agenda was extensive and diverse. The meeting consisted of a set agenda which included, the chairs report, an update on the proposed merger and a variety of reports from executives on a range of topics from their individual portfolios, reports from individual NEDs on the sub committees they chair and any other business. Staff presented the reports well and these were positively received. We observed challenges from both executives and NEDS to ascertain the level of assurance within the trust. The information for the trust board was available for staff to read before the meeting.

The trust board was supported in its role by the four subcommittees, each chaired by a non-executive director:

- Nomination committee.
- Investment and performance committee.
- Finance committee.
- Remuneration

Terms of reference for committees were reviewed annually and included a clear statement of intent, however was noted that the terms of reference for the Clinical Operational Board (COSQ) that reports to the Executive Board were out of date (2016). There were a number of committees and groups reporting up to the COSQ; information flow between all of these groups and up to the trust board was clear.

At ward and department level, quality was reviewed through daily safety huddles, department meetings and ward level quality data. We saw themes such as patient falls and learning from complaints were discussed at ward safety huddles. Each clinical division held a monthly multidisciplinary divisional board meeting. These meetings agenda included risk management, risk registers, incidents and complaints. Outcomes from these meetings were submitted to the COSQ committee.

Board assurance on effective processes and systems for medicines management was through the drug and therapeutics committee. The overall aim of this committee was to take a strategic, evidence based approach to all medicines management issues, advice, policies and regulations with the trust. The trust had a system for overseeing service level agreements for homecare providers. The terms of reference of the trust drugs and therapeutics committee were clearly set out.

NEDs participate in an initiative known as 3 x 3. The 3 x 3 initiative required NEDs to spend three hours every three months in a clinical setting working with staff to review their performance against CQC standards. Whilst this practice was now less rigid the principle of such visits continued. The COSQ receive these assurance reports. Staff told us that NEDs visited the wards and departments and they were able to be open and honest with them and raise concerns.

As an NHS foundation trust, the trust was required to have a council of governors. The governor’s role was to hold the non-executive directors to account for the performance of the board and represent the interests of members and the public. We met with a group of 15 of the governors.
They were unanimous in describing the trust as being friendly, welcoming responsive, very approachable with good communication. They were clear that patients were key to all that the trust did. They felt they were supported to meet their statutory duties. Meetings took place with the NEDs bi monthly and the working relationship with the NEDs was effective.

Board assurance Framework

There was a board assurance framework (BAF) in place to support good governance. Individual divisions were held to account by the board on financial, performance and quality.

The BAF was the structure used by the board to identify the principal risks to the organisation in meeting its objectives. The BAF identified the main risks to quality and safety across the organisation based on a range of information, including governance reports, the risk register and performance data. It detailed the controls and actions in place to minimise these risks. It was reviewed annually to reflect the trust strategic objectives for the coming year.

As part of the provider information request the trust provided their BAF for 2017/18, which detailed nine strategic risks and links them to the trust’s objectives.

A summary of these are below. All these risks were risk rated as 12. Risk ratings are calculated by multiplying the likelihood risk score by the consequence risk score. Please refer to the key below for details of risk scores.

<table>
<thead>
<tr>
<th>Strategic risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality (Objectives 1 – Clinical Outcomes, 2 – Patient Safety, 3 – Patient Experience and 4 - CQC and Performance Targets)</strong></td>
</tr>
<tr>
<td>Q1 – Risk that the Trust is unable to demonstrate ongoing compliance with standards</td>
</tr>
<tr>
<td>Q2 – Risk that the increase in the use of escalation areas as a result of increasing activity will have an impact on the quality of patient care</td>
</tr>
<tr>
<td><strong>Financial (Objectives 5 – Strategic Plans, 7 – Delivering Financial Targets)</strong></td>
</tr>
<tr>
<td>F1 – Risk that the increase in the use of escalation areas will have a financial impact of the increase cost of staff and a potential loss of business</td>
</tr>
<tr>
<td>F2 – Risk that the contracts will not be agreed at year end and the CCG will identify reasons not to pay (CQUIN / Contract Queries)</td>
</tr>
<tr>
<td>F3 – Risk is that the trust will not be able to control costs:</td>
</tr>
<tr>
<td>* Increasing agency costs</td>
</tr>
<tr>
<td>* Cost improvement plan delivery</td>
</tr>
<tr>
<td>* Managing cash</td>
</tr>
<tr>
<td><strong>Strategic (objective 5 – strategic plans)</strong></td>
</tr>
<tr>
<td>S1 – Risk that the trust hospital redevelopment programme will be negatively affected by the lack of funding from NHS Improvement</td>
</tr>
<tr>
<td>S2 – Risk is that the Trust is not prepared in relation to business continuity if there is an issue with the site, IT (cyber-attack) or major incident</td>
</tr>
<tr>
<td>S3 – Risk that the trust is distracted by the strategic plans to merge with Bedford Hospital that the performance of the hospital is negatively impacted</td>
</tr>
<tr>
<td><strong>Workforce (objective 6: Secure and develop the workforce)</strong></td>
</tr>
<tr>
<td>W1 - Risk is that if the trust does not recruit to vacancies or retain staff then there will be a reliance on agency staff and increasing costs</td>
</tr>
</tbody>
</table>
Risk Score Keys

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rare</td>
<td>1 Negligible</td>
</tr>
<tr>
<td>2 Unlikely</td>
<td>2 Minor</td>
</tr>
<tr>
<td>3 Possible</td>
<td>3 Moderate</td>
</tr>
<tr>
<td>4 Likely</td>
<td>4 Major</td>
</tr>
<tr>
<td>5 Certain</td>
<td>5 Catastrophic</td>
</tr>
</tbody>
</table>

(Source: Trust Board Assurance Framework January 2018, RPIR P113, p.6)

Strategic risks were linked to the BAF. The BAF was an assurance tool describing the trust’s strategic objectives and how it was to achieve them. Where there were risks to the strategy, the board was required to have assurance that control measures to reduce or remove the risks were effective. The BAF correlated with the corporate risk register and the audit committee was responsible for this. The chief executive was the overall executive sponsor for the BAF.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected. Serious incidents were reported and lessons learnt shared with staff, however, documentation on support provided to patients and their relatives was not always evident.

Incidents

From June 2017 to May 2018 the trust reported a total of 28 serious incidents (SI’s) to the strategic executive information system (STEIS).

The breakdown by core service was as follows:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>1</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1</td>
</tr>
<tr>
<td>Maternity</td>
<td>6</td>
</tr>
<tr>
<td>Medical Care</td>
<td>6</td>
</tr>
<tr>
<td>Outpatients</td>
<td>2</td>
</tr>
<tr>
<td>Surgery</td>
<td>9</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

From June 2017 to May 2018 the trust reported 6,973 incidents to the National Reporting and Learning System (NRLS). The majority resulted in no harm (67.5%), 28.9% resulted in low harm, 3.1% in moderate harm, 0.3% (23) in severe harm and 0.2% (13) in death. These included 186 incidents concerning unwitnessed falls. These were evenly spread over the 12-month period. The breakdown by core service was as follows:

<table>
<thead>
<tr>
<th>Core service</th>
<th>No. of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>70</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>59</td>
</tr>
<tr>
<td>Surgery</td>
<td>35</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>186</strong></td>
</tr>
</tbody>
</table>
The trust had a serious incident reporting policy and procedures that included promotion of learning. We reviewed five serious incident investigation reports and found that they were focussed on looking for improvements rather than blame. There were clear recommendations for further action. However, while the investigation into serious incidents and findings were clear and patients/their relatives were asked about their involvement, there was a lack of documentation on any support provided by the trust to patients and their relatives.

Our core services inspection in August 2018 highlighted variable practices with regards to learning from incidents. For example, some junior nurses were unable to provide examples of learning from incidents and staff within the medical division were unaware of never events. Following our inspection, the trust had acted to ensure learning from incidents was highlighted on the quality boards on every ward as a message of the month and divisions to include lessons learnt within their divisional performance reports.

We spoke with the serious incidents lead who said a section of learning from serious incidents was incorporated in the trust-wide quality newsletter which was issued every 6 months the most recent one being July 2018.

The risk and governance team monitored the status of incidents within the electronic reporting system including the timeliness of investigations and produced a fortnightly report of outstanding incidents along with a ‘handlers’ list. This report was sent to divisional management and clinical leads. The focussed piece of work being undertaken by the Risk Team to review and close incidents where there would be no meaningful benefit of an individual investigation has seen the number reduce by over 300 from the previous report. In July 2018, there were 1632 open incidents of which 1197 (73%) were overdue (Source – Trust board July 2018).

Guidelines for classification of harm were available on the electronic recording system and training sessions were provided to staff who required support in reporting and classification of serious incidents.

We saw evidence of how barriers to learning from serious incidents were dealt with by the trust. For example, the trust had arranged an independent colorectal review of clinical records following a serious incident which occurred within the surgical division.

We attended a serious incident panel which was attended by a medical director, risk and governance facilitator, a quality governance manager, chief nurse and other clinical staff who had been directly involved in the care of patients brought to the panel. Staff discussed cases in detail and agreed if an incident either met the serious incident criteria or not.

Following a serious incident which occurred within the medical care division, the trust had introduced a falls steering group and a ‘baywatch’ system to mitigate risk of falls. A healthcare worker was allocated to a bay which had cohorted patients with high risk of falls. Staff allocated to work within this area wore specific orange lanyards to indicate they were on ‘baywatch’ and could not leave the bay unattended, staff worked for two to four-hour intervals. Staff were relieved for breaks at different intervals over 24 hours. We observed staff carrying out ‘baywatch’ duties during our core service inspection and found this had been well embedded.

The trust had also introduced a risk assessment for level of enhanced observation of patients with risk of falls. The purpose of the risk assessment was to support professional judgement and decisions to reduce risk of harm, and identify appropriate interventions. The risk assessment was undertaken using the traffic light, RAG (red, amber, or green) rating system.

- Red (Level 4): Enhanced observation either within arms’ length or continuous eye contact. Baywatch or 1:1 nursing care.
• Amber (Level 3): Continuous observation within eyesight – nurse allocated to carry out observation either cohort or Baywatch to record/monitor behaviour.
• Green (Level 2): Intermittent level of observations; every 15/30 minutes.

Never events

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From July 2017 to July 2018, the trust reported four serious incidents that met the criteria for never events (NHS Improvement Never Events list 2018, January 2018). A summary of the never events by incident type and core service is shown below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Incident type</th>
<th>Core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2017</td>
<td>Wrong implant/prosthesis</td>
<td>Surgery</td>
</tr>
<tr>
<td>December 2017</td>
<td>Misplaced naso- or oro-gastric tubes</td>
<td>Critical Care</td>
</tr>
<tr>
<td>March 2018</td>
<td>Retained foreign object post procedure</td>
<td>Surgery</td>
</tr>
<tr>
<td>July 2018</td>
<td>Femoral block inserted on the incorrect leg.</td>
<td>Surgery</td>
</tr>
</tbody>
</table>

Duty of Candour

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Staff were aware of their responsibility to be open, transparent, and honest and gave examples of when they had offered patients and relatives an apology. Staff were aware of the trust’s policy and their requirement to apply duty of candour for any incident that was investigated and categorised as moderate or above and knew the thresholds for when duty of candour processes were triggered.

Our observation of records showed that when things went wrong, patients, and their relatives, were offered a verbal and written apology, which complied with the duty of candour process. This also included providing patients with the opportunity to get involved in the investigation.

Serious incident investigation reports submitted as part of the provider information request, evidenced that duty of candour had been applied in accordance with the regulation. Patients and/or their families were involved in the investigation process and informed of the outcome. Investigation reports were shared with the patient, family and/or representatives on completion, if requested. We saw that in all never events reported, the duty of candour was followed even when no harm had occurred.

Staff we spoke with were aware of the importance of being open and honest with patients and those close to them when something went wrong, and gave us examples of when they had done so. We found staff understood their responsibilities regarding the duty of candour and knew it should be applied when an incident resulted in moderate harm or above. The electronic incident reporting system also prompted staff to fulfil the duty of candour regulation for any incidents they graded as moderate or above.

Performance

The trust submitted data to NHS England as required so that performance against targets and national standards could be measured. Metrics or standards included four-hour waits in the
emergency department, cancelled operations, cancer waiting times, consultant-led referral to
treatment (RTT) waiting times and delayed transfers of care. Senior management committees and
the board reviewed performance reports. These were used to challenge and drive forward
improvements in care, where indicated.

As of July 2018, the trust’s year-to-date performance against the total median time in the
emergency department for all patients was 1.1. This was same as the national average of 1.1.

For the same period, we found trust performance in relation to RTT, cancer waits and diagnostic
wait times were generally in line with national targets. There were clear recovery plans in place to
achieve RTT in those specialities that did not achieve the standard. The trust had an action plan in
place which was monitored by the deputy chief executive. A referral to treatment (RTT) recovery
plan was put in place in February 2018 and was reviewed monthly by the board sub-committee
responsible for quality, the clinical outcome, safety and quality committee (COSQ). RTT
performance was also reported to the board through the quality and performance report.

The trust used national safety thermometers, including the classic, medication and maternity, to
support improvements in patient care and experience. The classic safety thermometer for
example, is a measurement tool for improvement that focuses on the four most commonly
occurring harms in healthcare: pressure ulcers, falls, catheter-acquired urinary tract infections
(UTIs), and venous thromboembolisms (VTE) (a condition where a blood clot forms in a vein).

From May 2017 to May 2018, the trust’s average combined harm free care score was 98%, which
was above the England average of 95%. (Source: Trust Board papers, July 2018).

Risk

Risks were recorded on the trust’s electronic risk management system. These were captured at
specialty, divisional and trust-wide level. The risk registers included a description of each risk,
alongside mitigating actions and controls in place. An assessment of the likelihood of the risk
materialising, its possible impact and the lead person responsible for review and monitoring was
also detailed. We saw that risks were regularly reviewed at specialty, divisional and trust wide
level. There was a corporate risk register in place, which clearly identify what the corporate risks.
Risks rated 15 or above (quite likely or significant) were reviewed at the COSQ committee and a
clinical risk report was provided to the board. Any risks rated 25 or above were escalated directly
to the chief executive for immediate review and management. We found comprehensive risk
registers were in place at specialty and divisional level, these were reviewed at divisional board
meetings.

The audit and risk committee discussed the corporate risk register in each quarter before the
report was presented to the board. Risks were those rated as 15 or above (quite likely or
significant). There were risks on the corporate risk register that had been there since 2011. Senior
staff told us that the risks had been managed.

There were three risks which related to estates and facilities recorded on the trust’s risk register.
These included electrical infrastructure, ventilation and gas supply. We spoke with the new
director of estates and facilities who said risks were well managed and there were plans in place
for upgrades.

Divisional risk registers and the BAF had a clear governance reporting framework in relation to risk
ownership. This ranged from clinical divisions to corporate and sub-board committees.

Agency usage was one of the trust’s top risks; this aligned with what front line staff told us. The
board papers for July 2018, showed the trust’s vacancy rate for nursing and midwifery staff was
14%, (June figures) which was higher (worse) than the trust target of 10%. Similarly, the
turnover rate was also worse at 16%, against a trust target of 10%. The sickness rate however, was generally in line with the trust target at 3.2%, against a target of 3.3%. *(Source: Trust Board papers, July 2018)*.

Staff recruitment remained a challenge and the trust had continued to carry out ad-hoc local recruitment, open days, targeted campaigns as well as overseas recruitment of nursing and medical staff. The trust had introduced a big recruitment drive had had been actively recruiting chest physicians and specialist registrars from abroad. There was a link coordinator for specialist registrars. The trust had established a project group called ‘retention matters’, with a target of reducing band 5 nurse and HCA turnover through four key work streams which included; improving data, transfer window/career conversations, working flexibly and retirement options. Senior staff we spoke with said exit interviews were carried out and the key themes included work-life balance, retirement and relocation.

The trust used a safer staffing tool to align nurse staffing to hospital activity and patient acuity. Staff levels, skills mix and patient acuity were monitored by senior staff regularly throughout the day. We attended meeting that were held throughout the day to review staffing levels and patient safety. Escalation plans were in place and we saw that actions were taken to address staffing shortages. These included the redeployment of staff where appropriate, and the use of bank and agency staff when needed. The senior leaders recognised that medical and nursing staffing shortages were not unique to the trust, and were exploring alternative workforce models.

The trust board received reports on the levels of planned and actual nursing registered and unregistered staff. This was broken down between day and night shifts and included the planned versus actual staffing levels. Staffing levels provided to the trust board from April to June 2018 showed;

- The trust had maintained an overall staffing fill rate of above 90%. However, trend analysis demonstrated difficulties in fill rates over the last 12 months, particularly on day shifts.
- Continued challenges in meeting the need of enhanced care of patients particularly on wards 14 and 15.
- On target to meet 0% healthcare assistant (HCA) vacancies by August 2018. *(Source: Trust Board Papers 25 July 2018)*.

The trust’s appraisal rate was at 80% which was below the trust’s own target of 90%. In addition to sending out non-compliance e-mails to individual members of staff, divisional leads were asked to focus their efforts on improving compliance. The clinical outcomes, safety and quality committee continued to monitor statutory training and appraisal compliance.

During our core service inspection in August 2018, we found not all patients had surgical pre-assessments carried out for planned surgery. We raised concerns about the inconsistency of pre-assessment with the trust who told us that they were reviewing the process for attendance at pre-assessment clinics. The trust had commenced an internal review in 2016 which revealed variation in pre-operative assessment practices across specialties. A business case had been presented and approved in summer 2017 for the construction of a pre-operative assessment hub. Managers told us that following a review of the pre-operative services provided by the trust, the pre-assessment processes were being redesigned and the new service would be launched in September 2018.

Following our well-led inspection, the trust sent further assurance which related to the pre-operative assessment redesign project which went ‘live’ on the 24 September 2018. Ear, nose and throat, urology and gynaecology had been rolled into the new model and the plan was to pre-
assess patients on the day they were listed into these specialties. The trust had designed pre-operative assessment patient information leaflets which detailed aims of pre-assessment and what happens after the assessment.

The hospital estate and future development was high on the risk register. The trust had a backlog of repairs and maintenance that required funding. The trust had submitted a capital bid to the department of health for additional funding to improve the estate and increase bed capacity. The estates risk register included upgrades of electrical infrastructure, review of ventilation and gas supply. *Source: Trust Board papers, July 2018.*

**Trust corporate risk register**

The trust provided a document detailing their 15 high-level risks. Each of these has a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/11/2016</td>
<td>1163</td>
<td>There is a risk that a range of issues (including unknowns, incorrect planning assumptions, changes to activity, weak market interest, unexpected revenue costs, etc.) could impact on the affordability of the hospital redevelopment at business case approvals or subsequently during operations</td>
<td>25</td>
</tr>
<tr>
<td>3/11/2016</td>
<td>1164</td>
<td>There is a risk that the complexity of the hospital redevelopment programme, constraints on the site and need for large multiple decants causes major disruption to the trust</td>
<td>25</td>
</tr>
<tr>
<td>16/06/2016</td>
<td>1212</td>
<td>If the trust go over the agency ceiling by 50% then NHS Improvement will downgrade the trust's financial rating</td>
<td>25</td>
</tr>
<tr>
<td>31/05/2011</td>
<td>650</td>
<td>There are insufficient funded beds within the trust to meet the increasing demand. To manage acutely unwell patients and offload ambulances additional bed capacity is created in elective areas which compromises 18 weeks patient experience</td>
<td>20</td>
</tr>
<tr>
<td>20/01/2017</td>
<td>1178</td>
<td>The FT may have insufficient cash to meet its obligations</td>
<td>20</td>
</tr>
<tr>
<td>16/06/2017</td>
<td>1211</td>
<td>If the backlog maintenance is not addressed then there would be a significant impact on the site and patient experience</td>
<td>20</td>
</tr>
<tr>
<td>16/06/2017</td>
<td>1213</td>
<td>If there is continued support provided to other external projects and pressure on management then this could impact on performance. The trust has a number of programmes of work including the sustainability and transformation partnership and if these take up too much time and resources then the trust performance may be negatively affected</td>
<td>20</td>
</tr>
<tr>
<td>31/05/2011</td>
<td>644</td>
<td>The 18 week target is a Monitor and contractual target. Target failure incurs financial &amp; reputational harm</td>
<td>16</td>
</tr>
<tr>
<td>5/09/2011</td>
<td>669</td>
<td>The trust may not achieve the target set out to achieve</td>
<td>16</td>
</tr>
<tr>
<td>16/06/2017</td>
<td>1210</td>
<td>If the trust does not have appropriate plans in place to recruit staff then there could be reliance on agency staff or stretch on services</td>
<td>16</td>
</tr>
<tr>
<td>1/11/2017</td>
<td>1278</td>
<td>As the trust progresses with the acquisition there is a financial risk associated with the transaction costs, capital funding and historic Bedford debt which may have a negative impact on</td>
<td>16</td>
</tr>
</tbody>
</table>
the trust’s financial position and future viability

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/11/2016</td>
<td>1165</td>
<td>If the hospital redevelopment programme does not go ahead there is a risk that the trust’s clinical facilities will not have the capacity for and will not be suitable for modern healthcare in the future</td>
</tr>
<tr>
<td>3/11/2016</td>
<td>1166</td>
<td>There is a risk that transition to the new model of care will be delayed or blocked by poor staff engagement / inability to recruit staff in short supply / cultural resistance</td>
</tr>
<tr>
<td>4/04/2017</td>
<td>1200</td>
<td>Delays in various projects has resulted in the capacity of the IT department to develop, implement and improve the trust cyber security defence, therefore preventing the trust in reducing cyber security risks.</td>
</tr>
<tr>
<td>25/10/2017</td>
<td>1253</td>
<td>Needs based care: length of stay savings and resulting ward closures not realised</td>
</tr>
</tbody>
</table>

(Source: Trust board level risk register, May 2018, RPIR P113)

The trust had implemented an emergency care pathway which aimed to keep outliers (a patient cared for in a bed outside of the division) to a minimum and worked with medical staff to identify the most appropriate patients. The pathway showed an agreed pathway for those patients who frequently fell between specialties when referred from A&E and stipulated that the appropriate team under which the patient should be admitted is determined by the primary clinical condition. The emergency care pathway highlighted a procedure for moving patients from a base ward to an outlying ward. This included:

- A consultant should identify suitable patients to outlie on the daily multi-disciplinary team meetings and board rounds.
- Patients suitable to outlie should be highlighted on the patient list view.
- The patient flow team will check the patient list.

There was a clinical risk management committee chaired by the chief medical advisor. Where a patient had been moved, the reason for their move would be documented including agreed actions and mitigations. We attended a bed meeting during our core services inspection and found staff discussed the number of medical and surgical outliers and discussed if they were awaiting a package of care. No staffing issues were reported during this meeting.

The trust had a policy for discharge from hospital which was due for next review in November 2018. The policy stated that every patient discharged from the Luton and Dunstable hospital either to their own home or other heath or social care facility, would have where appropriate, a multi-disciplinary assessment of their ongoing health and social care needs. The patient and/or their carer would be fully involved in the discharge planning process and all identified ongoing health and/or social needs would be communicated to individuals/agencies responsible for meeting those needs.

To help with capacity and flow through the hospital, the trust had set up a ‘discharge hub’. This hub had staff collocated from five partner organisations. It brought together discharge supervisors, and social care staff to address the difficulties in transferring patients out of hospital who needed multiple services. In addition to the hub, discharge coordinators were located on every ward and reported to the discharge team. Discharge coordinators focused on managing patient discharges and liaised with nursing and medical staff to discuss discharge plans. These plans were discussed
with patients and their relatives. Social workers attended ward rounds to ensure patients were escalated to the relevant organisations and authorities.

Complex discharges were reviewed at board rounds multidisciplinary ward meetings which highlighted and discussed patients with complex discharge issues. This was in line with the trust’s policy for discharge from hospital. Rotational board round meetings started in April 2018 and was held in various ward areas. This meeting was either chaired by the chief executive officer or deputy chief executive officer and was attended by a consultant, physiotherapist, occupational therapist, ward manager and other members of multidisciplinary team. We attended a board round meeting on ward 14 and found the multidisciplinary team discussed issues surrounding patients’ nutritional needs, discharge and whether patients were fit for discharge. Since the introduction of the board rounds meeting, average length of stay had reduced from 20 to 8 days.

Staff recorded medicines related risks electronically using an electronic incident reporting system. While risks were allocated to different clinical areas, if a risk was trust-wide, this was highlighted to the trust board. There was a clinical risk committee managed by the chief medical chair. This approach ensured that the board had visibility of significant risks.

The trust had a medicines safety officer who maintained oversight of medicines related risks and had implemented an electronic prescribing system in most areas. There was a dedicated team that continually reviewed how this system could be improved.

Data from the hospital pharmacy transformation programme and NHS England dashboard was used for benchmarking. This also took place informally when the chief pharmacist met with other lead pharmacists from other trusts.

Various medicines related audits were completed including:

- Controlled drugs
- Safe and secure storage of medicines
- Omitted doses

The trust employed a patient safety lead who led in identifying, assisting and in managing the biggest risks to patient safety. The team investigated sepsis and venous thromboembolism (VTE) cases. The team reported patient safety issues to the clinical management board and the COSQ committee. Information relating to sepsis and VTE was included in a quality report to the board.

Trends in risks to patient safety were analysed at ward level and appropriate training was delivered to improve safety and patient outcomes. Where a ward had been found to have a high number of cardiac arrests, the patient safety lead would investigate the culture on the ward involved and practice development nurses delivered specific training to the ward staff.

**Infection prevention and control**

The trust had a director of infection prevention and control and an infection prevention and control (IPC) lead nurse. There was an IPC committee which reported to the board, via the clinical outcomes board, and presented an annual report to the trust board.

The trust had a clear pathway in the management of patients with suspected communicable diseases. An IPC nurse attended bed meetings daily and ensured patients with suspected communicable diseases were source isolated as per trust policy.

There were systems in place to enable mandatory reporting of notifiable diseases to Public Health England and this was in line with the Health Protection Legislation (2010) which states that it is a
‘requirement for doctors and laboratories testing human samples to report cases of infectious
disease or contamination which present or could present significant harm to human health’.

The trust maintained an IPC dashboard, which reported on quality indicators at ward, divisional
and trust wide level. Performance was monitored against a range of quality indicators including
hand hygiene, MRSA (antibiotic resistant bacteria) and IPC training compliance, as well as rates of
MRSA, *Clostridium difficile* (*C. difficile*) (bacteria that can infect the bowel and cause diarrhoea).

From April 2017 to May 2018, the trust reported nine cases of hospital-acquired *C. difficile* blood
stream infections. The trust threshold for the year (April 2018 to March 2019) had been set at five.
The IPC team was unable to find evidence to suggest a point source outbreak or cross infection.

During our core service inspection August 2018, we found poor compliance with ‘arms bare below
the elbows’ and hand hygiene. We raised this with the trust who took immediate action to address
our concerns. For example, staff were reminded of the trust ‘arms bare below the elbows’ policy,
poster campaign had been placed on ward doors and screen savers had been issued. Staff
completed reminders of the need for ‘arms bare below the elbows’ and uniform policy at ward
safety huddles. Senior IPC staff we spoke with during the well-led inspection said they had
undertaken and will continue to undertake daily checks on compliance with the trust's dress code
and uniform policy.

Staff from the pharmacy department provided training to junior doctors with regards to medicine
ersors. Medicine errors were also discussed at the grand round with all medical staff. The trust
medication safety officer (MSO) attended regional meetings with MSOs from other trusts.

**Safeguarding**

*Safeguarding adults and children at risk was given sufficient priority within the trust. There
were clear systems, processes and practices in place to safeguard children and adults
from avoidable harm, abuse and neglect that reflected relevant legislation and local
requirements. The trust had comprehensive, well written safeguarding policies and
pathways in place, which were accessible to staff via the trust’s intranet.*

The trust had a well-resourced adult safeguarding team which felt well supported by immediate
line managers and felt the trust board listened to and actioned concerns. There was an
established safeguarding champion network throughout the hospital. The trust had 60
safeguarding champions who wore champion badges and met quarterly. Learning was
disseminated throughout the hospital.

We spoke with the children’s safeguarding lead and the general manager for children’s services
who said they had been able to increase capacity by recruiting more staff due to an increase in
children presenting with mental health issues. The safeguarding team worked in close
collaboration with the local safeguarding children board to raise awareness of child and adolescent
mental health services (CAMHS). There was a seven-day access to CAMHS assessment in the
emergency department.

Learning from serious case reviews was shared through safety briefings, newsletters, emails and
bruising flow charts. Serious adult reviews were put into the quarterly report and discussed at the
safeguarding board.
The hospital received 40 to 50 safeguarding alerts per month and the safeguarding team had strong links with the multi-agency safeguarding hub, the police and the local authority.

All staff were required to complete safeguarding adults and children training at the level appropriate to their role. Training was delivered via face-to-face sessions, which were multidisciplinary and multi-agency, and included scenario-based discussion and learning from local and national serious case reviews. The trust had identified specific staff who required safeguarding level three training and 86% had attended this training. This was slightly below the trust’s target of 90%.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£308 m</td>
<td>£334 m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£13 m</td>
<td>£15 m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£295 m</td>
<td>£319 m</td>
</tr>
<tr>
<td>Projected surplus (deficit)</td>
<td>£308 m</td>
<td>£334 m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust has had a financial surplus for the last 19 years. In 2017/18 the trust achieved a financial position of a £1.7m surplus, which with the additional Sustainability and Transformational Funding made a surplus total of £15m. For 2018/19, the trust has accepted its control total of a £3.92m surplus.

In 2017/18 the trust delivered its cost improvement programmes (CIP) of £12.9m of efficiency savings, all of which were classed as recurrent. For 2018/19 the trust has identified all £9.5m of savings required for its CIP programme, all of which have been classed as recurrent savings.

The financial performance of the trust was overseen through a monthly finance, investment and performance committee chaired by a non-executive director. Reports from this committee were presented to the quarterly board meetings. Risks to the trust's financial position included agency spend and cost improvement targets not being met, although this was part was being met by income over performance in some areas.

**Information management**

The trust collected, analysed, managed and used information well to support its activities using secure electronic systems with security safeguards. Staff received helpful data on a daily basis which supported them to adjust and improve performance. The information used in reporting performance and delivering quality of care was accurate, valid and reliable.

The trust employed a director of information and technology and a senior information risk owner (SIRO). The role of the SIRO was to take ownership of the organisation's information risk policy, act as an advocate for information risk on the board and provide written advice to the accounting officer on the content of their annual governance statement regarding information risk.
Information technology systems were used to monitor and improve patient care. There were robust arrangements in place which ensured data such as serious incidents were submitted to external providers as required.

The trust had formed a general data protection regulation (GDPR) programme board attended by a wider group including procurement, contract management, general Management as well as the Caldecott Guardian and SIRO and had run the board alongside the established information governance steering group. The IT security and cyber element of GDPR had recently had a GAP analysis performed by an external security expert, as well as completed external and internal penetration testing. All elements that required improvement were being addressed to allow national certification for the trust in terms of compliance (Source – Trust Board Papers 25 July 2018).

There was an information governance (IG) strategy in place which had been reviewed in September 2018. Executive and non-executive directors had responsibility in ensuring the trust was compliant with statutory duties and obligations. The IG structure was chaired by a SIRO and a deputy Caldicott director. The strategy highlighted strategic aims which included;

- Ensuring compliance with the mandatory elements of the Data Security & Protection Toolkit.
- Establishing, implementing and maintaining policies for the effective management of information.
- Recognising the need for an appropriate balance between openness and confidentiality in the management of information.
- Ensuring that IG is an integral part of the trust’s culture and its operating systems.
- Reducing duplication and looking at new ways of working effectively and efficiently.
- Minimising the risk of breaches of personal data.
- Minimising inappropriate uses of personal data.
- Ensuring that information sharing protocols and agreements between the trust and other organisations are managed and developed in accordance with IG principles.
- Protecting the services, staff, reputation and finances of the trust through the process of early identification of information risks and where these risks are identified ensuring sufficient risk assessment, risk control and elimination are undertaken.
- Ensuring there is provision of sufficient training, instruction and information to enable all employees to operate effectively within IG requirements.

We found IT was used to improve the quality of care. The trust used information systems across the organisation, which captured and recorded relevant clinical and demographic data about patients along their pathway, as well as patient flow and acuity across the hospital. There was evidence of integrated reporting, which was used to support decision-making at board level. Systems were in place to collect data from wards and services, and this was not over burdensome for front line staff. There was a holistic understanding of performance and data was used to challenge and drive forward improvements in service provision, where indicated. The information used in reporting, performance management and delivering quality care was generally accurate, valid, reliable, timely and relevant, and identified areas for improvement, which were acted upon.
The trust produced a monthly integrated audit report for each clinical group which listed their performance. Trust targets were set in relation to these indicators and performance was rated using the traffic light, RAG (red, amber, or green) rating system. This allowed managers to assess their performance at a glance and identify those areas which required further improvement or investigation.

The trust complied with the information governance toolkit. The information governance toolkit is a performance tool produced by the Department of Health, that NHS Digital is commissioned to develop and maintain. Each trust must undertake an annual self-assessment to identify and evidence its current level of compliance against standards and requirements. This is to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Information technology systems were used appropriately to monitor and improve the quality of care. For example, electronic rostering, patient tracking, digital dictation and a clinical systems roadmap were in place to monitor and improve the quality of care and the trusts response to the cyber-attack on NHS trusts in 2017.

The trust was awarded Global Digital Exemplar (GDE) status by NHS England in July 2017 and worked together with a partner hospital to secure their fast follower status which was confirmed in June 2018. As part of the ‘Global’ ambition of the digital exemplar programme, the team recently visited a hospital abroad with the aim to have a look at their digital journey and to learn from their experience in eliminating paper at the point of care, and incorporating that learning into the overall vision and aims of the trust's own programme.

The trust had digitised 1.25 million paper records as well as reclaiming 750 square metres of hospital space for clinical use, technology had saved the cost of delivering 1,000 paper records to outpatient clinics every day.

Information technology systems were used to monitor and improve patient care. There were robust arrangements in place which ensured data such as serious incidents were submitted to external providers as required.

The trust had formed a general data protection regulation (GDPR) programme board attended by a wider group including procurement, contract management, general Management as well as the Caldecott Guardian and SIRO and had run the board alongside the established information governance steering group. The IT security and cyber element of GDPR had recently had a GAP analysis performed by an external security expert, as well as completed external and internal penetration testing. All elements that required improvement were being addressed to allow national certification for the trust in terms of compliance (Source – Trust Board Papers 25 July 2018).

Data used was up-to-date and relevant, with the use of statistical process control charts in documents such as the quality performance report.

Staff in the trust could access summary care records. In addition, electronic prescribing had been implemented in most areas in the trust. As a result, there had been a reduction in errors related to prescriptions with poor legibility.

The trust had an e-pharmacy team that continually reviewed how the e-prescribing and medicines administration (EPMA) system could be improved. They also took responsibility for installing new versions and providing staff updates. The EPMA system allowed staff to extract data for the completion of medicines audits.
Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations.

The trust was a NHS foundation trust. NHS foundation trusts are independent legal entities and have unique governance arrangements. They are also accountable to local people, who can become members and governors. The governors actively promoted membership throughout the catchment area and worked on ways of seeking information about the trust from members as well as feeding back information. Lectures were run on a variety of topics which were popular with members and was a useful forum for feedback.

The trust had a structured and systematic approach to engaging with staff, patients, those close to them and their representatives. Rigorous and constructive challenge from patients, the public, stakeholders and regulators was welcomed and seen as a vital way of holding services to account. Examples included the patient and public participation group (PPPG) which was attended by patients, the general public, clinical commissioning group (CCG) and Healthwatch. The PPG were involved in writing the patient experience strategy 2016-2018, which was due for review in November 2018 and linked to the trusts quality strategy 2018-2021. The quality strategy included the four quality priorities:

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

To achieve the above we must also:

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

The four priorities encompass a broad range of work streams, with some work already in progress.

The trust invited patients, the public and stakeholder’s views and experiences. Outcomes from the PPPG were fed back to the senior leadership team via the COSQ committee, which fed into the trust board. The trust also invited patients to share their experiences at the COSQ committee, the patients experience and stories generally resulted from an incident or complaint to share learning. The service manager and matron for the area would attend to listen and support the patients and their careers.

The patient experience team linked with the foundation trust members group and joined public engagement events to gather feedback from members of the public from all communities about their experiences in specific services in the trust.

The trust had a patient and public participation group which met every quarter and also held two focus groups a year. Anyone who had contact with the hospital whether as a patient, carer or relative could join. The PPPG had reviewed and made suggestions about changes to the new trust internet site. It was reviewed for ease of navigation. Other feedback from the group has been used to help make changes to the Trust Welcome Booklet for patients.

A patient experience email with a specially designed logo had been introduced to enable patients and the public to share their feedback.

The trust held a learning disability and dementia coffee morning, where they invited current and past patients and carers to discuss their experiences and share information. For example, staff
had attended to show patients equipment they may come into contact with during an admission to help them understand the usage and become familiar with the equipment.

Patients could access written information about their medicines. An interpretation service was also available for patients who spoke other languages. The pharmacy team were keen to extend this by providing bilingual dispensing labels for patients for whom English was not a first language. The trust was still considering whether to fund this service at the time of the inspection.

Since July 2017, some members of the executive team such as the chief nurse and CEO, chair and one of the Medical Directors carried out a safety walkabout scheduled every Friday. The walkabouts are informal, the department was chosen at random and no notification is given in advance that areas will be visited. The executive team had the opportunity to observe activity within the chosen area, speak to staff and patients and identify any issues that arise. Most areas of the hospital have been visited including all the wards, outpatient areas, pharmacy, endoscopy and other non-clinical areas.

The trust had a strong focus on staff engagement and well-being, this was evident throughout the core service inspections and focus groups as well as during our well-led inspection.

The trust ran twice yearly ‘Good, Better, Best’ staff engagement events one in summer and one at Christmas. The 2018 summer ‘tent event’ took place in a large marquee which could hold approximately 300 people with full audio/visual equipment. Event sessions ran for an hour and were repeated throughout the day, including an early session at 8am for those finishing the night shift and one later in the evening. At this year’s event 75% of all trust staff attended during the week. The Quality Strategy 2018-2021 was presented to staff at this event.

The focus for the summer’s engagement event had been around the trust values and de-escalation techniques. Following feedback from staff, senior staff were concerned about the level of aggression and violence from patients. As a result, during the hour ‘tent event’ sessions, a 35-minute theatre session was performed by staff which provided interactive training around de-escalation techniques based on the empathise, clarify and take actions model.

In addition to the theatre session during the ‘tent event’, the trust ran an anti-abuse campaign which included posters and signs being put up around the emergency department and outpatients. The chief executive officer and director of human resources did a walkabout to gauge opinion of the signage which was positive. The aim was for patients to acknowledge that people have different perspective, but the trust has zero tolerance of abuse against staff.

The trust ran a series of initiatives based around staff health and wellbeing. These included:

- A fruit stall every Wednesday.
- Apples and pears – take the stairs. Staff were encouraged to climb five flights of stairs and back down to receive an apple, if repeated staff were also given a pear. Approximate 30/40 staff took part. Left over gifts such as torches were also used as incentives.
- Fit in 50 seconds was a booklet produced by an external company. It encouraged staff to do 50 seconds of exercise every hour. There had been lots of positive feedback around fit in 50, including teams who did not usually provide feedback.
- A health and wellbeing informal staff newsletter.
- Health and wellbeing day.
Wards, teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements. The trust participated in national patient surveys, for example the friends and family test.

Engagement surveys had been conducted with staff through engagement events for example in relation to the vision and the values and their opinions on the engagement process for the merger with a local NHS hospital. Managers ensured that there were regular communications and reports back to staff at team brief which aimed to raise awareness, and encourage involvement, support and feedback for the merger proposal.

Staff had also reported good communication between senior management and staff, high staff motivation at work, and the good quality of appraisals. However, staff reported that they had experienced harassment, bullying or abuse from patients, relatives or the public. An action plan was in place to address this. Steps had been taken to reduce abuse against staff with the introduction of new ‘Action against abuse’ notices, were displayed in public areas around the site.

**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust consistently scored over 90% for people recommending the trust as a place to receive care from July 2017 to June 2018. The trust’s performance over this period was mostly similar to the England average. The exception was August 2017, when the trust scored 91.0% compared to the England average of 95.6%.

(Source: Friends and Family Test)

The trust’s policy for discharge from hospital encouraged staff to invite comments and suggestions from patients and carers by making comment cards available to them. Ward sisters reviewed any comments received and discussed comments with ward staff and line managers to make necessary improvements.
Pharmacy staff could extract and analyse data specific to the pharmacy team from the trust survey. This information was used by the deputy chief pharmacist to look at areas for improvement. As a result, there was now a pharmacy staff forum which met monthly to discuss key areas, for example, job satisfaction and staff appraisal.

The trust had staff side representatives who were introduced to staff during their induction and supported them through their induction period by ensuring they had received the required training. A buddy system was in place to support new starters.

Union representatives attended joint staff management committee meetings which monitored the quality of staff performance, reviewed and challenged the outcomes.

**Learning, continuous improvement and innovation**

There was a strong focus on learning and improvement throughout the organisation. The trust was committed to improving patient care, experience and outcomes. There was participation in audits and research, and learning from deaths and serious incidents was shared.

During our core service inspection and focus group sessions we held, staff from across the organisation spoke with pride about improvements they had made to patient care and experience within their departments.

The trust had focused on addressing concerns we reported in the January 2016 inspection, and we found many improvements had been made to enhance patient care and experience, for example, as part of the needs based care model, the trust had introduced a frailty unit in April 2018. All patients were screened by the frailty team which included nurses and therapists with a view of reducing the length of stay and improving patient experience.

The trust participated in local and national improvement and innovation projects, and worked collaboratively with other providers and national bodies for the benefit of patients, some examples are discussed below.

The trust used the results of the national seven-day services audit to monitor progress on the trust’s delivery and had an executive sponsorship and regular board oversight for the seven-day services project. The delivery of seven-day services across England was a priority for NHS England which resulted in the trust carrying out a survey of the seven-day service provided. The last national audit in September 2017 showed that the trust was delivering Standard 2 - time to first consultant review to 63% of patients. This was a reduction from the March 2017 results of 74% compliance. Compliance rates were variable across the divisions with the biggest challenges within the surgical and maternity and gynaecology divisions.

The reduction in compliance resulted in an action plan to review the acute model and the improvement in documentation. The trust had undertaken a themed analysis to the lessons learnt from the results of the previous surveys and the following themes had emerged:

- Appropriate documentation is not always available to support accurate assessment of compliance with the standards. Feedback has been provided to clinical teams and steps have been put in place to improve documentation.

- Compliance with the 14-hour target for the afternoon admissions. As part of the Needs Based Care Project, job plans are to be aligned to operational needs, it is anticipated this issue will be addressed.

The trust had initiated a ‘needs based care’ model in June 2018, with consultant staff providing dedicated support to the front door of the hospital for all respiratory patients admitted as an
emergency. Staff we spoke with said length of stay had reduced from 20 to nine days. Introducing the needs based care had made a significant improvement to the length of time respiratory patients were staying in hospital, and the feedback from staff and patients has been positive. Needs based care was a model of delivering medical care and was a fundamental part of the medicine divisions strategy for the year. It involved staff from clinical, finance and administration teams. Factors which led to the need for a new model included:

- An in-depth mortality review due to a high HSMR with no indication that it was one team particularly to blame.
- Handover process a contributory factor.
- Multiple and sometimes excessive transfers between wards and teams with every transfer of care increasing risk to patients’ safety.
- Limited continuity of care for patients who were frequent attenders or who had chronic health conditions.

A new mobile app had been created by the trust to give staff better access to the information they needed. The app included news alerts for staff, links to important information, access to e-roster and emails, and major incident alerts.

The human resource department had strengthened the resources in the e-rostering team to support implementation of the rostering of junior medical staff and had appointed an additional resource to provide a focus on consultant job planning.

The trust had invested in the training of pharmacists who were encouraged and supported to become independent prescribers. The deputy chief pharmacist was the first pharmacist to receive a Clinical Doctoral Research Fellowship from the National Institute for Health Research (NIHR). The research completed looked at the development of a prediction tool to help hospital pharmacists identify patients at highest risk of preventable medication related problems.

Doctors saw the benefits of having clinical pharmacists who were able to prescribe and amend prescriptions immediately during ward rounds. Pharmacist prescribers could send discharge prescriptions immediately for dispensing, thereby speeding up the discharge process.

Learning from deaths

The trust’s learning from process was established and effective. There was a learning from deaths board that met monthly. Mortality reports and reports on learning from deaths were provided to the COSQ committee. The mortality board was chaired by a medical director and a variety of staff attended including a NED. However, the notes of the mortality group had limited details for example, no role detailed for staff attending, no action log, limited details of any lessons learnt and the content did not reflect the terms of reference.

Following a death an initial case review was completed by a consultant and a general manager. Each family was contacted to give them an opportunity to raise any concerns about their relative’s care. Inpatient deaths were triangulated with serious incidents (SIs), complaints and inquests. All potential avoidable deaths were reported as SIs and investigated accordingly. We saw evidence that improvements were made where indicated, and learning from deaths was shared with staff trust-wide. For example, during the staff engagement events, at patient safety breakfast meetings and medical staff quarterly half day meetings.

Learning from deaths was reported quarterly to the board through the quality and performance report and was included in the trust quality account. The trust contributed data to the learning disabilities mortality review programme (LeDeR). All learning disability deaths were given a
structured judgement review by the medical director lead for governance. Learning from deaths were discussed at divisional nursing quality and performance monthly meetings to validate data and identify further action required to make any improvements.

The Summary Hospital-level Mortality Rate (SHMR) for the year to February 2018 was 103 and the Hospital-wide Mortality Rate (HSMR) was 102 which was below the national average of 100. Both the SHMR and HSMR figures for the year ending February 2018 continued to be within statistical limits, meaning that any variation from the national average could be just normal statistical fluctuation. The latest Summary Hospital-level Mortality Indicator (SHMI) value, covering the year to September 2017 rose to 107 from 106 for the year ending in June 2017. It remained in the “as expected” range. The SHMI included both deaths in hospital and those that took place in the first 30 days after a patient had been discharged from hospital. The crude mortality rate for a full year remained steady although with significant fluctuations month by month. (Source: Trust Board Papers 25 July 2018).

While the picture for HSMR was overall low, the trust saw a deterioration in 30-day mortality for patients following emergency admission for a fractured neck of femur (NoF) during 2017. The reasons for the deterioration in performance had been explored by the fractured neck of femur committee and were multi-factorial and interventions to reduce time to theatre for patients had been introduced. For example, mornings were protected for NoF trauma surgery lists, the team had extended trauma surgery on Saturdays, a golden patient policy had been introduced and a Hot Week Rota for consultants had improved decision making. (Source: Trust Board Papers 25 July 2018).

As part of the trust’s primary review process, a senior team including medical directors reviewed all deaths and identified anywhere it was felt that deficiencies in medical or nursing care may have contributed to the patients’ death. Consultants then complete the full mortality review (a structured judgement review). The findings from October 2017 to March 2018 revealed the following key learning themes:

- Frequency of observations did not reflect risk of recurrence in a patient following a gastrointestinal bleed.
- Inadequate response to hypotension in a patient with learning difficulties.
- Failure to document a treatment escalation plan for a patient on an end of life pathway
- Delay in commencing non-invasive ventilation would have been avoided with a better plan following initial deterioration and escalation
- Documentation of end of life pathway and prescribing of anticipatory medicines

Complaints process overview

The trust had a clear process in place for dealing with complaints and concerns raised. There was a complaints policy in place, which was in date. Staff we spoke to were aware of the complaints procedure. Posters and leaflets about how to make a complaint were available throughout the trust. The trust’s website also contained information on making a complaint. The chief nurse was the executive lead for managing complaints with support from the Patient Advisory and Liaison Service (PALS) and patient Affairs team. Leaders said there was a positive culture for recording complaints.

Complaints could be made in person, by telephone and in writing by letter or email. All complaints would be acknowledged within three working days. For written complaints a member of the Patient Affairs team would contact the complainant to discuss their concerns and inform them of the
process. Complaints were sent to each divisional lead and divisional manager to investigate and respond. Each division had a divisional complaints' lead who would manage the process of collating all the information within the time lines. A weekly tracker was sent to each division on timelines and each division responded with information on the progress and any reasons for delay in responses.

The trust told us they received more comments and concerns via the PALS rather than formal complaints. Staff told us that most of complaints reported to PALS were due to communication issues from nursing and medical staff. Most of these complaints were resolved and responded to immediately as the PALS team would liaise directly with the departments involved to help find a resolution. Patients could complain through a variety of sources for example verbally, letters, email of visit the PALS. Some complainants would be offered a face to face meeting with the general manager and staff from the specific department to discuss their concerns and gave the trust an opportunity to respond.

All complaints and concerns were recorded on the trust’s electronic risk management system, to enable the identification of common themes and ensure learning was shared in response to complaints received. The trust had a Complaints group which was chaired by the chief nurse and attended by all divisional managers, a NED, patient affairs team and PALs to provide feedback on complaints, actions taken and lessons learnt.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the period from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust response</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?*</td>
<td>Three working days</td>
<td>97.5%</td>
</tr>
<tr>
<td>What is your target for completing a complaint?**</td>
<td>35 working days</td>
<td>55.0%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>-</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>3,717</td>
<td>-</td>
</tr>
</tbody>
</table>

*Responding to defined as initial contact made, not necessarily resolving the issue but more than a confirmation of receipt.

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken.

(Source: Routine Provider Information Request (RPIR) – P60 Complaints process overview tab)

**Number of complaints made to the trust**

The trust received 598 complaints from April 2017 to March 2018. Outpatients received the most complaints, followed by surgery.
<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>148</td>
<td>24.7%</td>
</tr>
<tr>
<td>Surgery</td>
<td>139</td>
<td>23.2%</td>
</tr>
<tr>
<td>Medical care</td>
<td>116</td>
<td>19.4%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>98</td>
<td>16.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>39</td>
<td>6.5%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>18</td>
<td>3.0%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>12</td>
<td>2.0%</td>
</tr>
<tr>
<td>Critical care</td>
<td>9</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>2.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>7</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>598</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The majority of complaints related to patient care (56.9%) followed by appointments and value and behaviours of staff, which both had more than 100 complaints refer to them.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The patient affairs team trialled a new procedure to help improve response rates. Where a complainant had provided a telephone number with their complaint letter, they would be contacted by the patient affairs team to acknowledge their complaint and to ask for any specific questions or queries they may have. Whenever possible, the complaint would be resolved without the need for formal complaint (Source – Trust board 25 July 2018).

The surgical division had a delay in responding to complaints which was due to staff shortages. The process of managing complaints was currently under review by the trust with a proposal to join all resources from each division, the patient affairs team and the PALs team to manage complaints centrally to provide support and improve communication between the teams. Staff we spoke who manage complaints were supportive and positive about this proposal.

We reviewed six complaint responses and found that all complaints had an apology from the trust and information on how the complainant could take their complaint further, if required. We saw that the patients affairs team telephoned some complainant initially to understand the complaint further and reassure the complainant that their concerns were going to be investigated. In appropriate cases, complainants were offered a meeting with staff members. All the responses we saw had addressed all the points that had been raised and were generally sympathetic to the complainant.

However, in two of the complaints investigations reviewed, there were potential missed opportunities for actions to be taken and for lessons to be learnt. For example, one patient complained that they did not receive a letter about a change in appointment for a procedure and arrived several hours earlier than expected, although the patients received an apology we did not see any actions taken to prevent reoccurrence or any lessons learnt from this complaint. We raised this with the trust who would review this complaint.

The chief executive responded directly to all formal complaints received. If the complainant was dissatisfied with the trust’s response, stage two of the complaints process was instigated and the complaint was reviewed. The trust endeavoured to resolve the issues raised by writing a further letter and/or offering a meeting with the relevant clinicians. If the trust’s further efforts to resolve the issues were deemed unsatisfactory by the complainant, they were signposted to the Parliamentary and Health Services Ombudsman (PHSO).
Ombudsman Investigations

From July 2017 to July 2018, six complaints were referred to the Parliamentary Health Service Ombudsman (PHSO). Of these, three were not upheld, one was partially upheld and two complaints were waiting decisions from the PHSO. No recommendations were made from the ombudsman (PHSO).

Compliments

The trust received 3,422 compliments from April 2018 to March 2017, however they were only able to identify core services for 7.4% of them, due to the remaining compliments being manually collated and not recorded on the risk management system. Breakdowns of core services for the assigned compliments, as well as the number of unassigned compliments can be seen in the table below.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total with core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>77</td>
<td>30.4%</td>
</tr>
<tr>
<td>Surgery</td>
<td>64</td>
<td>25.3%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>54</td>
<td>21.3%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>27</td>
<td>10.7%</td>
</tr>
<tr>
<td>Maternity</td>
<td>24</td>
<td>9.5%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>6</td>
<td>2.4%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total with core service</strong></td>
<td><strong>253</strong></td>
<td><strong>7.4%</strong></td>
</tr>
<tr>
<td>Unassigned</td>
<td>3,169</td>
<td>92.6%</td>
</tr>
<tr>
<td><strong>Total compliments</strong></td>
<td><strong>3,422</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

The trust held an initiative as part of the “Experience in Care Week”. General information and information about the PALS was provided for patients and visitors. Patients and visitors were encouraged to complete comments cards and provide verbal feedback. The trust continued to use the comments cards to gather information from visitors as well as patients. Key feedback identified parking and signage as challenges for people coming to the hospital. Signage was an issue taken forward by the hospital redevelopment team.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.
<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
<th>Core service or clinical area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy - 18/1/18</td>
<td>Medical care</td>
</tr>
</tbody>
</table>
| Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189 | Cellular pathology - 19th April 2018  
Chemical biochemistry - 19th April 2018  
Blood gas and blood glucose analysis - 10th June 2014 (every 4 years)  
Haematology - 19th April 2018  
Microbiology - 23rd January 2018 | Medical care |
| Human Tissue Authority                                        | Cellular pathology - 18th February 2017 last inspection assessed every 2 years    | Pathology                     |
| MHRA                                                          | Wholesaler dealers licence (visit on a risk based assessment)                      | Pharmacy                       |
| MHRA                                                          | Blood transfusion - April 2018 and annual                                          | Pathology                     |
| SGS ISO13485 and EU Directive                                 | Sterile services - July 2016 for three years                                       | N/A                           |
| Antenatal Newborn Screening Programme                         | Maternity antenatal, antenatal screening and antenatal pathology - July 2017      | Maternity                     |

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

Medical care (including older people’s care)

Facts and data about this service

Luton and Dunstable University Hospital has 358 medical inpatient beds located across 14 wards:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Speciality or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology diagnostics including respiratory physiology</td>
<td>Cardiology</td>
<td>-</td>
</tr>
<tr>
<td>Catheterisation laboratory</td>
<td>Cardiology</td>
<td>-</td>
</tr>
<tr>
<td>Diabetes centre</td>
<td>Diabetes</td>
<td>-</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Endoscopy</td>
<td>-</td>
</tr>
<tr>
<td>Haematological oncology ward</td>
<td>Haematological oncology</td>
<td>10</td>
</tr>
<tr>
<td>Limbs &amp; orthotics</td>
<td>Orthotics</td>
<td>-</td>
</tr>
<tr>
<td>Ward 3 (medical short stay)</td>
<td>Geriatric medicine</td>
<td>21</td>
</tr>
<tr>
<td>Ward 5</td>
<td>Winter ward</td>
<td>18</td>
</tr>
<tr>
<td>Ward 6 (coronary care unit)</td>
<td>Cardiology</td>
<td>13</td>
</tr>
<tr>
<td>Ward 10</td>
<td>Respiratory medicine</td>
<td>33</td>
</tr>
<tr>
<td>Ward 11</td>
<td>Gastroenterology</td>
<td>33</td>
</tr>
<tr>
<td>Ward 12</td>
<td>Endocrinology</td>
<td>32</td>
</tr>
<tr>
<td>Ward 14</td>
<td>Geriatric medicine</td>
<td>32</td>
</tr>
<tr>
<td>Ward 15</td>
<td>Geriatric medicine</td>
<td>32</td>
</tr>
<tr>
<td>Ward 16</td>
<td>Cardiology</td>
<td>28</td>
</tr>
<tr>
<td>Ward 17</td>
<td>Stroke medicine</td>
<td>31</td>
</tr>
<tr>
<td>Ward 18</td>
<td>Infectious diseases</td>
<td>29</td>
</tr>
<tr>
<td>Ward 19A</td>
<td>Medically fit</td>
<td>18</td>
</tr>
<tr>
<td>Ward 19B</td>
<td>Rehabilitation</td>
<td>28</td>
</tr>
</tbody>
</table>

Medical care services provided at Luton and Dunstable University Hospital include cardiology, gastroenterology, respiratory medicine and stroke services.

As part of its plans to meet future growth in demand, the trust was currently changing its model for medical care from an age-related service to a need based service.

Under this plan, in future all patients regardless of presentation route would be assessed and admitted under the clinical team best suited to meet their needs and expected length of stay.

The hospital’s new frailty unit would ultimately be based within the hot block to support a range of interventions quickly to prevent a long length of stay for this high-risk group of patients. Those patients with speciality or complex needs would be managed by an appropriate physician to meet the needs of the patient.

The needs based care model includes a seven-day consultant cover for all specialities.

The trust has also introduced a “hospital at home” scheme. This allows inpatients to be discharged and continue to receive acute care in their own home. Patients participating in the scheme are visited at home by clinical staff and remain under the hospital consultant, until deemed suitable for discharge back into the community.

(Source: Routine Provider Information Request (RPIR) Sites tab and acute RPIR context acute)
tab; trust website)

The trust had 38,881 medical admissions from March 2017 to February 2018. Emergency admissions accounted for 21,864 (56.2%), 250 (0.6%) were elective, and the remaining 16,767 (43.1%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 15,792
- Geriatric medicine: 6,462
- Gastroenterology: 5,194

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The service did not always provide mandatory training in key skills to all staff.

The trust regularly monitored the number of training places that were available to ensure there was sufficient supply to meet demand. Where additional classroom sessions were required, these were sourced internally through the trust’s subject matter experts, or externally by procuring additional courses.

The medicine division received monthly reports which identified compliance against core mandatory topics reported to the board. Reports were also sent to managers which identified individuals who needed to update their training.

The mandatory training figures for the medicine service showed that both nursing and medical staff had not met the trust target for key skills such as immediate life support, fire safety and infection control. Senior staff confirmed there was a training plan to ensure staff nursing reached the trust requirements and staff spoken with confirmed they had been informed of any training due. We saw training schedules on display within the wards.

All staff received monthly updates regarding their compliance and one-to-one support was available if required. Staff confirmed that mandatory training was covered during their annual appraisals.

Staff could access e-learning and the trust had provided additional computers in the library which were accessible to staff. Staff spoken with confirmed they could use the computers in the library but preferred to complete their training at home due to work constraints.

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for registered nursing staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and handling (theory)</td>
<td>351</td>
<td>422</td>
<td>83.2%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>350</td>
<td>422</td>
<td>82.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control - level 1 and 2</td>
<td>348</td>
<td>422</td>
<td>82.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>346</td>
<td>422</td>
<td>82.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling (practical)</td>
<td>330</td>
<td>409</td>
<td>80.7%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support (ABLS)</td>
<td>325</td>
<td>417</td>
<td>77.9%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support (ILS)</td>
<td>93</td>
<td>307</td>
<td>30.3%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medical care the 80% target was met for five of the seven mandatory training modules for which registered nursing staff were eligible.

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for medical staff in medical care is shown below:
In medical care the 80% target was met not met for any of the five mandatory training modules for which medical staff were eligible. The percentage of medical staff that had completed adult basic life support was particularly low: 20.4%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust provided us with an action plan to address the low compliance figures regarding adult basic life support (ABLS) for medical staff and immediate life support (ILS) for nursing staff.

The resuscitation department had reviewed their ABLS training and developed training requirements across the trust to ensure that the appropriate training levels were allocated.

It was recognised that nursing staff were not collecting their pre-course material resulting in them being removed from the course. To address this, ward managers collected the manuals and distributed them to the appropriate staff. In conjunction with this, the training and development department uploaded the pre-course multi-choice questionnaire on to the trust’s electronic system which staff acknowledged. This process took effect from June 2018 and the service was in the process of evaluating training compliance.

The trust informed us they were continuing with on-going evaluation of both ABLS and ILS training which would include:

- Close monitoring of resuscitation training to be reported monthly to heads of departments as part of statutory training compliance
- “Pop up” sessions to target the lowest ABLS compliance
- The feasibility of weekend courses to be assessed for 2019
- Input from the managers, senior nursing team and medical director to monitor compliance
- Outcomes to be reported quarterly to the resuscitation committee

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Most staff had completed their adult and children’s safeguarding training.

The trust had a policy and procedure in place to safeguard children and vulnerable adults at risk of abuse which had been reviewed and were up to date. Nursing staff showed how they would locate them on the trust’s intranet system. From April 2017 to March 2018, the medical division made 74 adult safeguarding referrals. The main theme identified was poor discharge which included for example; lack of equipment and issues around prescription of medications on discharge letter. The trust created an action plan to address areas of concern identified and we saw that this had been completed and signed off by the board.

Nursing staff were aware of the signs of abuse and told us they would report any concerns to the person in charge of the shift or the ward/unit manager. Senior staff and ward managers confirmed they completed referrals direct to the safeguarding team and the local authority. We looked at 15

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety</td>
<td>106</td>
<td>152</td>
<td>69.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling (theory)</td>
<td>102</td>
<td>152</td>
<td>67.1%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control - level 1 and 2</td>
<td>96</td>
<td>152</td>
<td>63.2%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>84</td>
<td>152</td>
<td>55.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support (ABLS)</td>
<td>31</td>
<td>152</td>
<td>20.4%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>
records which showed that patient’s mental health and safeguarding needs were appropriately assessed, and action taken for onward referral/care where appropriate.

**Safeguarding training completion rates**

The trust set a target of 80% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for registered nursing staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - level 1 and 2</td>
<td>406</td>
<td>422</td>
<td>96.2%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 and 2</td>
<td>381</td>
<td>422</td>
<td>90.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 3 core</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medical care the 80% target was met for two of the three safeguarding training modules for which registered nursing staff were eligible. Only eight registered nurses were eligible for safeguarding children level 3.

The January 2016 inspection found that not all medical staff had the required level of safeguarding adults and children’s training. During this inspection we found that medical staff had achieved the trust target for safeguarding children level three training but continued to be below the trust target for both safeguarding children and adult’s levels one and two.

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - level 3 core</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 1 and 2</td>
<td>103</td>
<td>152</td>
<td>67.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 and 2</td>
<td>98</td>
<td>152</td>
<td>64.5%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medical care the 80% target was met for one of the three safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

PREVENT is one of the arms of the government’s anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. The safeguarding and training teams had introduced Healthwrap 3 training to help staff identify individuals who may support terrorism or become terrorists themselves as part of the Home Office counter-terrorism strategy “Prevent”.

NHS England had classed Luton as a high-risk priority area and required the trust to achieve a target of 85% of trained staff by April 2018. The safeguarding report for January to March 2018 showed:
• Basic prevent awareness training at 81% compliance.
• Healthwrap 3 training at 70% compliance.

The trust had not yet met the required result and this had been included on the trust risk register. The trust was aiming to be compliant by the time it was mandatory. A training plan had been incorporated throughout the medical service to increase compliance which included an online programme for Healthwrap 3. This was confirmed by staff spoken with who said they had undertaken their training.

Staff had good awareness of female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Staff confirmed FGM was included in their induction training.

The adult safeguarding team had attended a training session provided by the Bedfordshire police on trafficking and modern-day slavery. This was incorporated within the level 3 safeguarding programme. Senior staff confirmed they knew of the process to implement the training session which continued to be a work in progress.

A local Woman’s Centre (LAWC) aided the trust in raising awareness on domestic violence and abuse, forced marriage and honour based violence. This was incorporated into the level 3 adult safeguarding training throughout 2018. We saw leaflets available within the wards for both patients and staff. Senior staff said they were looking at having the leaflet available in other languages to support the needs of patients whose first language was not English.

Cleanliness, infection control and hygiene

Whilst the service mostly controlled most infection risks well, some staff did not use appropriate control measures to prevent the spread of infection. We observed both nursing and medical staff not adhering to the trust policy of being “arms bare below the elbow” or appropriate hand hygiene practice. The records showed that medical staff were below the trust target for infection control at 62%. This area was identified as an issue in the last inspection.

The trust had policies in place to manage effective infection control and hygiene processes. Staff demonstrated how they could access the policies on the trust’s electronic system. We observed that policies had been reviewed and were up to date.

Hand sanitising gel was available at the entrance to all clinical areas and was situated by each bed. Lever-operated taps were in place at all hand wash basins, with liquid soap dispensers and paper hand-towel machines nearby. This was in line with health building notes (HBN) 00-09. Personal protective equipment, such as gloves and aprons were available in sufficient quantities.

It was identified during the January 2016 inspection that not all staff adhered to infection control prevention guidance. During this inspection we observed that not all staff were following the trust’s policy regarding compliance with hand washing techniques. This was not in line with the National Institute for Health and Care Excellence (NICE) Quality Statement 61 (Statement 3). We observed some nursing and medical staff moving from one clinical area to another without washing their hands or using the alcohol gel on arrival and departure despite hand hygiene gels being available throughout the wards. This was observed on ward 17, ward 18 and the emergency assessment units. This was brought to the attention of senior staff who confirmed they would include our observation in the daily huddle meeting. Most staff across the medical service knew how to follow the five moments for hand hygiene. The World Health Organisation defines this as they key moments when health-care workers should perform hand hygiene. The correct hand washing technique was displayed on posters by the hand wash basins.
During the inspection, we observed that while most staff followed the trust’s policy regarding being “arms bare below the elbow” not all staff were compliant. This was identified on ward 19a, the endoscopy suite and the emergency assessment units where we saw medical and nursing staff wearing watches and bracelets. This was brought to the attention of senior staff. The trust responded to our concerns with an action plan which included:

- All staff reminded of trust policy regarding “bare below the elbow”. A poster campaign on ward doors, screen saver issued. Reminders completed at ward safety huddles of the need for staff to be bare below the elbow and to adhere to the uniform policy.
- Senior staff have undertaken and will continue to undertake daily checks on compliance with trusts’ dress code and uniform policy.
- Chief Executive reminded staff at the monthly staff briefings on the 20th August and September 2018 and monitoring of compliance of bare below the elbow, glove use and hand hygiene via daily ward rounds is undertaken.

We saw the harm free care dashboard results for June 2018 regarding hand hygiene which was red, amber and green (RAG) rated. For example, 12 wards had achieved from 92% to 100% (green rated), four wards between 81% and 89% (amber rated) while the endoscopy unit had the lowest achievement rate of 48% (red rated). During the inspection we observed three staff on the endoscopy suite wearing jewellery with large stones and watches which was not in line with trust policy.

The national target for MRSA bacteraemia is zero and the trust reported three cases from April 2017 to March 2108. The trust reported nine cases of hospital acquired C. Difficile for the same period. When a bacteraemia was identified the service completed a root cause analysis report to ensure lessons learnt were recognised.

From April 2107 to March 2018 there had been 60 reported cases of MSSA (methicillin sensitive staphylococcus aureus) (a skin infection) bacteraemia. Ten (16%) of these were apportioned to hospital acquired infection. The ICT (infection control team) reviewed the cases to identify any process failures in the management of these patients.

Senior staff said they monitored adherence to infection control through monthly audits. The infection control audit results from April 2107 to March 2018 which was RAG rated showed a compliance rate between 86% and 94%. The results showed that overall the medical division was rated amber.

<table>
<thead>
<tr>
<th>Department</th>
<th>Ward Status</th>
<th>Below 85%</th>
<th>85-94%</th>
<th>95-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 3</td>
<td>94%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward 5</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward 11</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward 12</td>
<td>88%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward 18</td>
<td>88%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward 19a</td>
<td>88%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy</td>
<td>86%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Evidence Source: P78 – Infection control report January to March 2018)

The environment and equipment in the wards were visibly clean and tidy. We saw equipment with dated “I am clean” stickers which enabled staff to instantly recognise when equipment was last cleaned. We observed housekeeping staff completing various tasks throughout the course of the
We saw daily completed cleaning schedules. Patients told us they were happy with the cleanliness of the wards and public areas.

Staff recorded the insertion of urinary catheters within the patients’ medical notes. The details included the date, responsible clinician and type/size of catheter used. The records also identified the monitoring and removal of urinary catheters.

The Department of Health (DoH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. We saw that the processes adapted at Luton and Dunstable Hospital were in line with Department of Health recommendations which meant there was a clear system in place regarding the tagging and numbering of endoscopes and their traceability.

We observed processes in place which ensured that the decontamination of endoscopic equipment was adhered to. The endoscopes were transported directly to a dedicated decontamination area. All scopes had tags on them which included a use by date and time which enabled the scopes to be traceable. Clean endoscopes were placed in sterile trays, transported to a drying unit and then placed in an ultraviolet cupboard and appropriately stored. We saw staff working in the decontamination area wearing appropriate disposable gowns, face shields and hair nets.

Patients with known communicable infections were treated at the end of endoscopy lists to enable additional time for deep cleaning of the environment prior to the next patient. Equipment was quarantined and kept separate to the departments other equipment to reduce any risks of cross infection. Staff said they would liaise with the infection control lead and consultant microbiologist for advice when required.

Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharp bins. We observed these bins were not overfilled and there were risk assessments in place for needle stick injuries. Spill kits were readily available in each of the sluices we visited which allowed staff to safely collect and dispose of bodily fluids including blood and urine.

There were multiple wards with side rooms available for use when patients had a suspected communicable infection. Most of the side rooms had an en-suite facility. Patients with communicable infections were identified with posters on the door requesting that personal protective equipment was used, or to speak to the nurse prior to entering. During the inspection we observed staff supporting families in the use of aprons and gloves.

Deep cleans were arranged following the discharge of patients with an infection. We saw notices in the dirty utility rooms advising staff what type of cleaning to organise when a patient was discharged.

Environment and equipment

The service had suitable premises and systems in place to ensure equipment was well looked after. The clinical engineering department covered the provision of maintenance and report of all medical devices apart from point of care testing and imaging.

We saw the July 2018 water sampling certificates completed by an external company which showed the trust was complaint with no detection of legionella (a collective term used for diseases caused by legionella bacteria) and pseudomonas (a common bacterium found in soil and water which can cause chest and wound infections).
Monthly temperature monitoring had highlighted issues around poor control valves and circulation. Two recent actions have resulted in for example the loss of cold water to a medical block. We saw action plans in place which included the staggered installation of new shower filters across the service for example, Wards 11 and 18 were due to be refurbished mid-August 2018.

Resuscitation “crash” trolleys containing medicines and equipment required in an emergency were accessible. They were safely secured with tamper proof seals. Daily checks were in place to ensure medicines were available and ready for use. We saw that all medicines and equipment were in date with no issues or concerns highlighted.

There was sufficient equipment to maintain safe and effective care such as blood pressure and temperature monitors, commodes and bedpans. During our inspection, we did not see any bariatric equipment in the clinical areas. For example, there were no large size commodes for patients. However, staff told us bariatric equipment was available and could be hired when required for specific patients.

There were processes and procedures in place for tracking equipment used for each patient’s endoscopic investigation, including sterile equipment used for biopsies and details of staff members who operated and decontaminated the equipment. Following use, equipment was decontaminated and stored in appropriate storage cabinets. The endoscopy staff monitored the decontamination system daily and weekly, ensuring that there was sufficient clean equipment to meet the demands of the service.

Assessing and responding to patient risk

Staff did not always assess, monitor and record patients’ safety to ensure they were supported to stay safe.

Patients admitted through the emergency assessment units (EAU), (Wards 1 and 4) were assessed upon arrival by a nurse practitioner and a doctor. This process ensured the completion of the initial assessment in preparation for treatment and consultant review. We observed the service had processes in place to ensure that a consultant reviewed all patients within 12 hours of admission, which was in line with NHS England standards.

All patients were assessed on admission using the malnutrition universal screening tool (MUST). The nursing assessments and care plans booklet states that all patients should be screened within six hours of admission. However, the trust policy states that “nursing and midwifery and medical staff have individual responsibility to ensure nutrition screening is performed: within 24 hours of admission to hospital or to a new clinical area (or as early as their clinical condition permits).”

During the inspection we looked at 29 records and found inconsistencies in the completion of the MUST tool in 15 records. The non-completion of the admission date and time made it difficult to assess whether patients were assessed within trust guidance. This meant that we could not be assured whether patients were assessed within trust guidance or that all patients received their assessment and treatment in a timely manner. The trust responded to our concerns and confirmed a re-audit would take place in August 2018. Further areas for improvement included:

- Nutrition nurses creating a ’10 top tips’ on how to do MUST which were to be distributed to all wards
- Dietitians to undertake MUST training for each ward on a quarterly basis
- Individualised action plans being developed for each ward area following the April 2018 audit
• The emergency assessment units (Wards 1 and 4) to commence MUST assessments on all patients admitted overnight from 15 August 2018.

The trust undertook a MUST audit in April 2018 which was based on 10 beds on each adult ward except ward 32 and the contingency ward. We saw the results of the audit were addressed in the nursing sister’s meeting of June 2018.

<table>
<thead>
<tr>
<th>MUST audit April 2018</th>
<th>April 2018</th>
<th>August 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has MUST screening been done within 24 hours of admission</td>
<td>47%</td>
<td>40%</td>
</tr>
<tr>
<td>Is there evidence of appropriate nutrition care plan for</td>
<td>39%</td>
<td>---</td>
</tr>
<tr>
<td>Medium/High risk?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the patient has been in hospital &gt;seven days has MUST</td>
<td>48%</td>
<td>27%</td>
</tr>
<tr>
<td>been repeated weekly?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evidence Source: DR21 sister meeting June 2018 re MUST audit**

During our inspection we saw some of these actions underway. For example, Ward 12 had created their own spreadsheet to monitor compliance with the MUST tool. Senior staff confirmed this was a new format and continued to be a work in progress. We saw that the completion of MUST records had been highlighted as an agenda item on the May 2018 clinical governance meeting. The trust’s Ambassador magazine had an article called “let’s do MUST better” in their August 2018 issue.

We also found that within the nursing assessment and care plans booklet there was no area within the mobilisation (adult moving and handling) assessment to include the admission date or time which meant that we could not be assured that patients were being appropriately assessed within six hours of admission and review every seven days or if the patient’s condition changed.

Our observations were reported back to the nurse in charge of the wards and the trust. Nursing staff informed us the nursing assessment documentation was being reviewed to improve compliance and was in the process of being ratified.

During the inspection, we identified ligature points within the discharge area on Ward 1 (emergency assessment unit), which was brought to the attention of the nurse in charge and the trust. A ligature point is a place to which patient’s intent on self-harm might tie something to harm themselves. Items and areas identified included ceiling grills, drip stands (on wheelchairs), trolleys with bed rails and hand sanitisers. We also observed examination rooms adjacent to the discharge being left open and unattended with access to plastic bags, needles, syringes and tourniquets. During the revisit on 20 August 2018 we saw the trust had removed the partition which enabled staff to have visibility of the discharge area. We observed workmen blocking off pipes to reduce the ligature risk and the matron confirmed they would be working with their mental health colleagues to create a risk assessment for the area. The examination rooms, when not occupied with patients, remained locked. During our revisit we saw that one was occupied with a patient while the other remained locked. Nursing staff confirmed that drawers had been emptied and identified items removed. All staff spoken with were aware of the identified procedures and confirmed that the rooms remained locked when not in use.

The level of patient falls was monitored by the service. Since 2015 the trust has seen a reduction of 58% in falls with harm. The medicine wards’ harm free care dashboard from April to June 2018 showed a total of 187 falls across the medical service of which 34 had a diagnosis of dementia. Because of incidents and complaints regarding falls, the trust had introduced the enhanced observation care management strategy named “Baywatch.” Baywatch reviewed the enhanced
care and observation required for individual patients identified from completed risk assessments. The risk assessments enabled matrons to identify areas of concern daily and review the patient’s individual behaviours and risks to facilitate staff allocation across the division.

Baywatch was designed to provide uninterrupted monitoring of vulnerable patients in a dedicated area, 24 hours a day. The bay was identified by using a ‘lollipop stand’ outside the bay. A maximum of four patients in a bay could be identified as requiring enhanced observation. Staff were expected to remain in the bay until a replacement had been allocated which ensured continuous visual contact with the patient(s) identified as being at risk. We observed staff were clearly identifiable to colleagues and visitors through the wearing of an orange Baywatch lanyard.

![Number of Falls and Harms levels whilst under Baywatch](chart.png)

**Evidence Source: DR129 Falls incidences following introduction of Baywatch**

Across the trust there had been a reduction of 68% in hospital acquired pressure ulcer incidences. However, the medical service informed us the pressure ulcer rate was currently showing an upward trend which resulted in the setting up of a share and learn forum to support learning from incidents. Staff spoken with reported it to be very beneficial. The following pressure ulcers were reported in the harm free care dashboard for June 2018:

- Three grade three (Wards 12, 18 and 19b)
- Eight grade two (Wards 10, 11, 12, 15, 16 and 17)

Patients identified as being at risk of pressure ulcers were provided with alternating pressure relieving mattresses, which was in line with the Royal College of Nursing Management of Pressure Ulcer guidance. Nursing staff reported having access to specialist equipment to meet individual patient needs when required.

The medical service had access to the tissue viability team (TVT) which adopted an integrated approach to wound care management. All incidences of hospital acquired pressure ulcers were subject to a root cause analysis (RCA) with learning being shared through the TV champions and divisional governance forums.

The first SSKIN (surface, skin inspection, keep your patient moving, incontinence/moisture and nutrition/hydration) champions and TV team meeting was held in May 2018. SSKIN is a five-step approach to preventing and treating pressure ulcers. The meeting focussed on the barriers that
prevent staff giving the care the patients need. We saw the action plan with identified areas for improvement which had a completion date of December 2018 with full implementation by March 2019. Key areas of focus were: effective documentation, an increased focus on nutrition and the impact of manual handling on skin damage, the need for robust assessment and care planning and increasing awareness of how patients and carers can help to make a difference.

The inspection of January 2016 found that not all venous thromboembolism (VTE) (a blood clot) assessments were completed in accordance with trust policy. During this inspection we found that VTE initial assessments were completed appropriately on admission in accordance with NICE guidance (CG92). The trust audited the percentage of patients having a VTE assessment and reported on these. Senior staff informed us that compliance with the completion of VTE assessments had improved with the introduction of the electronic prescribing and medicines administration (ePMA) system. Records showed that most medical wards had achieved 100% for their VTE risk assessment compliance with the other medical wards achieving between 97% and 99%.

The trust had introduced a “Stop the clot” campaign to raise awareness on the risks of hospital associated thrombosis. This had resulted in an audit compliance rate of 99% (May 2018) for VTE which was above both the national and trust target of 95%.

To deal with sepsis, a life-threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs, the trust had appointed a sepsis lead to effectively steer the sepsis programme. This programme was in conjunction with the divisional medical and nursing leads for sepsis. The medicine service participated in the sepsis and acute kidney injury steering group which was chaired by clinicians. The meeting minutes for June 2018 stated that 98% of appropriate patients were screened for sepsis and a collaborative had been set up to improve the timeliness of treatment which was currently 78%.

The national early warning score (NEWS) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: ‘Acutely ill adults in hospital: recognising and responding to deterioration’ (2007). Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate and the monitoring of a patient’s clinical condition. There were clear directions for actions to take when patients’ scores increased, indicating a deterioration and members of staff spoken with were aware of these. We reviewed 29 patients’ records and found NEWS was recorded appropriately on the electronic system. The electronic system was a mobile clinical system that monitored and analysed patients’ vital signs providing clinicians with accurate, real-time information.

Medical staff informed us that they did not assess patients deemed as “stable” and “fit for discharge” at weekends. However, the records showed that patients had received a daily weekday review which was also confirmed by the patients spoken with.

During our visit to Ward 11 (gastroenterology) we saw that the day room was being used for inpatient beds. However, the day room did not have any suction of oxygen available. Drug trollies stored in the adjoining room could only be accessed through the day room which could pose an infection control risk. We saw this was included on the risk register and the ward had implemented actions to mitigate the risk which included:

- All patients to be risk assessed prior to being placed in the day room
- Ensure patients at risk or have an infection are not placed in the day room
- Only the most stable patients to be admitted to the day room
Staff spoken with were aware of the procedures to complete prior to placing a patient in the day room.

The medicine service had processes in place for urgent percutaneous coronary intervention (PCI) (a procedure to improve the blood flow from the arteries of the heart to the heart muscle) should the machinery fail. We saw there were emergency arrangements in place with local hospitals in the event of an occurrence. The catheter laboratory staff said they could change their lists at short notice when required.

New patients requiring non-invasive ventilation (NIV) (a system that supports the patient’s breathing without the need for intubation or a tracheostomy), were managed in the high dependence unit (HDU). New patients were supervised by the respiratory physiologist who managed the patient risk until they were either transferred to HDU, or became stable. Ward 10 (respiratory) only admitted patients already stabilised at home and who could bring in their own NIV equipment.

Patients presenting with confusion were screened for their cognitive function using the mini mental state examination. This examination was not used to make a diagnosis but could be an indicator in the presence of cognitive impairment, such as a patient with a suspected dementia or following a head injury. Patients presenting with “acute confusion/delirium were screened using a confusion assessment method assessment which was available for use in the medical admission proforma.

Behavioural charts were used to record patient behaviours and formed part of an overall assessment. Behaviour monitoring charts were in use for those patients presenting with increased confusion or behavioural and psychological symptoms in dementia. These had been recently introduced to the trust following a cross sustainability and transformation plan (STP). Senior staff informed us they were letting the process embed before undertaking a formal evaluation or audit. On-going monitoring was being undertaken by the matrons through the trust’s electronic incident reporting system which was confirmed during the inspection. Staff spoken with had good awareness of the behaviour charts and we saw these in use throughout the service.

The diabetic service had implemented a foot screening tool. This included an initial triage to identify the presence for example of ulcers or cellulitis (a bacterial skin infection) an examination of the foot as well as a risk assessment. We saw staff had been given a small mirror to examine patient’s feet during their stay on the ward. Staff confirmed they found the tool useful and made it easier to examine the patient’s feet.

The wards had processes and procedures in place, which gave a complete overview of a patient’s health needs including their mental health. Records seen identified when referrals had been made to the mental health services.

We observed a handover between day and night services on Ward 4 (emergency assessment unit 2) and Ward 17 and found it was structured and methodical. This occurred in a private room away from patients to maintain confidentiality. Staff discussed outstanding tasks, those patients requiring further review and those at risk of deterioration. This included information about patients with high fall risks, infection control risks and those with do not attempt resuscitation (DNACPR) orders in place. We noted staff identified patients with special support needs, for example, dementia and patients who were on time specific medicines.

**Nurse staffing**

The service had nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
There were systems and processes in place to assess, plan and review staffing levels, including staff skill mix. A staffing tool was used to calculate the number of nurses and health care assistants required for each shift based on the acuity (level of care a patient requires) and needs of the patients. The staffing tool was in line with NICE staffing guidance.

The trust reported their registered nursing staff numbers as below as of March 2017 and March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Luton and Dunstable University Hospital</td>
<td>334.1</td>
<td>409.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 26.3% for registered nursing staff in medical care. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 17.9% for registered nursing staff in medical care. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 3.8% for registered nursing staff in medical care. This was higher than the trust target of 3.25%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 38.4% for qualified nursing staff in medical care.

This was made up of 23.9% bank staff and 14.5% agency staff.

Over the same period 9.7% of shifts were not filled by bank or agency staff to cover staff vacancies, sickness and absence.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Senior staff confirmed they maintained a focus on recruitment and retention activities across the medical service. They confirmed the trust was participating in the ‘NHS Improvement nursing retention initiative’ which aimed to support trusts to identify innovative ways to improve their retention rates. Staff said they continued to attend local schools, university job fairs, jobcentre careers days and academy events to promote the diversity that the NHS could offer in careers.

The planned levels of staff and the actual levels were displayed on each ward/unit and updated daily. We reviewed these during the inspection and discussed the staffing levels with the nurses in charge. During the inspection, although required staffing levels did not always meet the actual staffing levels, we saw the nurse in charge had re-structured the ward to ensure staffing levels met the needs of the patients. For example, we saw this in place during the inspection whereby a
nurse from another ward was allocated to support staff on the emergency assessment unit. Staff confirmed that if they had concerns about staffing levels, they would escalate this to senior management for their review. Staff also said that they could ring the matron who would put procedures in place to ensure they received the appropriate support.

Matrons were responsible when assessing daily staffing requirements to include information from the risk assessments/behavioural charts. These determined the ideal levels of observation required. Requests for additional staff were made usually 24 hours in advance to the staff bank to cover the gaps. There were occasions when these requests remained unfilled and subsequently the nurse in charge of the ward would review the risks and reduce it to its lowest level possible with the resources available both within the ward, the division and if necessary from across the other divisions.

New agency staff had an induction checklist completed to ensure they were familiar with the ward layout and processes. We saw completed folders on the wards visited. Most agency staff spoken with had worked on the wards previously and confirmed they had received a comprehensive induction and felt they had sufficient support from nursing staff. They said staff answered questions and provided guidance when required.

Medical staffing

The service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.

The trust reported their medical staffing numbers as below as of March 2017 and March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Luton and Dunstable University Hospital</td>
<td>136.5</td>
<td>157.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 30.2% for medical staff in medical care. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 15.1% for medical staff in medical care. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 0.8% for medical staff in medical care. This was lower than the trust target of 3.25%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
The trust was unable to provide the numbers of shifts worked by medical locum and agency staff over the most recent year as requested in the Routine Provider Information Request (RPIR). Instead they supplied the sums of money spent on temporary medical staffing in each area, and these have been used to calculate temporary staffing rates for medical staff in each core service area.

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 41.4% of total spending on medical staff in medical care. This was made up of 20.4% on bank medical staff and 21.0% on agency medical staff.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

As of December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 161-whole time equivalent (WTE) staff working at Luton and Dunstable University Hospital NHS Foundation Trust

### Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>26%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Daily safety huddles and board rounds were embedded into practice across the medicine service to improve handovers of care. We observed two doctor’s board which included a brief review of each case, the formulation of a management plan and possible discharge arrangements. We observed there was some focal teaching relevant to each case for example, unusual echo cardiogram interpretation and action to be taken for less commonly used drugs. We noted there was good rapport between professionals.

The emergency assessment units (Wards 1 and 4) had a seven-day service with patients seen on arrival by an admissions nurse and within four hours by a senior clinician. Dedicated doctors were on site from 8am until 8pm with a reduced service at weekends. Outside of these hours, all shifts were filled using the on-call rota.

Ward 10 (respiratory) had two consultants who conducted daily board rounds Monday to Friday. There was an on-call service at weekends with no consultant rounds.
On Ward 3 (medical short stay) they had a consultant for the week who worked Monday to Friday. Each day the consultant would see all new patients, as well as those previously reviewed patients who presented with concerns. The registrar would see the remaining patients. However, on alternative days the consultant would see all patients including those not seen the previous day. At weekends, the on-call system was in place.

Records

Staff kept appropriate records of patients’ care and treatment. However, records were not always stored securely and we witnessed an unattended computer screen showing a patient personal details.

We reviewed 29 sets of nursing and medical records and found these to be in good order. Patient records were found in three different locations which included; the trust’s electronic system, an electronic system for patients’ vital signs and a paper based record located at the end of patient’s beds.

The trust audited the medical records of a range of specialties each year and there was a schedule of planned medical records audit across the medicine service for 2018/19 as part of the clinical audit forward plans. As at July 2018 these were either in progress or yet to start.

The July 2017 record audit showed a compliance rate of 87% (49/56) for the recording of clinical standards (green), 11% (6/56) were amber with moderate compliance and 2% (1/56) had low compliance (red). A total of 40 cases (75%) were selected across the medical service of which five were from elderly medicine, cardiology, acute medicine, general medicine, respiratory and stroke, three from diabetology and seven from gastroenterology.

Nursing and medical paper records for inpatients were not stored securely in locked trolleys. During our visit, we saw some patient records left on various surfaces such as counter tops. We also witnessed an unattended computer display screen showing patient personal details which could be accessed by unauthorised personnel. We raised this concern with the ward managers during the inspection who confirmed they would address the matter at their next safety huddle.

The medical service completed monthly harm free care dashboard audits which reviewed the content of the nursing records. Areas reviewed included; the number of falls, pressure ulcer incidences and medication errors. For example, the June 2018 audit showed an overall score of 95%. However, it was noted that the harm free care audit did not include the completion of the nursing assessments and care plans booklet’s contents which included for example, the MUST nutritional assessment, the pressure ulcer risk assessment chart, the mobilisation (adult moving and handling) assessment and their related care plans. We found that nursing care plans were standardised and it was difficult to find information about specific aspects of a patient’s care. It was also unclear if the patient had been involved in their care plans to ensure they received the care that was appropriate to them.

The records included details of a patient’s admission, risk assessments, pre-assessment forms and treatment plans. However, not all records reviewed had the date and time of admission recorded which meant that we could not verify if assessments were timely completed. Records were legible, and the entries signed with the designation of the person making the entry identified.

Nurses and allied health professionals contributed to information in patients’ medical records and medical staff completed a review of the patient at least daily. The records also identified the input from the multi-disciplinary team such as therapists and dietitians.

Daily care records such as the NEWS scores were stored on an electronic system. We looked at a sample of the electronic records and found these were up to date and completed appropriately.
Intentional care rounding was completed by healthcare assistants (HCAs) on the medical wards. Intentional care rounding is a structured process with staff carrying out regular checks with individual patients at set intervals. For example, we observed HCAs visiting patients to check that call bells and drinks were within reach and asked if the patient was comfortable or in any pain. We saw these were documented in the patients’ records reviewed.

There were processes in place when patients moved between teams, services and organisation, which included referral, discharge, transfer and transition. We saw all the information needed for their ongoing care was shared appropriately.

**Medicines**

Staff prescribed, gave, and recorded medicines well. Patients received the right medication at the right dose at the right time. High ambient temperatures at the time of the inspection meant that some medicines were not kept at the recommended temperature. There were inconsistencies in the escalation of clinical room and fridge temperatures when this exceeded accepted guidance levels.

Since the last inspection of January 2016, the trust had implemented an electronic prescribing and medicines administration (ePMA) system across all inpatient clinical areas. This system was used to support and improve medicine safety.

There was a clinical pharmacist available Monday to Friday, 9am to 5pm. The wards had access to the out of hours pharmacy and inpatient pharmacist seven days a week, 8am to 8pm. Pharmacy topped up medicine stock once a week and an order could be placed via ward pharmacist for non-stock items.

Medicines were supplied by the onsite trust pharmacy. Staff ordered, dispensed and disposed of medicines safely and securely. Arrangements were in place to facilitate medicine supplies out of hours. This meant that staff could access medicine supplies throughout the day and out of hours. Medicines and equipment for use in emergencies were ready and accessible to staff and were checked regularly. The trust had employed a system that provided assurance that blood glucose testing kits were calibrated before use.

Medicines were stored securely in locked cabinets and fridges within locked clinical treatment rooms. Only relevant clinical staff could access them. Medicines used for internal use and external use were stored separately. Medicine storage rooms had suitable preparation facilities for all types of medicines for example; controlled drugs and antibiotics. Controlled drugs (CDs) are medicines such as morphine which are controlled under the misuse of drugs legislation. We saw all CDs were checked daily by two nurses in accordance with guidance. All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff. The pharmacy team undertook quarterly audits with any identified issues fed back directly to each ward for learning and improvement.

Medical wards had a hypoglycaemia (low sugar) box, which they could us in an emergency. This included a flow chart, glucose sweets and a nutritional drink high in calories. We saw the “hypo” box audit undertaken by the diabetes team for March 2018. Non-compliant wards were revisited in April 2018. A total of 27 wards were visited which included medical wards and the emergency assessment units. Findings showed that 17 of the 27 wards visited were compliant on replenishing and checking the expiry dates. We saw the action plan which included for example:

- The diabetes team undertaking random checks for issues and compliance for a period of three months
• An annual hypoglycaemic box audit to be undertaken to include staff’s understanding of the hypoglycaemia management algorithm

During the inspection we found inconsistencies across the medical service in the completion of the hypoglycaemia box checklist to ensure items were within date. For example, we did not find a checklist in place on Ward 12 (endocrinology and diabetes ward) and items missing on Ward 15. This was brought to the attention of the nurse in charge who said that they would address this with the matron and staff.

Staff understood the importance of monitoring the fridge and room temperatures daily and we saw evidence of guidance to manage both fridge and clinical room temperatures when they were not within recommended ranges which included reporting to the pharmacy team. For example, we saw clinical room temperatures above the recommended levels on Wards 12, 14 and 17 and no action had been taken. This meant that we were not assured that the trust had robust systems in place to monitor fridge temperatures consistently. This was brought to the attention of the trust who provided us an action plan which included:

• The standard operating procedure for ward temperature monitoring was updated and circulated to all wards (including flow chart of actions needed).

• All wards checked to ensure that the printed flyer was on display and attached to temperature monitoring folders.

• Monthly pharmacy checks of temperature monitoring have been instigated with training needs (for ward staff) identified

During our revisit on 20 August 2018 we observed printed flyers on display across the medical service and found improvement with no concerns in the recording of medicines on the emergency assessment units (Wards 1 and 4) and Ward 15. However, during our revisit to Ward 3 we saw the clinical room temperature was at 29.8°C and the fridge temperature at 12.6°C. We found no evidence of these having been escalated to the pharmacy for advice. We also observed the previous week temperature was above 25°C with no evidence of any escalation of concerns. This was brought to the attention of the nurse in charge.

Pharmacists or pharmacy technicians visited the wards daily and provided advice in the use of and management of medicines across the wards. Pharmacists attended ward rounds, conducted medicines reconciliation, and any medicines related activity. Medicine reconciliation is the process of ensuring that the list of medicines a person is taking is correct. Medicines reconciliation completed within 24 hours was low. In the March 2018 audit, 31% of patients received a medicines reconciliation within 24 hours with 80% of these medicine reconciliations undertaken within the admission area. We saw this figure had reduced considerably in May, June and July 2018. Reasons for low compliance included staffing pressure due to high medical vacancies with the two prescribing pharmacists often pulled into “to take away” (TTA) prescribing which limited other activities. For example, on Ward 15 we saw that three of the 10 patients’ medicines reconciliation had not been completed in the first 24 hours of admission.

<table>
<thead>
<tr>
<th>Pharmacy reconciliation</th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
<th>July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients receiving medicines reconciliation across directorate</td>
<td>34%</td>
<td>15%</td>
<td>16%</td>
<td>17%</td>
</tr>
</tbody>
</table>

_Evidence Source: DR174 Pharmacy reconciliation_
The trust target was that 80% of all TTA medicines are completed within two hours. These targets had been continually breached over the last 12 months. There was a quality improvement project underway to review and improve processes and look at ways to maximise the benefit to dispensary from the introduction of the electronic prescribing and medicines administration (ePMA). Ward staff said they were looking at pre-empting discharges, especially at weekends, to support the pharmacy staff regarding the availability of TTAs. Pharmacy staff confirmed they worked closely with the ward staff regarding TTA prescriptions.

Pharmacy intervention audits were carried out three monthly which looked at antibiotics, anticoagulants and controlled drugs with feedback to the individual directorates. The service had introduced the ePMA to address some of the common themes that were identified such as missed doses and the safer prescribing of oral anticoagulant drugs. Staff said they liked the ePMA system and felt it had improved patient safety and reduced the possibility of prescribing errors such as poor handwriting or ambiguous terminology.

We saw the medication safety review group meeting minutes for January, February and March 2018. Areas identified included: administration errors, missed dose monitoring and a review of medication related incidents. For example, the minutes identified that throughout 2017 there had been a total of 192 administration errors with the top three being: wrong drug (36), wrong frequency (29) and wrong dose (26). Antibiotics (42) and opioids (31) were the most prevalent drugs involved with wrong frequency (10) and wrong dose (7) being the most common errors. We saw the related action plan which included the anticipated outcome and the current progress and comments. We noted that all actions continued to be a work in progress and that the action plan was reviewed monthly and updated as required.

We checked a sample of 10 ePMA records across the medical wards/services visited and saw they were completed fully with no missing administrations. For example, all known allergies or sensitivities to medicines were recorded on the medicine records seen. This information is important to prevent the potential of a medicine being given in error and causing harm. However, we saw that the ePMA system did not alert staff if medicines were administered at incorrect intervals or when patients were on time specific medicines. We observed this information was shared during handover meetings to the appropriate staff. We saw insulin and fluid charts were kept on paper charts and referenced to the ePMA system to prompt staff. This was brought to the attention of staff and the trust who responded with an action plan. These included:

- Memo circulated to all ePMA live areas informing ward staff to review the ‘Admin Chart’ on ePMA before prescribing or administering any medication on ePMA.
- Testing being undertaken on potential functionality change that may prompt nursing staff for late or early administrations
- Lead pharmacist and nurse for ePMA attended medication safety review group to discuss issue.

When drugs were being administered we saw the use of the red tabard system which advised staff and visitors not to disturb staff. The aim of the procedure is to improve the effectiveness of a drug round and reduce incidence of medication errors. However, during our visit we saw staff interrupting staff during the administration of the drug round which meant there was a risk of staff becoming distracted and providing patients with the incorrect medicine.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the
wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The trust had recently reconfigured its incident process to ensure the system was accurate and provided meaningful data to support quality improvements.

The trust reported to the National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports. Data provided by the trust showed that the median time of reporting had improved from 32 days to nine days demonstrating the effectiveness of improved reporting processes.

The trust reported all serious incidents (SI) to the strategic executive information system (STEIS). Serious incidents or suspected serious incidents must be declared internally as soon as the healthcare provider becomes aware of the incident. Evidence provided by the trust showed that all SIs referenced for medicine were uploaded within the two working days of identification.

Most staff recognised incidents and reported them appropriately. The trust used an electronic incident reporting system and staff we spoke with knew how to report incidents. Most staff understood their responsibilities to raise concerns and report incidents. The service had several methods to ensure lessons were shared and disseminated the learning from incidents. Examples included:

- Newsletters for example, quarterly quality and patient safety and medication safety
- Ward safety huddles
- Use of patient stories in training

Medical services had a monthly share and learning forum which was attended by consultants, registrars, junior doctors, senior nurses and the patient safety team. We saw the minutes of the July 2018 meetings where quality issues, such as serious incidents, audits and lessons learned were discussed. The forum cascaded through the patient safety newsletter and updated patient information leaflets as required. For example, we saw updated leaflets regarding the consequences of refusing prophylaxis (treatment given or action taken to prevent disease) which was in line with NICE guidelines.

Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff told us there was good communication about incidents through the safety huddles and discussion at ward meetings. Managers said they fed back to staff information from the quality improvement programme meetings about incidents and learning from them.

Serious incidents were investigated following NHS guidance and learning was identified and communicated to staff. Actions were identified for the speciality and for the directorate. For example, because of identified pressure ulcer incidents the service had adopted the “React to Red Skin” programme. React to red skin is a pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them.

There had been 4,578 incidents reported against the medicine division from July 2017 to June 2018. The top five categories were; falls (787), pressure ulcers (784), moisture lesions (600), medication/drug incident (341) and accidents and injuries (275). As of the end of June 2018 the medicine service had 425 open incidents of which 279 were overdue. Senior staff said they were aware of the overdue incidents and confirmed they worked with the clinical leads to reduce the shortfall.
From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person.

Duty of candour compliance was managed and monitored through the trust’s electronic incident reporting system. Incidents reported with a level of harm of ‘moderate’, ‘severe’, or death were highlighted as being subject to duty of candour.

The medicine division had a nominated individual with responsibility for monitoring and leading on duty of candour compliance. They supported the clinical teams to establish whether the criteria for the legal duty was met, assisted with the drafting of letters and liaised with the patient or their relevant other as appropriate. Nursing and medical staff spoken with understood their responsibilities regarding the duty of candour legislation and would discuss any identified concerns with the patient and provide a full apology.

Quarterly mortality forums identified contributing factors and themes for improvement. Senior staff confirmed they shared the minutes to increase awareness, reduce variability and share areas of best practice through team meetings. We saw meeting minutes were available for staff to review and read. The trust had embedded policies and processes to support duty of candour and for staff to raise concerns.

Since 2015 the mortality rates have improved and there had been a reduction in the hospital standardised mortality ratio (HSMR) by 8%. The trust had a robust mortality review process using the Department of Health structured judgement review documentation. This included for example an evaluation of all cardiac arrests with associated work streams. The work streams reviewed the timeliness of vital sign observations, escalation of concerns, medical response times, action taken to prevent further deterioration and the appropriateness of treatment escalation plans (TEP). A TEP is a process for planning the care of a patient at risk of deteriorating.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported no incidents classified as never events in medical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type was as follows:

- Sub-optimal care of the deteriorating patient: three
- VTE meeting SI criteria: two
- Diagnostic incident including delay (including failure to act on test results): one

The time taken by the trust to report these six SIs to STEIS was variable:
• 15 to 30 days: two
• 31 to 60 days: two
• 90 days or more: two

Two of these SIs were reported within 30 days, two took the trust from 31 to 60 days to report and two took the trust more than 90 days to report.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 26 new pressure ulcers, 11 falls with harm and 14 new urinary tract infections in patients with a catheter from May 2017 to May 2018 in medical care.

We saw data on display on information boards across the medical service. These included for example, the number of falls, pressure ulcers and complaints as well as feedback from patients.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Luton and Dunstable University Hospital NHS Foundation Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter
Safety Alerts

Senior staff confirmed they were provided with updates from the risk team regarding any safety alerts which they responded to accordingly.

The risk team maintained oversight of safety alerts. They received alerts from the central alerting system (CAS) and managed and monitored them through an internal tracker and the CAS website. An example of this in the last year was for NHS/PSA/W/2018/001 (Oxygen Cylinders) as the trust had previously investigated a patient death as a serious incident when the cylinder valve had not been switched on.

An audit, completed in April 2018, to determine nursing staff knowledge in relation to the use of portable oxygen cylinders showed that 93% (75/81) could explain how to switch on an oxygen cylinder and 81% (61/75) could explain how they would ensure the valve was switched to the “on” position when probed. The respiratory team and medical gas committee continued to manage this work.

The estates compliance report for April 2018 showed that fire-fighting equipment was up to date which included the servicing of extinguishers and hydrants. Senior staff informed us that work had commenced on updating the fire alarm system. This was due to be completed in October 2018 and was being phased in conjunction with other refurbishment work across the hospital.

Nursing staff told us there had been a change to the mandatory fire training. Senior staff confirmed that training would be mandatory for all staff on a bi annual basis and must include a face to face session every other time. The year in between all staff must complete and record an evacuation walkthrough for their respected area of work.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and had evidence of its effectiveness. Managers assessed staff compliance with guidance and identified areas for improvement.

A wide range of policies and guidelines were available for staff. They were based on national guidance and provided references to these. Updates on new policies were communicated via e-mails and a list was circulated to each speciality.

The trust’s clinical quality department ensured that each released guidance update from organisation such as the National Institute for Health and Care Excellence (NICE) was allocated to the appropriate clinical lead who completed a declaration form regarding compliance. We saw NICE folders on the wards visited which included guidance on for example: NG51 Sepsis: recognition, diagnosis and early management.

The service was compliant with NICE guidance CG 50 Acute Illness, Recognising and Responding to the deteriorating patient in all clinical areas. Medical wards had an electronic observation system in operation which used the National Early Warning Scoring (NEWS) system. The rehabilitation wards used colour banded charts which were based on the early warning scoring system.

We saw evidence that patients’ needs were assessed and treatment delivered in line with legislation, standards and evidence-based guidance. For example, the endoscopy service followed NICE professional guidance for endoscopic procedures and the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) procedures.

Endoscopy services used the American Society of Anaesthesiologists (ASA) grades as a guide regarding a patients’ fitness to undergo an anaesthetic. This was in line with NICE guidance. The ASA physical status classification system is a simple scale describing fitness to undergo an anaesthetic. For example, ASA1 or ASA2 are relatively low risk patients. ASA3 patients have a higher risk of complications during anaesthesia due to other comorbidities they may have.

The trust had implemented a sepsis improvement plan for 2018/19. This included the execution of sepsis screening tools which provided clear management strategies for patients who trigger for sepsis. These had been re-designed to align with the requirements for NICE and the Commissioning for Quality and Innovation (CQUIN) for 2017/19. CQUIN is a framework which supports improvements in the quality of services and the creation of new, improved patterns of care. Ward 17 (stroke) were trialling the introduction of a visual prompt/red card to be given to the nurse to indicate a patient had been diagnosed with sepsis and needed to receive an antibiotic within one hour. We saw this in use during the inspection.

Staff told us they used a range of integrated care pathways and protocols to standardise practice and improve outcomes for patients. These included a urinary catheter pathway, guidance on the prevention of venous thrombo-embolism (blood clots often referred to as VTE), and dementia/delirium pathway.

There were processes in place to manage and protect the rights of people subject to the Mental Health Act 1983 (MHA). Senior staff understood the holding powers under the MHA section 5(2) doctors’ holding power and section 5(4) nurse’s holding power. They could contact the psychiatric liaison team for additional support or guidance.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required.

Patient’s nutrition and hydration needs were assessed using the malnutrition universal screening tool (MUST). This was in line with NICE guidance QS15 Statement 10: “Physical and psychological needs” 2012). During our inspection, we observed MUST assessments were not consistently completed across the medical service.

We saw completed fluid balance charts to monitor patients’ fluid intake with referrals to dietitians following for example, concerns about the amount patients were eating or their weight.

Patients had jugs of water within reach on their bedside tables. We observed these to be regularly refilled. Intravenous fluids were also prescribed and recorded appropriately.

The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required.

Pain relief

The service managed patients’ pain effectively and provided or offered pain relief regularly.

Pain was risk assessed and recorded using the National Early Warning Score (NEWS) scale and we saw these were completed. We observed staff asking patients if they were in any pain. Staff had access to tools to help assess the level of pain in patients who were non-verbal.

The service met the core standards for pain management services (Faculty of Pain Medicine, 2015). We saw that patients with acute pain had an individualised pain management plan appropriate to their condition. Pain was assessed during observations and recorded on NEWS charts. The service had access to the pain management team for advice when required.

Most patients were provided with pain relief in a timely manner. Patients we spoke with said they were asked if they were in any pain usually during interactions with staff. We observed staff discussing pain during handovers and concerns were referred to the consultant.

Staff said that when choosing pain relief for their patients they started with common medicines, moving to more powerful medicines. Commonly used painkillers were prescribed routinely, but if these were not effective, they could ask the pain team for advice and additional medicines be prescribed to ensure patients were pain free and comfortable.

Patient outcomes

The service monitored the effectiveness of care and treatment and consistently used the findings to improve performance. However, some of the processes for patients were variable and we saw action plans in place to manage these across the service for example; the stroke and diabetic service.

Information about the outcomes of patient’s care and treatment, both physical and mental were routinely collected and monitored. This was done through both local and national audits. Examples included the national lung cancer audit, the stroke audit and national diabetes inpatient audit. There was variable performance in many national audits relating to patient safety and treatment. We saw the specialties discussed audit results as part of their local governance and where necessary had action plans to address any developments.
The infection control report from January to March 2018 identified that the central line care bundle had remained at or above 96% in eight of the 12 months from April 2017 to March 2018.

The endoscopy service had maintained its Joint Advisory Group Gastroenterology Society (JAG) accreditation (October 2017). The accreditation was based on the results of audits which were founded on JAG’s quality and safety in endoscopy global rating scale (GRS) (British Society of Gastroenterology Quality and safety indicators for endoscopy, 2009). The GRS audit is divided into four areas which are: clinical quality, patient experience, workforce and training.

The JAG report highlighted recommendations within its report. We saw an action plan to address the areas identified which included for example; improvement with patient waiting time. The updated action of August 2018 showed that:

- The addition of a fourth procedure room had generated additional capacity to work through previous backlogs
- Flow mapping exercises of the endoscopy service was currently in progress
- Additional booking staff had been recruited to maximise list utilisation
- Access policy had been revised to ensure lists were validated

A turnaround lead had completed work to improve the pathways within endoscopy. The pathway focussed on optimising patient and carer experience of the endoscopy procedure from decision to admit for investigation to communication of results and agreed management plan. We saw that administrative, nursing and medical staff worked together and alongside patients to put them at the centre of their clinical journey.

The endoscopy unit had adapted the World Health Organisation (WHO) surgical safety checklist. This was used for every patient undergoing an endoscopy procedure. The tool encouraged dialogue within multidisciplinary teams to minimize harm to patients. The checklist was made up of three components; the sign in which included confirmation by the patient of their identity, site of surgery and consent; the time out which included confirmation by the staff team of any identified concerns and thirdly time out which includes details of the procedure, recorded and that all instruments used have been accounted for. We saw evidence of the WHO checklist in use during the inspection with no issues identified.

We saw the endoscopy service had made improvement in the monthly WHO checklist compliance figures from May to July 2018.

**WHO checklist compliance 2018**

<table>
<thead>
<tr>
<th>Month 2108</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>53%</td>
</tr>
<tr>
<td>June</td>
<td>63%</td>
</tr>
<tr>
<td>July</td>
<td>81%</td>
</tr>
</tbody>
</table>

*Evidence Source: DR155 WHO Endoscopy audit and action plan*

The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. The SHMI had remained in the “as expected” range from the inception of the mortality indicator. From June 2016 to the latest value in September 2017 the SHMI has remained in a narrow range of between 1.06 and 1.09 against the England figure of 1.0.
The trust’s Hospital Standardised Mortality Ratio (HSMR) performance had improved patient outcomes through work streams within the mortality board. These had contributed to a reduction in the rolling HSMR from 108.9 at the end of January 2017 to 101.7 as of January 2018. This was slightly higher than the England figure of 100.

We saw the results of the September 2017 to May 2018 audits of the psychological track and trigger system relating to the completion of the National Early Warning System (NEWS). This was completed monthly based on 10 sets of patient health care record. Areas reviewed included; the frequency of the observation and the action taken if the patient was deteriorating. Medical wards ranged from 95% (Ward 19a) to 100% (Ward 15 (elderly care) and ward 3 (medical short stay). The other medical wards averaged 98%.

The trust undertook a monthly Patient Led Assessment of the Care Environment (PLACE) audit at which trust representatives and members of the trust governors participated. Areas audited included the cleanliness of the ward, patient’s food and privacy, condition and appearance and how the trust managed patients with dementia and disability. We saw the PLACE result for June 2018.

### Results of PLACE audit for June 2018

<table>
<thead>
<tr>
<th>Ward</th>
<th>Cleanliness</th>
<th>Privacy</th>
<th>Condition and appearance</th>
<th>Dementia</th>
<th>Disability</th>
<th>Food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 1</td>
<td>97%</td>
<td>54%</td>
<td>100%</td>
<td>63%</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Ward 3</td>
<td>94%</td>
<td>73%</td>
<td>84%</td>
<td>62%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Ward 11</td>
<td>93%</td>
<td>54%</td>
<td>82%</td>
<td>68%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Ward 14</td>
<td>96%</td>
<td>80%</td>
<td>91%</td>
<td>91%</td>
<td>100%</td>
<td>78%</td>
</tr>
</tbody>
</table>

**Evidence Source: DR91 PLACE audit**

The trust participated in the Commissioning for Quality and Innovation (CQUIN) national goals. The aim of the CQUIN framework is to improve the quality of services and provide better outcomes for patients. The board minutes for April 2018 identified that for quarter four (January to March 2018) submission for the 2017/18 CQUIN had been completed in line with the deadline. Results showed the trust had achieved the following CQUINs for the year 2017/18.

- Healthy food and drink for staff, visitors and patients
- Clinical review of antibiotic prescriptions including the reduction in consumption of antibiotics.

**Relative risk of readmission**

**Luton and Dunstable University Hospital – elective admissions**

From February 2017 to January 2018, patients at Luton and Dunstable University Hospital had a similar expected risk of readmission for elective medical admissions compared to the England average.

- Patients in medical oncology and gastroenterology had similar to expected risks of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
Luton and Dunstable University Hospital – non-elective admissions

Over the same period, patients at Luton and Dunstable University Hospital had a similar expected risk of readmission for elective medical admissions compared to the England average.

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine and gastroenterology had higher than expected risks of readmission for non-elective admissions

Non-Elective Admissions - Luton and Dunstable University Hospital

Over the same period, patients at Luton and Dunstable University Hospital had a similar expected risk of readmission for elective medical admissions compared to the England average.

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine and gastroenterology had higher than expected risks of readmission for non-elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics (HES) - Readmissions (01/02/2017 - 31/01/2018))
The trust’s performance is shown in the tables below.

### Overall Scores

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-Mar 17</th>
<th>Apr 17-Jul 17</th>
<th>Aug 17-Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
</tbody>
</table>

### Patient centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-Mar 17</th>
<th>Apr 17-Jul 17</th>
<th>Aug 17-Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>E</td>
<td>B↑↑↑↑↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
<td>C</td>
<td>D↑</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
<td>C</td>
<td>D↑</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
<td>C↑</td>
<td>B↑</td>
<td>B</td>
</tr>
</tbody>
</table>

### Team centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-Mar 17</th>
<th>Apr 17-Jul 17</th>
<th>Aug 17-Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>E</td>
<td>B↑↑↑↑↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>C</td>
<td>C↑</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>E</td>
<td>E</td>
<td>C↑↑↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>A↑</td>
</tr>
</tbody>
</table>

Source: Royal College of Physicians London, SSNAP audit)
Performance against the one hour to thrombolysis pathway deteriorated during January to March 2018 (Q4 of the 2017/18 financial year). Thrombolysis is where a clot busting drug is administered to a stroke patient who is deemed would benefit from receiving the drug. A review group was convened to examine the underlying causes of the decline in performance while ensuring that appropriate remedial actions were taken. During the review it was confirmed there had been eight one-hour breaches in January 2018, six in February 2018 and seven breaches in March 2018. This represented an achievement of less than 30% for the quarter, compared to previous quarters where average performance had been around 60%.

The June 2018 report for the clinical outcomes, safety and quality (COSQ) committee reported on the stroke thrombolysis performance. The action plan identified a positive impact on thrombolysis as highlighted in the graph below.

Evidence source: DR3 - clinical outcomes, safety and quality committee stroke thrombolysis performance report June 2018

**Heart Failure Audit**

In-hospital Care Scores

Results for Luton and Dunstable University Hospital NHS Foundation Trust in the 2015/16 Heart Failure Audit were worse than the England and Wales averages for three of the four standards relating to in-hospital care. To address the results an action plan was presented to the medicine governance meeting November 2017.
Discharge Scores

The trust scored better than the England and Wales averages for six of the nine standards relating to discharge. The trust scored similar to the England and Wales average for one standard, and worse than the England and Wales average for two standards.

![Discharge Scores](chart.png)

Discharge Scores

We saw the action plan from the national heart failure audit which showed that the trust had achieved all outcomes and were waiting for the results of the national audit analysis for 2016/17 to assess achievement. For example, the 2015/16 audit identified that only 14% of patients were admitted under cardiology and 27% seen by a cardiologist which was significantly lower than the national average. To manage this shortfall the unit had increased capacity to the cardiology unit from a 22-bedded cardiology unit to 30 beds.

From January to June 2018 the cardiac arrest rate had shown a downward trajectory. The average rate was 0.83 which was a reduction on last year which was 1.1 in the same period. Staff
confirmed there was a comprehensive approach to monitoring deteriorating patients and acting promptly to prevent further deterioration. In addition, where appropriate, a treatment escalation plan was implemented in accordance with each patient's needs and wishes. We saw this in place during the inspection.
Cardiac arrest performance from July 2016 to June 2018

(Evidence source: DR152 quality performance report)

National Diabetes Inpatient Audit 2017

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year. Quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The audit, published March 2018, identified 115 in-patients with diabetes at Luton and Dunstable University Hospital in 2017. The hospital was in quartile 4 (the highest 25% of hospitals) in terms of diabetes prevalence amongst inpatients. The proportion of the trust’s inpatients that had diabetes was 20.6% compared to the England average of 17.5%. Of the inpatients identified as having diabetes, 5.7% had type 1 diabetes and 30.2% had type 2 diabetes treated with insulin. The remaining 64.1% had diabetes that was managed without insulin.

Of the 115 in-patients with diabetes, 83.1% reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital. The result placed this site in quartile 2 (the second-to-worst quartile of hospitals) and compared to the overall England result of 83.4%. This was an improvement from the hospital's performance in the 2016 audit, when its satisfaction rate was 78.8% (this had placed the trust in quartile 1, the worst quartile of hospitals).

The hospital was in the best 25% of hospitals for one of the metrics in the audit:

- The percentage of patients reporting that staff were, or to some extent, able to answer their questions was 91.4% compared to the England average of 79.3%. This was an improvement from 2016, when 81.8% of the trust’s inpatients answered yes to this question.

The hospital was in the worst 25% of hospitals for nine metrics:

- The percentage of emergency admissions was 95.6% compared to the England average of 87.0%.
- 42.9% of patients received a foot risk assessment within 24 hours of admission compared to the England average of 64.9. This was a deterioration from 2016, when all the trust’s patients included in the audit received a foot risk assessment within 24 hours.
• 57.1% of patients received a foot risk assessment during their stay compared to the England average of 74.5%.

• 10.0% of patients received an insulin infusion compared to the England average of 8.3%. However, none of this use was found to be inappropriate, compared to the England average of 6.3%.

• 22.2% of patients experienced a glucose management error compared to the England average of 18.5%.

• 24.4% of patients experienced an insulin error compared to the England average of 18.6%.

• 21.1% of patients experienced a mild hypoglycaemic episode compared to the England average of 16.7%.

• 52.3% of patients reported that timing of meals was suitable, compared to the England average of 62.6%.

• 72.1% of patients reported that all or most staff caring for them were aware that they had diabetes compared to the England average of 81.9%.

There were another three metrics where it was not possible to calculate quartiles due to the high proportion of trusts that returned a result of zero. The trust’s result was zero for all three metrics:

• Average dietitian hours per week per patient. The England average was 0.09 hours (five minutes).

• Average podiatrist hours per week per patient. The England average was 0.16 hours (10 minutes).

• Average diabetes specialist pharmacist hours per patient. The England average was 0.07 hours (four minutes).

(Source: NHS Digital)

We saw the action plan based on the findings of the NaDIA audit. We saw the risks identified and the actions taken. Most actions had an achievement date of March 2019. We saw processes in place which included the examination of patient’s feet when attending the service especially if they had not been recognised as having been reviewed within the last 12 months on the trust’s electronic system.

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 3.1% of patients with non-ST-elevation myocardial infarction (nSTEMI) were admitted to a cardiac unit or ward at Luton and Dunstable University Hospital, compared to the England average of 55.8%. In addition, 99.5% were seen by a cardiologist compared to the England average of 96.2%.

The proportion of nSTEMI patients who had an angiography at this hospital was 87.4% compared to the England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research)
Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit.

The crude proportion of patients seen by a cancer nurse specialist was 66.5%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 63.8%.

The case-mix adjusted proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.4%. This was within the expected range compared to other hospitals. In 2016 the trust’s performance for this metric was not significantly different from the national level.

The proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 50.5%. This was within the expected range compared to other hospitals. The trust’s performance in the equivalent measure from the 2016 audit was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer receiving chemotherapy was 73.5%. This was within the expected range compared to other hospitals. In 2016 the trust’s performance for this metric was not significantly different from the national level.

The case-mix adjusted one-year relative survival rate for the trust in 2017 was 29.3%. This was within the expected range compared to other hospitals. In 2016 the trust’s performance for this metric was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

At Luton and Dunstable University Hospital the crude proportion of patients who had a vision assessment (if applicable) was 76%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 32%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 43%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 79%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

We saw the national audit of dementia spotlight on delirium assessment 2018 which looked at the assessment of delirium in patients. The results showed the trust was below the national average in all three questions asked. During the inspection we saw processes in place to review patients who may have a diagnosis of delirium. Staff discussed patient’s condition during the daily handover and board rounds.
Nursing assessment for National Delirium Audit 2018

<table>
<thead>
<tr>
<th>Question asked</th>
<th>National audit spotlight 2017: % Number/Denominator (Median/Inter Quartile Range (IQR))</th>
<th>Luton and Dunstable hospital Spotlight 2017 % Number/Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a nursing plan for delirium/ pathway for delirium in the notes? (yes/no)</td>
<td>20 %  434 / 2228  (10%, 0% - 29%)</td>
<td>10%  2/20</td>
</tr>
<tr>
<td>Was the patient assessed for constipation as a possible cause of delirium at or within 24 hours of admission? (yes/no)</td>
<td>41 %  917 / 2228  (37%, 19% - 60%)</td>
<td>25%  5/20</td>
</tr>
<tr>
<td>Was the patient assessed for pain as a possible cause of delirium, at or within 24 hours of admission? (yes/no)</td>
<td>53 %  1175 / 2228  (58%, 25% - 80%)</td>
<td>40%  8/20</td>
</tr>
</tbody>
</table>

Evidence Source: DR81 National Audit of Delirium 2018

Competent staff

The service made sure staff were competent for their roles. Most staff had been appraised to review staff’s work performance and held supervision meetings with them, when required, to provide support and monitor the effectiveness of the service.

However, there had not been any improvement in attendance at conflict resolution training identified as a concern in the January 2016 inspection, this meant that staff may not have the necessary skills to deal with patients who displayed challenging behaviour.

Nursing and medical staff we observed and spoke with had the skills and experience to deliver effective care and treatment to patients. Nursing staff and healthcare assistants (HCAs) described ways in which they managed and cared for patients living with dementia or a learning disability.

Work was underway to map all competencies onto the trust’s electronic system so staff could check their own compliance. This continued to be overseen by managers.

To ensure staff were kept up to date with current legislation they completed a statutory training programme which all staff were required to attend. Attendance was monitored at divisional level. Staff spoken with during the inspection confirmed they had completed their statutory training.

Nursing staff had received training to support their role. For example, training on how to care for patients with a central line (a long thin tube inserted into a vein in the chest), the insertion of a cannula (the insertion of a plastic tube into a vein to allow direct administration of fluids and medicines) and the monitoring of blood glucose levels which included knowledge of hyperglycaemia (high blood sugar level) and hypoglycaemia (low blood sugar level).

Staff told us they received a comprehensive induction when they commenced work at the trust. This included a trust wide induction and local induction. The local induction included orientation to the area and local competencies. Staff told us they found the induction helpful. The trust wide induction included areas such as information governance, infection prevention and control and fire safety.
Staff were informed of contractual and statutory duty of candour requirements as part of the hospital induction training. Clinical staff were updated annually as part of the statutory and mandatory training programme. Ad-hoc training courses were provided to clinical staff needing to participate in duty of candour discussions and written correspondence as required.

We saw completed induction checklists for each agency staff on the wards visited which included an orientation to the area and local competencies.

The acute kidney injury (AKI) steering group (May 2018) had identified a shortfall in the training of doctors in the recognition of AKI. We saw AKI was included in the e-learning training programme for all new junior doctors who arrived in August 2108 as part of their induction. This meant that the trust had plans and processes in place to ensure junior doctors had the competency to recognise and manage AKI.

The inspection of January 2016 found that many nursing staff had not received their conflict resolution training. During this inspection we saw the compliance figures for the end of March 2018 ranged from 54% to 70%. This meant that there had been little improvement since January 2016 and staff may not have the necessary skills to deal with patients who displayed challenging behaviour. Conflict resolution is a process where staff attempt to resolve a situation through for example, effective communication, negotiation or mediation.

**Conflict resolution training figures (July 2018)**

<table>
<thead>
<tr>
<th></th>
<th>Number of staff requiring training</th>
<th>Number of staff who had received training</th>
<th>% Conflict resolution training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medicine</td>
<td>124</td>
<td>67</td>
<td>54%</td>
</tr>
<tr>
<td>Medical inpatients</td>
<td>500</td>
<td>308</td>
<td>62%</td>
</tr>
<tr>
<td>Medical specialities</td>
<td>224</td>
<td>157</td>
<td>70%</td>
</tr>
</tbody>
</table>

*Evidence Source: DR150 Conflict Resolution – Medicine*

Senior staff confirmed that they recognised that compliance with conflict resolution training required improvement and actions had been implemented which included:

- Additional classes for staff with specific sessions for those working in high-risk areas
- Senior managers were in the process of booking staff onto training courses

We spoke with five nursing students who were happy with the training opportunities provided within the medical services. Student nurses had a qualified nurse mentor who worked alongside the students to ensure essential skills were learnt and safety was maintained. Nursing students had skills booklets and competencies to be achieved in each area.

The psychiatric liaison team, the leads for dementia and learning disability provided support for staff working with these patients. The learning disability and dementia leads provided awareness training to staff working in the hospital.

**Appraisal rates**

From June 2017 to May 2018, 77.8% of staff within medical care at the trust received an appraisal compared to a trust target of 90%.

The breakdown by staff group is shown in the table below. Please note that the trust was unable to provide separate appraisal completion data for registered nursing staff. In the trust’s appraisals data these staff are included in the staff group “nursing and ward based staff”.

<table>
<thead>
<tr>
<th></th>
<th>Number of staff</th>
<th>Number of staff who had received training</th>
<th>% Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medicine Central</td>
<td>124</td>
<td>67</td>
<td>77.8%</td>
</tr>
<tr>
<td>Medical inpatients</td>
<td>500</td>
<td>308</td>
<td>77.8%</td>
</tr>
<tr>
<td>Medical specialities</td>
<td>224</td>
<td>157</td>
<td>77.8%</td>
</tr>
</tbody>
</table>

*Please note that the trust was unable to provide separate appraisal completion data for registered nursing staff. In the trust’s appraisals data these staff are included in the staff group “nursing and ward based staff”.*
As well as registered nursing staff, this group also includes healthcare assistants, health care support workers, modern matrons and nurse managers, dental medical care assistants and play specialists.

<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>58</td>
<td>67</td>
<td>86.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>101</td>
<td>128</td>
<td>78.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing/ward based staff</td>
<td>332</td>
<td>436</td>
<td>76.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>491</td>
<td>631</td>
<td>77.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The staff survey undertaken from September to December 2017 identified that in the staff survey only 53% felt that an appraisal helped them feel valued, which was 27% less than elsewhere across the trust. However, staff spoken with confirmed they had received an appraisal and found they could discuss their progress, learning objectives as well as the opportunity for additional training needs. They stated they found their appraisal to be very helpful and they could discuss any concerns with their matron or manager.

Trainee doctors were provided with a named clinical supervisor as outlined in the foundation programme reference guide and standards for trainers outlined in the General Medical Council publication “The Trainee Doctor.”

Trainee doctors received supervision from senior medical staff which included for example, training, sign-posted training opportunities and work based assessments. Trainee doctors were provided with feedback during ward rounds and the completion of procedures.

All junior medical staff were allocated an educational supervisor whose role was to support, guide and monitor the progress of a named trainee. They were also responsible for discussing the learning opportunities available and the development of a personal plan.

Doctors confirmed they were supported to complete their revalidation with the General Medical Council. The trust offered 360° feedback to support their revalidation.

Nursing staff were required to demonstrate that they were fit to practise under the “code, professional standards of practice and behaviour for nurses and midwives.” Staff confirmed the trust had supported them to complete their revalidation in line with their registration requirements.

Multidisciplinary working

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Effective multidisciplinary team (MDT) working practices were established and teams worked well together to improve the effectiveness and timeliness of care. Relevant staff teams and services were involved in assessing, planning and delivering patient’s care and treatment and worked
together to understand and meet the range and complexity of patient’s needs. We observed patient care on medical wards was supported by a variety of teams. This included pharmacists, a pain management team and physiotherapists.

Clinical staff said that Schwartz rounds were valued within the organisation and recognised the opportunities for non-service-specific MDT reflection and support. Schwartz rounds provide a structured forum where all staff, clinical and non-clinical come together regularly to discuss the emotional and social aspects of working in healthcare. However, most nursing staff spoken with were unaware of the Schwartz rounds and said they had not participated in any.

Multidisciplinary ward and board rounds were well embedded on the medical wards which supported an effective handover between medical and nursing teams.

Care pathways were multi-disciplinary and staff of all disciplines developed and supported each other in the planning and delivering of patient care. Each professional group recorded their assessments in patient’s medical notes and it was therefore easy to access information about the outcome of the valuation and the ongoing care of the patients from each professional’s perspective.

The pharmacy worked well with staff on the medical wards and provided the following services; medicines reconciliation, an assessment of the patient’s own drugs and drug history gathering, the prescribing of discharge medicines to facilitate speedier discharge while providing discharge counselling and advice when required.

We observed good integration between the vulnerable adult’s specialist nurse, safeguarding lead nurse and the dementia nurse specialist who provided support and advice when required. We saw good examples of staff supporting patients with a learning disability to ensure they received parity of care. Staff liaised with patients, their community and the specialist learning disability nurses at the hospital.

**Seven-day services**

**The medical service was working towards a seven-day service.**

The delivery of seven-day services across England was a priority for NHS England which resulted in the trust carrying out a survey of the seven-day service provided. The last National audit in September 2017 showed that the trust was delivering Standard 2 - time to first consultant review to 63% of patients. This was a reduction from the March 2017 results of 74% compliance.

The reduction in compliance resulted in an action plan to review the acute model and the improvement in documentation. We found no issues or concerns within the records seen which identified patients being seen in a timely manner by consultants.

The seven-day survey within the medicine division showed the following results:

<table>
<thead>
<tr>
<th>Admitting speciality</th>
<th>Weekday</th>
<th>Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within 14 hours</td>
<td>Outside of 14 hours</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>25</td>
<td>7</td>
</tr>
</tbody>
</table>
General ward patients should be reviewed by a consultant-delivered ward round at least once every 24 hours, unless it had been determined that this would not affect the patient’s care pathway. The results for January 2018 showed 77% compliance during weekdays and 46% compliance at weekends.

Pharmacy offered a dispensary service from 9am to 5:30pm Monday to Friday and 9am to 5:15pm over the weekend and bank holidays. The pharmacy also offered a satellite dispensary service 10am to 4pm Monday to Friday.

The on-call pharmacist offered an emergency out of hours service Monday to Friday from 9am to 5:30pm. They also provided an out of hours service from 5:30pm Monday to Friday.

All cardiology patients received a 365-day echo cardiogram service and seven-day consultant cover which included Ward 16 and the coronary care unit. This meant that all new patients and those with complex conditions received a consultant review seven day a week including weekends. Other patients were seen if requested by the on-call senior house officer.

The emergency assessment units EAU) (Wards 1 and 4) provided 24-hour cover seven days a week. The EAU service are acute units where they assessed patients for emergency medical problems.

Therapy staff worked across the service Monday to Friday 8am to 4pm. This included two qualified physiotherapists, three therapy technicians, two occupational therapists. Handover for the weekend was via a paper copy and a file on the shared electronic system. The service provided one technician on Saturday from 8am to 4pm, and one assistant on Sunday for five hours.

Health promotion

Staff supported patients to manage their own health, care and well-being and to maximise their independence following endoscopic surgery and as appropriate for individuals.

Staff identified patients who may need extra support. We saw health promotion information and materials on display on the wards. Examples included; eating a healthy diet, moderating alcohol intake, increasing physical activity and smoking cessation.

The trust was engaged in the CQUIN to reduce risky behaviours and offered advice to all smokers and those with lower levels of risk associated alcohol consumption. The trust had been working in collaboration with colleagues from public health and providers of support organisations to ensure a smooth referral process was set up and staff made the appropriate referrals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always understand their roles and responsibilities under the Mental Health Act (MHA) 1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We found inconsistencies in the completion of patient records who were under the MCA or DoLS.

The trust had recently approved a new consent policy in June 2018. We saw the policy had been developed in conjunction with Department of Health guidance and the current legislation regarding consent; The Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 Part 3, Section 2-11, Need for Consent. As the policy had only been recently published the
trust was unable to provide us with a consent audit. They informed us that an audit of compliance was not scheduled until late 2018.

Consent within the inpatient records were scanned onto the trust’s electronic digital health record as they used a paper based recording system. During the inspection we found no issues or concerns within the records seen.

Consent to care and treatment was obtained in line with legislation and guidance, including the MCA. Staff understood their responsibilities and the procedures in place to obtain consent from patients prior to undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed authorised forms for treatment and exploratory investigation during the inspection. We observed that consent had been obtained for all patients prior to their surgical procedure.

Medical and nursing staff we spoke with explained the consent procedures and what to do if a person lacked capacity to consent for care and treatment. They outlined the principles of the MCA and the implications for their practice. They spoke about how they supported patients to make decisions and knew of the role of independent mental capacity advocates (IMCAs). However, we found inconsistencies in the 11 records reviewed regarding the involvement of an independent mental capacity advocate (IMCA). Five records had made the correct application, five did not have evidence of the involvement of an IMCA and another had details of an IMCA but this was not dated or signed. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who can represent the person.

We saw the last mental capacity act (MCA) audit from August to October 2016 (published February 2017). No further audits had been completed and the trust informed us the next MCA audit was due to commence in September 2018. The result of the audit was based on 41 records and 37 staff survey forms. The records audit found that 38/41 of clinical records reviewed evidenced the need for a mental capacity assessment to be completed. Of the 38 cases, 28 were completed and of those, only nine were completed fully. The key areas identified within this part of the audit were:

- Missing signatures.
- No evidence that a best interest decision was made as the section had no documentation or was incomplete.
- No evidence to support staff’s attempted various means of communication during the assessment period.
- Consent form four was completed in place of a mental capacity form.

During the inspection we looked at 22 patient records of those under the MCA or DoLS and found eight had been completed fully. Our findings for the remaining 14 were:

- Five records identified with no consultation with relatives
- Seven records not fully completed or signed
- No evidence of section 132 (patient rights) for two patients under the Mental Health Act (MHA).

Our results reflected the outcome of the MCA audit from August to October 2016 showing there continued to be inconsistencies in the completion of patient records who are under the MCA or
DoLS. This meant that we were not assured of staff knowledge in supporting patients who may be subject to a MCA or DoLS application. We raised this with the trust and communication has been sent to all staff to remind them to complete the forms fully and daily audits on compliance were being carried out.

Mental Capacity and Deprivation of Liberty training completion

The adult safeguarding team provided training which included the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). During the inspection we observed staff demonstrating awareness of DoLS which was reflected in the records seen.

Staff said that mental health training was not included during staff induction. The psychiatric liaison service conducted mental health training three times annually but said they did not have capacity to extend this. Nursing staff confirmed they had received their MCA and DoLS training alongside dementia and learning disability awareness training. We saw this was reflected in the training records seen. Staff also had access to further information and guidance on the trust intranet.

The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) levels 1 and 2 training was completed by 83.2% of staff in medical care compared to the trust target of 80%. This included 90.3% of registered nursing staff and 64.5% of medical staff. Therefore the 80% target was not met for medical staff in medical care.

Deprivation of Liberty Safeguards training is covered under the trust’s Safeguarding Adults Level 1 and 2 and Safeguarding Adults Level 3 training modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

As part of the agreement the local mental health team provided bespoke training to staff and specific training to hospital managers who were involved in the detention management process.

Patients we spoke with told us they were given all the information they needed to decide about the treatment being provided. They said medical staff had fully explained their treatment and additional information could be provided if required.

Senior staff informed us they worked closely with the local mental health provider to support the management of patients detained under the Mental Health Act (MHA). A service level agreement covering MHA management in respect of all patients detained in the hospitals regardless of the area of residence had been agreed. This agreement ensured that every detained patient had an identified responsible clinician and that all aspects of record keeping in relation to the detention was appropriate with notification to relevant individuals and bodies.

The deprivation of liberty safeguards (DoLS) protect people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff spoken with showed good awareness of the action plan and the processes and procedures required should a patient require a Deprivation of Liberty Safeguards (DoLS) referral.

The trust completed a safeguarding audit from March 2018 to May 2018 which identified staff knowledge relating to DoLS. A total of 63 staff took part consisting of medical staff and band five, six and seven nursing staff. The results identified that staff knew how to access, support, advice and provide guidance on DoLS. However, the report identified lack of evidence regarding informing the patient, their next of kin, family or advocate regarding an application for DoLS. The
audit also acknowledged staff’s lack of awareness that an advocate should be considered on a DoLS application when a patient had no next of kin or representative. During the inspection we looked at 15 records and found no issues or concerns with the records seen.

Staff said that elective patients with a learning disability or those living with dementia would be involved in a pre-operative meeting with the carer or family member to ensure there was a plan in place for their admission. Staff said that carers or family members were encouraged to stay with the patient and operating lists would be adjusted to suit patient needs.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. Patients praised staff for their kindness and their understanding of their needs.

Staff promoted privacy, and patients were treated with dignity and respect. We observed staff spending time with patients, and interacted with them during tasks and clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.

Feedback from patients confirmed that staff treated them very well and with kindness. Staff respected patients’ privacy and dignity during procedures on the endoscopy unit. For example, the endoscopy unit had introduced “dignity pants” for inpatients and those patients undertaking certain procedures. We observed staff maintaining patient’s dignity prior to their endoscopic procedures.

We saw the respect and dignity audit for 2016/17 which was based on 118 patients. The results showed that 100% of patients were satisfied with their experience regarding respect and dignity and 99% confirmed they had been treated as an individual and with dignity. However, 29% of patients felt that information about them was shared inappropriately for example, in a way that could be overheard or overseen. During the inspection we observed some ward handovers for example; the emergency assessment units (Wards 1 and 4) being completed at the end of patient’s bed which highlighted the patient’s condition and treatment. There was a potential for this information to be overheard by other patients. This was brought to the attention of senior staff who said they were looking at having their meetings in a room away from the wards to maintain patient confidentiality.

The trust participated in the National Cancer Patient Experience Survey 2016, published July 2017, of which 268 patients were sent the survey and 257 (96%) were completed. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of nine. Ninety seven percent (299 patients) said they had been given the name of the clinical nurse specialist and 92% (159 patients) said they had all the information needed about chemotherapy treatment which was above the national average of 90% and 84% respectively.

Friends and Family test performance

From May 2017 to April 2018 the Friends and Family Test (FFT) response rate for medical care at the trust was 24%. This was based on 6,326 responses. This was similar to the England average of 25%.

A breakdown of FFT performance by ward for medical wards at this hospital with total responses over 100 for the period from May 2017 to April 2018 is shown below. All the wards scored 90% or above for the 12-month period overall.

The lowest monthly scores were for wards 12, 14, 17 and 18.
Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(\textit{Source: NHS England Friends and Family Test})

\textbf{Emotional support}

Staff provided emotional support to patients to minimise their distress.

Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, “staff are really helpful and I can ask them anything.” Patients also said that staff were approachable and provided moral support when required.

Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care across the services and ensured that the delivery of spiritual, pastoral and religious care was adequate and appropriate. The chaplaincy liaised with communities to ensure they accommodated patients of other faiths where required.

Staff understood the emotional stress of patients having an aesthetic prior to an endoscopic procedure. We observed staff being supportive and reassuring patients before their anaesthetic to minimise their anxiety and stress. Post-operative care within the recovery area was sympathetic and staff did everything they could to ensure patients were comfortable and free from any pain.

Nursing staff showed an awareness of the impact that a patient’s care, treatment or condition could have on their well-being and those close to them. Patients were given information about relevant counselling services and peer support groups where applicable.

\textbf{Clinical nurse specialists were available for advice and support in several specialties including stroke services, cancer services and for heart failure patients.}

\textbf{Understanding and involvement of patients and those close to them}

Staff involved patients and those close to them in decisions about their care and treatment.

Patients said they felt involved in their care and had been asked for permission and agreement first which meant that the views and preferences of patients were considered. Patients and relatives had been given the opportunity to speak with the consultant looking after them. Patients said the doctors had explained their diagnosis and that they were fully aware of what was
happening. Most patients were very complimentary about the way they had been treated by staff.
We observed most staff introduced themselves to patients, and explained to patients and their relatives about the care and treatment options. We observed doctors on the emergency admission units sitting down to talk with patients so that they were on an equal level. Patients said this made them more at ease and did not feel doctors were “looking down on them.”

Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. Staff said that they had systems in place to identify the communication needs of patients. This included access to language interpreters, specialist advice or advocates. This meant the service was compliant with the Accessible Information Standards (2015). These standards direct and define a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

Staff used the “this is me” passport, which outlined the communication needs of patients, communication aids such as symbols were available to ensure patients could understand and be involved in their care and treatment.

We saw staff greeting patients by their first name and patients calling nursing staff by their first.

Staff took time to explain information to patients in an appropriate manner while making sure patients knew how to contact them if they needed more information.

We saw gift packs had been introduced onto some medical wards which provided essential toiletries for emergency patients.
Is the service responsive?

Service delivery to meet the needs of local people

The medicine service planned and provided services in a way that met the needs of local people.

The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. Services were planned in a way which ensured flexibility and choice. For example, the endoscopy service offered weekend appointments for patients who were unable to attend on a weekday.

The trust had specialist stroke nurses who assisted with the management of patients admitted to the hospital with suspected strokes or transient ischaemic attack (a mini stroke).

The trust screened all patients over 75 years and this information was held on their electronic system. There was also an identification butterfly symbol in use for patients with a known diagnosis of dementia. This meant that the service had knowledge of each patient and what support staff could provide to meet their individual needs.

The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions to hospital, to make best use of its beds, and to discharge patient’s home in a timely way. The trust’s hospital discharge team worked closely with many different professionals, including doctors and nurses, therapists and the community teams such as the rehabilitation team and the stroke team to improve discharge arrangements.

The service was working closely with local social services to facilitate timely and appropriate discharges for those patients requiring complex social care packages in the community.

Planning the delivery of the service was coordinated at daily bed management meetings.

Meeting people’s individual needs

Services were planned to consider the individual needs of patients. Adjustments were made for patients living with a physical disability. The hospital had disabled access across all areas of the medical services.

The hospital had taken a new approach to providing care for its medical patients that was called “needs based care.” This approach placed all patients on a ward based on their medical needs and not their age. The aim of the needs based care approach was to provide a higher quality of care, better continuity of care, a shorter length of stay while improving the overall experience to meet patient’s individual needs.

As part of the needs based care model, the trust had introduced a frailty unit in April 2018. The aim of the frailty model was to review and transfer suitable patients from the two emergency assessment units, the female medical short stay ward (Ward 3) and other recent admissions who met the criteria to the frailty unit. All patients were screened by the frailty team which included nurses and therapists with a view of reducing the length of stay and the patient journey/experience.

John’s campaign had been rolled out across the trust to provide better support to patients living with dementia and their families. John’s campaign supports the rights of carers and families to stay with patients with dementia while in hospital. We saw posters on display across the medical service. Staff showed good awareness of the campaign especially on those wards which had patients living with dementia, for example Ward 15 who had open hours to enable patients to be supported by their family/carers.
Wards had long periods of time when they were open to visitors. The wards protected patient mealtimes to ensure they could eat their meals without interruption. Family members were encouraged to attend at mealtimes if the patient required assistance with eating so that they could provide extra support. Medicines were not routinely administered during mealtimes to allow patients time to eat without interruption. Wards used red trays during mealtimes. A red tray is used to help staff identify which patients need extra support when eating, or had modified textured food such as mashed or pureed foods. We observed mealtimes during the inspection and saw staff supporting and assisting patients with their meals where necessary.

The service had access to a neurology clinical nurse specialist who provided expert support and advice to staff and patients about epilepsy and other neurological conditions. To support their role the hospital was due to appoint a dedicated epilepsy clinical nurse specialist who would support patients while they were an inpatient and continue their support in the community to maintain patient safety and avoid hospital admission.

The resolution team, an external provider, visited the wards daily in the morning, and offered ongoing treatment and support for patients who suffered with substance misuse and alcohol problems. Staff said the service was very responsive and offered good support and advice.

Matrons, clinical senior nurses who were bleep holders, the learning disability liaison nurses and the integrated discharge team received daily email alerts regarding the number of patients living with learning disability within the hospital. This meant that staff could plan and consider the patient’s individual needs.

Dementia boxes were available for patients living with dementia. Dementia boxes were designed to either assist patients to recall events and experiences or provide activities to occupy the patient. On Ward 15 we saw they had introduced a technology tool call the reminiscence interactive therapy and activities (RITA). We saw RITA in use on the ward and staff demonstrated the many ways RITA could be used to support patients which included; memory recall and the encouragement of conversations and interactions with families and staff. This could be achieved through the watching of a movie, playing interactive games or the creation of a life story. Staff said they found RITA a very positive tool and a welcome distraction from the clinical environment and felt that patients appeared a lot happier.

The butterfly logo was used to identify patients living with dementia. Staff could access specialist dementia nurses who gave expert practical, clinical and emotional support to families of patients living with dementia.

Patient passports and “This is me” documents were used which enabled staff to provide individualised care to patients. Patient passports included information about patients’ likes and dislikes, eating and drinking preferences, special requirements and personal information such as what the patient enjoyed doing in their spare time and information about their family and pets. Communication requirements and preferences were documented.

The trust offered face to face and telephone interpreting for spoken languages, translation services (including braille) and British Sign Language interpreters. Staff knew how to access the translation services and we saw posters on display with clear guidance and contact telephone numbers.

**Access and flow**

Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.
In response to the pressures within the emergency department (ED) the hospital had two emergency assessment units (Wards 1 and 4) to help divert medical patients from the ED while ensuring that acute medical patients were provided with a better directed and streamlined service.

In 2017 the endoscopy department met the demand of around 11,200 patients. This left an unmet demand from screening services and patients on waiting lists of approximately 2,800 patients. To reduce the demand on the endoscopy service they had introduced Saturday listings to reduce the pressure on the waiting list. Staff confirmed they had pulled together as a team to support patients on the waiting list. Patients spoken with said they had waited a very short time before being seen and could not fault the service.

The board meeting minutes for April 2018 stated that the endoscopy team had worked very hard to improve the backlog position for patients waiting more than six weeks (42 days) for diagnostic tests to 27 days at the end of March 2018 which enabled the trust to meet the diagnostic target for March 2018. Staff confirmed they had been supportive in backfilling lists wherever possible and the booking process and new access policy had delivered the effective administration of the waiting list, and the booking and running of endoscopy sessions.

The endoscopy service plan for 2018/19 identified an increase to three procedure rooms in April and May 2018 and four rooms from June 2018. The extra room capacity meant the service would be able to see over 15,200 patients which was above the projected demand.

### Endoscopy unit activity 2018/19

<table>
<thead>
<tr>
<th>2017 actual</th>
<th>Unmet demand</th>
<th>Total demand 2017</th>
<th>Projected 2018/19 demand</th>
<th>Projected 2018/19 capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>11,258</td>
<td>2,850</td>
<td>14,108</td>
<td>14,627</td>
<td>15,287</td>
</tr>
</tbody>
</table>

**Evidence Source:** DR84 Endoscopy Unit Activity 2018

The catheter laboratory had two units of which only one was functional. Catheter laboratory two had never been commissioned as a functional second suite but temporarily housed a computed tomography (CT) scanner (a computer to create detailed images of the inside of the body), a specialist echocardiogram machine (a scan used to look at the heart and nearby blood vessels) and direct current (DC) cardioversions (a procedure to convert an abnormal heart rhythm to a normal heart rhythm). Staff spoken with felt that by not having the second unit fully functional, this reduced their ability to support patient flow through the hospital.

Staff informed us that the pre-planned daily catheter laboratory lists could be revised to maintain optimal efficiency. However, staff said that rescheduling expectant patients was time consuming and could be very distressing, often involving ringing patients or telling them in person that their procedure was delayed, postponed or rebooked. Senior staff told us that some of the main reasons for delay included extended procedures due to complex needs and emergency cases taking priority over scheduled cases.

Staff confirmed and we saw lists were cancelled for either a whole day or part of a day. This decision occurred either on the day or a few days in advance, depending upon the reason. Exampled reasonings for cancelled lists included:
• Infestation of flies over the spring and autumn months for the past two to three years resulting in lists being suspended and rescheduled and the theatre cleaned. We observed this matter had been resolved using anti-infestation chemicals and sealing of the roof tiles. Confirmation that these measures had been effective would be seen in the autumn when the life cycle of the flies would be expected.

• An area of persistent damp at the base of a concrete column adjacent to the nurses’ station had not encroached directly upon the work of the laboratory. The source had been located to a leak in the flat roof above that part of the building. This had been resealed and the diagnostic drill holes into the concrete were due to be resealed the end of August 2018. Recent bucket testing on the roof suggested that this problem had been fixed.

For these two issues, infection control and management had been fully involved and extra lists had been implemented to support patients waiting for their procedure.

Senior staff informed us that the catheter laboratory recovery beds were not protected from encroachment by general medical admissions. Nursing was provided by cardiology staff, nurses loaned from elsewhere in the hospital, or bank and agency staff. During the winter, staff confirmed that lists were shortened due to the lack of recovery beds which they felt impacted on the access and flow of patients through the hospital.

Patients had an escalation plan which supported their safety during increased attendance to the hospital. The aim of the escalation plan was to assess the risk to patient safety through advanced planning, early escalation and clinical engagement. This enabled the hospital to escalate in a responsive way but also to de-escalate quickly regarding any identified concerns.

Nutrition and dietetics services triaged referrals into high, medium and low priority with high priority being seen within one working day, medium seen within two working days and low priority seen within five working days. We found no issues or concerns in the records reviewed with referrals clearly identified and followed up.

Inpatient therapies referrals had 48 hours as a maximum target to be seen which had been achieved consistently for physiotherapy, occupational therapists and speech and language therapists. Records reviewed identified timely oversight and recordings by therapists.

Discharge processes involved medical staff, staff on the wards, allied health professionals and an integrated discharge team comprising both trust staff and staff from the relevant local authorities. The integrated discharge team provided collaborative working between the trust and health and social care to offer an individualised and focused approach to discharge planning. Discharge coordinators attended regular discharge planning meetings and said they could raise any relevant issues with the multi-disciplinary team to ensure resolution prior to discharge.

Discharge co-ordinators confirmed they worked closely with patients, relatives and cares regarding discharge and provided them with information, timescales and the appropriate level of support being provided. The discharge coordinator also linked with the pharmacist and prescriber to ensure “to take away” (TTAs) prescriptions were ready for patients being discharged. We observed good interaction between staff teams during the inspection.

Discharge was highlighted as a concern by the adult safeguarding board and it was discussed with the clinical commissioning group and at the clinical outcomes, safety and quality (COSQ) meetings. A discharge audit completed by the adult safeguarding team in January 2018 identified areas of concern which included:

- Lack of discharge letter on discharge from hospital
• Late discharges
• Lack of/issues around prescription of medications on discharge letter
• Inappropriate support on discharge
• Lack of equipment

A daily report was being trialled on some of the medical wards to manage discharge concerns raised. For example; Wards 10 (respiratory), Ward 11 (gastroenterology), Ward 12 (endocrinology and diabetes), Ward 14 (geriatric) and Ward 17 (stroke) captured the status of every patient on the ward after the board round. The discharge team produced a daily report showing the status of all patients analysed by pathway and every Tuesday and Thursday there was a patient tracking list meeting between the discharge team, local discharge managers and managers of social care teams to review all patients. The report showed for example, how long a patient had been in hospital, and how many days at each of the various stages of their patient journey. The aim of the tool was to reduce the length of stay of patients by highlighting awareness on how long a patient had spent waiting for something to happen and identifying the barriers to progressing the patient pathway. We spoke with the discharge co-ordinators assigned to the medical wards who demonstrated how they used the tool to support timely discharges.

Ward 18 was flagged as an area of concern in January 2018 particularly around discharges. This resulted in an action plan and feedback seen identified no discharge related concerns since this had been implemented.

Ward 10 had become a respiratory ward from June 2018 with admission and discharges ranging an average of six daily. We saw the ward facilitated 136 discharges in July 2018 and that identified outlying respiratory patients were transferred to the ward in line with the harm free care programme.

To facilitate good discharge from the emergency assessment units and improve flow to the appropriate ward, patients were reviewed by a junior doctor and then a consultant. Patients who required specialist input, for example with respiratory conditions, were reviewed by specialist consultants once assessed by the medical nurse practitioner.

The monthly SSNAP report for June 2018 identified that the stroke unit had improved the number of patients directly admitted within four hours of clock start. Meetings had taken place to revise the pathway from the emergency department to the stroke unit resulting in a breach report of all patients that did not get to the unit within four hours.
Stroke Unit (SU) accessed within four hours July 2017 to June 2018

(Evidence source: DR5 SSNAP report June 2018)

Staff on Ward 17 (stroke ward) explained that stroke patients were transferred to rehabilitation beds (Ward 19B) for continued therapy input once they were medically stable. The availability of rehabilitation beds ensured that there was flow through the acute stroke beds within the medicine service. A stroke nurse coordinator told us that they attended the emergency department (ED) to assess patients with suspected stroke which facilitated patient flow from ED onto the stroke inpatient ward.

Referral to treatment (percentage within 18 weeks) - admitted performance

From May 2017 to April 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medical care was consistently better than the England average. 100% of patients were admitted within 18 weeks of referral in June 2017 and March and April 2018. Otherwise the trust’s performance was consistently better than 93%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

From May 2017 to April 2018 six specialties were above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>98.9%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Specialty grouping</td>
<td>Result</td>
<td>England average</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.7%</td>
<td>93.9%</td>
</tr>
<tr>
<td>General medicine</td>
<td>96.6%</td>
<td>96.2%</td>
</tr>
</tbody>
</table>

Over the same period one specialty was below the England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)

Patient moving wards per admission

From April 2017 to March 2018, 95.7% of patients on medical wards did not move wards for non-clinical reasons during their admission, and 3.6% moved once. The percentage of patients that moved wards more than once was 0.7%.

(Source: Trust Routine Provider Information Request P51)

Patient moving wards at night

From May 2017 and April 2018, there were 1,285 patient moves at night on medical wards. The highest numbers of ward moves were reported in February, March and April 2018 (162, 129 and 132 respectively).

The highest numbers of patient moving at night over this period were reported for wards 3 (medical short stay, 213), 12 (gastroenterology, 122) and 11 (also gastroenterology, 112).

(Source: Trust Routine Provider Information Request P52)

All patients for transfer to a speciality ward were risk assessed to ensure that their condition was stable and staff had the appropriate skills to manage their condition. The responsibility of the patient remained with the admitting speciality team and consultant.

Staff informed us that care was taken to only move patients for non-medical reasons when unavoidable and in mitigation of potential clinical risk to another patient.

Average Length of stay

Luton and Dunstable University Hospital

From March 2017 to February 2018 the average length of stay for medical elective patients at Luton and Dunstable University Hospital was 5.5 days, which was similar to the England average of 5.9 days.

Average lengths of stay for elective specialties:

- Average length of stay for elective patients in cardiology and general medicine were similar to the England averages.
- Average length of stay for elective patients in geriatric medicine was shorter than the England average
Over the same period, for medical non-elective patients, the average length of stay was 5.9 days which was equal to the England average of 6.4 days.

Average lengths of stay for non-elective specialities:

- Average length of stay for non-elective patients in general medicine was shorter than the England average.
- Average length of stay for non-elective patients in geriatric medicine was longer than the England average.
- Average length of stay for non-elective patients in gastroenterology was equal to the England average.

(Source: Hospital Episode Statistics)

We saw the length of stay figures which had reduced to seven days across the medical service. This was just higher than the trust target of six days.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Lessons learned from complaints were shared with all staff members effectively.

Patients and relatives spoken with said they were aware of how to make a complaint. The hospital website set out how patients or their relatives could raise a concern. The patient and liaison service (PALS) were visible at the front of the hospital and leaflets were available on the wards. We saw posters on the wards with information on how to raise concerns via PALS. PALS worked closely with patient affairs and would escalate if a complainant wished to make a formal complaint. The patient affairs team were available to go to clinical areas to meet with the complainant at their request.

The patient affairs team coordinated the initial part of the complaints process and the final checking and sign off process. They reported to the chief nurse. The medicine division had a complaint lead that took ownership of the investigation and response before it was referred for executive checking and sign off.

Learning from complaints took place through various forums at local divisional/directorate level and across the trust. These include divisional governance meetings, newsletters and patient stories to the board. For example, poor communication at handover on a ward resulted in a patient being approached inappropriately. This resulted in patient boards being introduced by their beds on the wards with icons to identify a patient’s individual specific need.

Literature and posters were also displayed within the ward areas, advising patients and their relatives how they could raise a concern or complaint, either formally or informally. Notice boards on the wards included ‘You said’ ‘We did’, in response to patient comments.

Summary of complaints

From April 2017 to March 2018 the trust received 116 complaints about medical care. The trust took an average of 35.6 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 35 working days.

(Evidence Source: DR143 Medicine Length of Stay)
The breakdown by subject is shown in the table below. Because one complaint can have multiple subjects, the total below exceeds the total number of complaints.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>151</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>33</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>22</td>
</tr>
<tr>
<td>Communications</td>
<td>9</td>
</tr>
<tr>
<td>Appointments</td>
<td>7</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>4</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>2</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>229</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We saw the acute medicine performance regarding their response to complaints which are set out below:

April 2018 complaints within the medicine service

<table>
<thead>
<tr>
<th>Formal complaints received</th>
<th>Complaints due for Acknowledgement in month</th>
<th>Complaints acknowledged within 3 days</th>
<th>%Complaints acknowledged within 3 days</th>
<th>Due for response in month</th>
<th>Replied to within 35 days</th>
<th>%Complaints replied to within 35 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>12</td>
<td>10</td>
<td>83%</td>
<td>14</td>
<td>9</td>
<td>64%</td>
</tr>
</tbody>
</table>

(Evidence Source: DR84 Acute Service Executive Performance)

Number of compliments made to the trust

From April 2017 to March 2018 the trust received 131 compliments about medical care:

- 77 about medical inpatient care
- 54 about acute and emergency medicine which includes urgent and emergency care

In their RPIR the trust did not provide a breakdown by subject or theme for compliments in each core service. However, they noted that the overall theme identified from compliments received across the trust over the period above was excellent care from staff in various teams.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Compliments

During the inspection, we saw compliments on display within the wards. Examples of feedback included “thank you so much for all the care you gave to my mother while she was in your ward. Everyone was so kind” and “thank you for looking after my mother so well during her end of life.”
Is the service well-led?

**Leadership**

The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.

The medical service had core service level leaders with the necessary skills and knowledge required to lead the service effectively. They understood the challenges to quality and sustainability such as financial pressures and bed capacity.

The leadership team was committed to nurturing and developing a more coordinated approach and support to enable quality improvement to be embedded across the service. Senior leaders were involved in ensuring that, on a day to day basis, there was a safe and effective approach to clinical staffing and patient flow.

We met with the ward managers and registered nurses during the inspection and found they were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward’s performance against the trust priorities and the areas for improvement. When we raised issues with them, they responded to address them immediately.

We saw matrons were visible on the wards. Ward managers said they were supported by the matrons and medical divisional leaders. Staff knew how to contact the medical and nursing lead for their area. Staff told us that ward managers and matrons were approachable and supportive and offered advice and training.

Managers arranged ward or departmental unit meetings regularly to ensure staff were kept up-to-date with information about their department and the service. There were various methods of communication across the teams, including meetings, newsletters, notice boards and e-mail. Areas covered included; patient safety, staffing and staff vacancies and ward performance.

Leadership development needs were assessed at appraisal in discussion with line managers and in discussion with senior leaders such as the director of nursing and the director of human resources. There were specific programmes for band 6 and 7 nurses.

Team leaders could access courses such as the chartered management institute level 3 and 5 which was funded through the apprenticeship levy.

Since January 2018, the hospital had been developing an organisational development strategy with their partners with a local NHS trust. This document underpinned workforce transformation and outlined key priorities for the next 12 months which included; training, developing and investing in staff while securing the best staff to deliver outstanding health services.

**Vision and strategy**

The service had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff.

The trust had a culture strategy that aimed to deliver safe, sustainable high-quality care alongside four quality priorities which were based on; patient experience, patient safety, delivering excellent clinical outcomes and prevention of ill health. Staff said they had attended the trust engagement event and participated in the formation of the strategy.

The trust vision was “to attract the best people, value our staff and develop high performing teams that deliver outstanding care to our patients.” Staff spoken with directed us to posters on display and explained how they could access the trust’s vision on the electronic system.
Through the “Good Better Best Event” in July 2017, over 2,000 staff were asked to select the words that they identified with the trust’s values. Staff confirmed they had attended the event and had provided feedback on the trust’s values. The five words which were the most important were:

- Teamwork – 76%
- Helping others - 56%
- Supportive - 45%
- Learning - 34%
- Compassion - 31%

The medicine service had a strategy which was complemented by individual service plans. We saw the plans for many services which included; stroke, endoscopy, cardiology and respiratory.

The key objectives for the dementia strategy for 2016 to 2018 was to deliver excellent clinical outcomes by improving: patient experience, improving patient safety, the delivery of national quality and performance targets and the development of the trust’s workforce to meet the needs of the patient. This was to be implemented through the development of staff’s skills and knowledge of dementia through a training programme. Clinical care and treatment would be person centred by adopting evidence based clinical excellence when delivering care to the patient with dementia. The hospital aimed to be a dementia friendly organisation with environments and processes to support patients living with dementia. During the inspection, we observed good working among staff when responding to a patient with a diagnosis of dementia.

Staff within the cardiology unit were aware of the cardiology objectives for 2018/19 which included:

- The delivery of quality priorities outlined in the quality account which included improving patient experience and safety.
- To work collaboratively in delivering integrated care.
- Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups.

We saw the endoscopy service line plan for 2018/19. Areas covered included:

- Challenges – workforce recruitment and retention
- Dependencies, risks and investments – decontamination facilities
- Efficiencies and quality - room and list utilisation, pre-assessment clinic implementation.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Both medical and nursing staff on medical wards reported a good culture. Staff felt supported by their colleagues and matrons in their individual areas. They told us they were proud to work within the trust. Staff said their line managers looked after them well. We also observed positive and supportive interactions between matrons and ward managers. Matrons described having an open-door policy where any member of staff could see them privately. This was confirmed by staff spoken with who felt they could address any concerns with the matrons and managers.

There was a strong culture for delivering high-quality care. Most staff felt valued and supported to deliver care to the best of their ability. There were good independent reviews about the support to trainee doctors. Openness and honesty was encouraged at all levels and most staff said they felt...
able to discuss and escalate concerns without fear of retribution. There were good systems for performance reviews for staff.

The trust had a freedom to speak up guardian. The role had a dedicated e-mail and telephone number so that staff could access confidentially. However, most staff spoken with were unaware of who the freedom to speak up guardian was but knew of their role and said they would go on the trust intranet to obtain their contact details.

All the staff we spoke with talked about an open and transparent culture within the hospital. Quotes from staff included, “everyone is friendly” “we work well as a team and support each other.” Staff also confirmed they enjoyed caring for their patients and we observed good interaction during the inspection.

Service leaders spoke highly of staff on the wards and how hard they had worked and adapted to the winter pressures.

Some ward staff expressed a sense of unfairness when asked to move from their regular ward to support another ward that was short of staff. Nursing staff told us they preferred their own ward because they knew the team. However, all staff understood the reasons for moving and the importance of patient safety. Senior staff told us they would be reviewing staff moves to other wards to ensure it was fair and this would be included in the winter pressures planning meetings.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

We found that clinical group leadership understood the importance of governance and recognised the value of a standardised approach. All staff spoken with confirmed there was a good structure in place across the medical services with meetings being attended by both divisional leads and senior staff.

Staff confirmed medicine executive meetings included feedback from the board as well as input from ward staff. These were disseminated to staff through team meetings. Anything urgent was discussed at the staff huddle meeting each day and put on display on the staff board. As of April 2018, the medicine executive meetings had been discontinued and reintroduced into the divisional board meeting from May 2018. We saw in place a new term of reference guidance for this meeting. Senior staff said the new meeting provided an opportunity to bring forward cross-directorate issues for discussion. We saw the meeting minutes for May 2018 and noted that it covered areas such as; incidents, safety alert responses, complaints, clinical audits and feedback from the quality and performance board which included learning and sharing.

Managers, matrons and leaders of the service described the systems and processes of accountability within the medicine service. Most staff of all levels understood their roles and what they were accountable for. Nursing staff said they attended ward meetings and we saw meeting minutes were available for staff to read in the staff room.

The trust used a monthly harm free care dashboard to triangulate quality and safety metrics with workforce indicators which was reported to the clinical outcomes, safety and quality committee (COSQ), a subcommittee of the trust board. The divisional boards monitored and reviewed quality, safety and workforce data and a safe staffing report was reported directly to the trust board.

Senior staff confirmed there was improved governance around the ‘handling’ of incidents which included; improved monitoring and timely management of incidents within the divisions by the
divisional risk leads. The circulation of a fortnightly “incident handlers report” confirmed this. Staff also confirmed learning from incidents, complaints, audits and other quality improvement initiatives were communicated to them in a variety of ways such as; handover meetings, quality safety meetings, e-mails and information on the notice board.

Learning from deaths was reported quarterly to the board through the quality and performance report and was included in the trust quality account. The medical service contributed data to the learning disabilities mortality review programme (LeDeR). All learning disability deaths were given a structured judgement review by the medical director lead for governance. Learning from deaths nursing quality and performance meetings were attended by members of the medical division. These were held monthly to validate data and identify further action required to make any improvements.

The leadership teams completed a focussed programme of quality reviews to assess quality across the different services. Leaders were assigned a “buddy” area and were required to complete a cycle of visits every two months against one of the Care Quality Commission (CQC) domains. During the inspection senior staff described how they had recently undertaken a review of the CQC “caring” domain and were awaiting the results which they would cascade to staff.

We saw the results of the previous review (well-led) which took place during the months of October and November 2017. Combined results for the medicine division showed that 15 questionnaires were submitted with an overall score of 85%. We saw identified areas of good practice for example, Ward 17 (stroke ward) which included staff responding positively to the cultural needs of patients which included allowing family to bring in food from home and freeing up a room for prayers. Areas for improvement across the medicine service was to ensure that staff at all levels were clear about their roles and that they understood what they were accountable for and to whom. During the inspection staff spoken with were clear regarding their roles and responsibilities.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The divisional leads identified and reviewed the risks for the service, which was evidenced in the divisional risk registers. Risks identified across the medicine service included; nursing staff recruitment and retention, increased violence and aggression on staff especially on Ward 11 and day rooms used for inpatient beds. We saw risks were included in the agenda of the medicine clinical governance and assurance meeting. For example, the May 2018 meeting minutes identified the addition of four new risks and the closure of four. There was a total of 61 risks identified for the medicine service of which seven were high risk, 35 medium risk and 19 low risk. Examples of high risk include; the failure of duodenoscopes (hollow, flexible, lighted tubes that provide doctors with access to the patient’s intestine) and day rooms being used for inpatient beds.

The nursing leadership team had introduced a trust wide pressure ulcer share and learn forum and falls forum and there were monthly senior nurse’s meetings for ward managers and nursing staff. This enabled staff to network and share issues and ideas for improved practice and acted as a problem-solving forum.

Managers monitored a range of performance issues including quality and safety indicators, patient experience indicators and staffing and training indicators. Wards were assessed on their performance in relation to a subset of these which were referred to as the harm free care
dashboard. This was based on ward audits and key performance indicators. A ward manager told us the ward was classified as red, amber or green for each of the measures monthly and covered areas such as pressure ulcers and falls. They said that if they had a red indicator they had a meeting with their matron to discuss the issues and actions implemented to improve the quality and service provided.

The harm free care data was sourced through a one-day snapshot audit. The trust continued to deliver harm free care above the national expected threshold of 95%. We saw the results from April 2016 to May 2108.

### Harm Free Care April 2016 to May 2018

![Harm Free Care Graph](image)

*(Evidence source: DR152 Quality Performance Report Quarterly)*

### Information management

The service collected, analysed, managed and used the information to support its activities.

The trust produced a monthly integrated audit report for each clinical group which listed their performance. Trust targets were set in relation to these indicators and performance was rated using the traffic light, RAG (red, amber, or green) rating system. This allowed managers to assess their performance at a glance and identify those areas which required further improvement or investigation.

Audit data was reviewed at divisional meetings. This meant that the service was aware of its performance. The medical directors had oversight of all specialities within the division and escalated to the trust board appropriately. This enabled decision makers to have the relevant, up to date information to inform decisions being made about the service.

Medical leaders had a holistic understanding of performance. Information was used to measure improvements. There were clear and robust service performance measures in place, which were monitored at monthly governance meetings.

The service had a wide range of information available to them to enable managers and service leads to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.

Information technology systems were used to monitor and improve patient care. There were arrangements in place which ensured data such as serious incidents were submitted to external providers as required.
Engagement

The service engaged well with patients and staff to improve services.

Patient experience feedback was in use on each ward with a view of increasing the number of patients from whom feedback was obtained. Nursing staff spoken with confirmed they were aware of the incentive and had attended meetings where they listened to patient’s views. Senior staff said that the views of patients had helped them in the development of the medicine strategy.

Staff confirmed the trust had engaged with them regarding the proposed merger with a local NHS trust. Work continued with individual medical specialties across both sites around the planning and development of future services. For example, the lead endoscopy nurse from a local NHS trust was working across both sites to ensure good collaborative working.

Staff said they enjoyed the twice yearly “good, better, best” events which was used for sharing information with staff. Staff said they found it a good opportunity to meet up with colleagues and share learning. The events also provided time to reflect on the patient’s experience and to hear about new initiatives for health and wellbeing.

Most staff within the medical service felt engaged with their senior management and felt their views were reflected in the planning and delivery of services. Staff said they contributed to the annual staff survey and gave examples of improvements made following the staff survey such as improved access to leadership training.

The NHS staff survey from September to December 2017 identified good communication between senior management and staff; staff motivation at work; quality of appraisals and the percentage of staff reporting experiences of harassment, bullying or abuse. However, the hospital was in the worst 20% of trusts regarding staff experiencing physical violence, harassment, bullying or abuse from patients. During the inspection, staff confirmed awareness of the survey results but had not been personally involved in any confrontation. They said they felt confident in discussing any concerns with their immediate manager.

In April 2017 the trust launched the trust quality buddy system (TQB). The purpose of the TQB was to gain a level of assurance on the standard of care across the trust through the gathering of soft intelligence using a wide network of senior trust staff. The trust quality buddy assessments had focussed on well-led during the months of October and November 2017. The overall response rate was 52% and the trust score was 84%. The results identified that staff felt supported, respected and that their views are reflected in the planning and delivery of services and in shaping the culture. However, staff did not always feel valued and not enough understanding of the pressures staff faced.

The trust had implemented a mobile staff “app” to give staff better access to the information they needed. These included news alerts, links to important information, access to the e-roster, e-mails and major incident alerts.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong. During this inspection, we found some areas had improved while others had shown little improvement from the January 2016 inspection.

During the inspection of January 2016, we highlighted the following concerns and found little improvement during this inspection:

- Safeguarding children and adult’s level one and two continued to be below the trust target.
• Poor compliance with hand washing techniques and infection control preventions.
• Little improvement with conflict resolution with compliance figures continuing to be low.

However:
• We found that all venous thromboembolism (VTE) (a blood clot) assessments were completed in accordance with trust policy.
• The trust had implemented an electronic prescribing and medicines administration (ePMA) system across all inpatient clinical areas to improve the management of medicines safely.

Staff felt they could approach other experienced staff for advice and support when required. Staff told us they felt they had picked up valuable skills and awareness by working with colleagues who had such knowledge and expertise.

The medical service had introduced an enhanced care and observation process called Baywatch. Baywatch was designed to provide uninterrupted monitoring of vulnerable patients in a dedicated area, 24 hours a day. The introduction of Baywatch had reduced the number of falls across the medical service.

The diabetic service had implemented a foot screening tool. This included an initial triage to identify the presence of ulcers. We saw staff had been given a small mirror to examine patient’s feet during their stay on the ward which staff found to be useful when examining patient’s feet.

The medical service had adopted the John’s campaign to support the rights of carers and families to stay with patients with dementia while in hospital.

Ward 15 had introduced a technology tool called the reminiscence interactive therapy and activities (RITA) which supported patients with memory recall, the encouragement of conversations and interactions with families and staff. This could be achieved through the watching of a movie, playing interactive games or the creation of a life story. Staff said they found RITA a very positive tool and a welcome distraction from the clinical environment.
Surgery

Facts and data about this service

Luton and Dunstable University Hospital NHS Foundation Trust has 116 surgical inpatient beds located across four wards. The trust has 12 operating theatres in two separate areas.

The complete list of surgical wards, theatres and other reporting units in surgery at the hospital is shown in the table below:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Speciality or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology bungalow</td>
<td>Audiology</td>
<td></td>
</tr>
<tr>
<td>Centre for obesity research</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Eye day surgery unit</td>
<td>Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>Macmillan chemotherapy unit</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Neurophysiology</td>
<td>Neurophysiology</td>
<td></td>
</tr>
<tr>
<td>Oral and maxillo facial surgery</td>
<td>Oral and maxillofacial surgery</td>
<td></td>
</tr>
<tr>
<td>Short stay surgical unit</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Surgical arrivals and pre-assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatres 1-6</td>
<td>Theatres 1-6</td>
<td></td>
</tr>
<tr>
<td>Theatres A-D and E-F</td>
<td>Theatres A-D and E-F</td>
<td></td>
</tr>
<tr>
<td>Ward 20 (Head and Neck Unit)</td>
<td>Ear, nose and throat (ENT)</td>
<td>28</td>
</tr>
<tr>
<td>Ward 21 (Surgical Assessment Unit)</td>
<td>General surgery</td>
<td>27</td>
</tr>
<tr>
<td>Ward 22</td>
<td>General surgery</td>
<td>31</td>
</tr>
<tr>
<td>Ward 23</td>
<td>Trauma and orthopaedics</td>
<td>30</td>
</tr>
</tbody>
</table>

Excluded from the list above is the Cobham Clinic, a private surgical service which is also located at the hospital. The Cobham Clinic has 13 beds.

The trust also has an Orthopaedic Centre located a short distance away from the main hospital. The centre provides mainly out patients service including a range of musculoskeletal healthcare, including orthopaedic, medicine and surgery. We did not inspect the orthopaedic centre on this inspection.

Surgical services provided at the trust include:

- Breast surgery
- Ear, nose and throat (ENT)
- General surgery
- Ophthalmology
- Oral and maxillofacial surgery (OMFS)
- Orthopaedics
- Trauma care
- Urology

Luton and Dunstable University Hospital is the regional centre for head and neck cancer surgery, bariatric surgery and the hub of the local OMFS network. The urology department provides a Holmium Laser Enucleation of the Prostate service.

The trust had been commissioned to establish a restorative dentistry service and was in the
process of establishing this service.

Several services were provided by specialist surgeons from other NHS hospitals such as the vascular service and the plastics service. The ENT service shared an out of hours on call rota with another local NHS hospital.

(Sources: Routine Provider Information Request (RPIR) Sites tab and acute RPIR Context acute tab; trust website)

The trust had 31,640 surgical admissions from March 2017 to February 2018. Emergency admissions accounted for 9,549 admissions (30%), 17,941 (57%) were day case, and the remaining 4,150 (13%) were elective.

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it with attendance at some life support courses being particularly low.

The trust had a total of seven topics that had mandatory training status. Staff compliance with mandatory training was monitored through the trust’s governance processes with monthly divisional reports sent to the board and cost centre managers which identified staff who needed to update their training.

All staff and their managers received monthly reminders of when training was due. Managers in some areas told us that they would organise mandatory training to take account of busy periods and staffing issues, for example annual leave during the summer months. We saw that managers monitored compliance in the clinical areas, however immediate life support training for nursing staff fell below the 80% target. We requested information from the trust about this shortfall and plans to address this. Information received from the trust stated that the resuscitation department had recognised the reduced numbers of staff attendance and identified an issue as staff not collecting pre-course materials within the stipulated time frame. Arrangements had been made for ward managers to collect the materials and distribute it to staff. In addition, a pre-course test had been uploaded onto the e-learning system. The trust is evaluating the impact of the change and had reported that the number of wasted places had reduced from 49% to 33%. The service was also assessing the feasibility of providing ILS training courses at weekends for 2019 onwards.

The trust monitored the number of training places that were available to ensure that there was sufficient supply to meet the demand. The trust actively promoted e-learning and had increased the number of supported e-learning sessions that were provided so that individuals who required additional help or a quiet place to work could complete the relevant modules. Additional computers had been provided in the library which were accessible for staff and an app for mobile devices had also been developed to improve access for staff so that they could also access the e-learning from home.

Staff that we spoke to told us that mandatory training was discussed at their appraisals and that they could access mandatory training in a variety of ways. These included on line training which staff could access from home and face to face sessions as appropriate.

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for registered nursing staff in surgery is shown below:
A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control - Level 1 and 2</td>
<td>218</td>
<td>244</td>
<td>89.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling (theory)</td>
<td>212</td>
<td>244</td>
<td>86.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>212</td>
<td>244</td>
<td>86.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>210</td>
<td>244</td>
<td>86.1%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling (practical)</td>
<td>204</td>
<td>244</td>
<td>83.6%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support (ABLS)</td>
<td>198</td>
<td>244</td>
<td>81.1%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>50</td>
<td>135</td>
<td>37.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 80% target was met for six of the seven mandatory training modules for which registered nursing staff were eligible.

In surgery the 80% target was not met for any of the five mandatory training modules for which medical staff were eligible. The percentage of medical staff that had completed adult basic life support was particularly low: 21%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Further information provided by the trust detailed that at the end of August 2018 the compliance with basic life support for both medical and nursing staff was 58%, with theatres at 80%. For intermediate life support compliance was 46% an improvement of 10% over the past few months.

The trust advised that life support training figures have now been added to the workforce board report for ongoing monitoring.

The resuscitation department had evaluated the availability of training sessions and had confirmed that there was sufficient capacity to cater for all medical staff who required adult basic life support training (ABLS). Since May 2018 the resuscitation department, together with the training and development department, had evaluated all resuscitation training requirements across the trust to ensure that the appropriate training levels were allocated to each individual role. The resuscitation department identified that due to the working patterns of medical staff there may be some individuals who had difficulty accessing the training on offer. To help reduce this ‘pop up’ training sessions had been delivered within working areas including theatres and surgical wards. These had been successful in providing in-situ training. Further training was planned, areas with the lowest ABLS compliance would receive training first. The service recognised that the success of these sessions could be limited due to the availability of staff on duty at the time, so monthly evaluations would occur.

In addition to the pre-planned training sessions, ad-hoc training for individuals and small groups was delivered when they have been unable to attend any other training session. The issue of poor compliance had been escalated to service managers and the medical directors.
Mandatory training was monitored through the workforce report that is reported to the board quarterly and the clinical outcome, safety and quality committee monthly, a sub-committee of the board. The training and development department reviewed poor compliance and contacted those areas for a more focused review of the issues with the division. Clinical directors were involved to support the management of this process.

The trust informed us that in relation to the impact of lack of completion, if a consultant had applied for a consultant award scheme (CEA awards), these would not be considered unless appraisals and training were completed. The trust had a senior staff professional study leave policy which currently did not prohibit study leave if mandatory training was not completed. The trust was reviewing the policy and considering prohibiting study leave should mandatory training not be completed.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it. Compliance rates for level three childrens safeguarding training was below the trust target.**

The trust had a policy and procedure in place to safeguard children and vulnerable adults at risk which had been reviewed. Staff knew how to access the information on the trusts intranet system. Over the previous 12 months 573 adult safeguarding referrals had been made, data provided had not broken this down into divisions.

Staff we spoke to had a good knowledge of safeguarding and escalating concerns. They were aware of the signs of abuse and told us that they would report any concerns to the nurse in charge of the shift or to the ward/unit manager. Senior staff and ward managers told us that they sought support from the safeguarding team when making safeguarding referrals. Staff knew how to contact the safeguarding team for support and advice. We saw that information about the safeguarding team and how to access them was displayed on ward notice boards. The Trust had an electronic information sharing system through which staff could share information directly with the safeguarding team. This enabled staff to inform the safeguarding team of any concerns they had about a young person in their care, and receive advice and support. Staff told us that if they had any safeguarding concerns about young people aged 16-18 years on the ward they would contact the safeguarding team and liaise with the children’s safeguarding team for support and advice.

The trust had adult safeguarding champions who attended meetings with the safeguarding teams and disseminated information about for example, legislative or policy changes to ward and departmental staff. The trust had an internal adult safeguarding board that met quarterly. The purpose of this board meeting was to provide leadership and direction to ensure that adult safeguarding was managed effectively and robustly within the trust.

The safeguarding team incorporated specialist nurses including the vulnerable adults and dementia nurse specialists to provide robust safeguarding support to staff. The safeguarding team also liaised and collaborated with the local safeguarding board. The safeguarding team had recently been peer reviewed by the local safeguarding board and the trust had been commended on the delivery of level three safeguarding training.

Safeguarding posters which included information about different types of abuse were clearly displayed in ward areas.
Safeguarding training completion rates

The trust set a target of 80% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for registered nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - Level 1 and 2</td>
<td>237</td>
<td>244</td>
<td>97.1%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - Level 1 and 2</td>
<td>227</td>
<td>244</td>
<td>93.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - Level 3 Core</td>
<td>7</td>
<td>14</td>
<td>50.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 80% target was met for two of the three safeguarding training modules for which registered nursing staff were eligible. Only 14 registered nurses were eligible for safeguarding children level 3. Managers told us that band 6 nurses had completed level 3 safeguarding training to improve compliance. We requested updated training figures for nursing staff who had completed safeguarding children level 3, the trust advised that at the end of August 2018 the position remained the same at 50%. The safeguarding children team had been reviewing the guidance and identified those nurses in surgery who require level 3 core training and these staff will be compliant by the end of October 2018.

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - Level 3 Core</td>
<td>19</td>
<td>23</td>
<td>82.6%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - Level 1 and 2</td>
<td>139</td>
<td>213</td>
<td>65.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children - Level 1 and 2</td>
<td>132</td>
<td>213</td>
<td>62.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 80% target was met for one of the three safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust had an up to date safeguarding policy which identified all forms of abuse, actions for staff to take and outlined the training requirements for staff.

Safeguarding training encompassed a range of topics including PREVENT, child sexual exploitation (CSE) and female genital mutilation (FGM).

PREVENT is one of the arms of the government’s anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. Prevent training formed part of the wider safeguarding agenda and encouraged staff to view a patient’s vulnerability as they would any other safeguarding issue. The safeguarding and training teams had introduced Health-wrap training to help staff identify signs of radicalisation and how these issues were escalated within the hospital setting.
FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Information provided by the trust stated that internal safeguarding procedures applied when FGM had been identified in an adult over 18 years old. However, there was no direct reference to FGM within the safeguarding procedures. Staff we spoke with were aware of FGM and actions to take.

The trust chaperoning policy had been updated and there with increased publicity for chaperones in multiple languages in key areas of the Trust. Staff we spoke with were aware of the chaperone policy and told us that a female member of staff was always asked to chaperone during examinations.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The wards and theatres were visibly clean although there was some building work being undertaken on one surgical ward (Ward 22) during our inspection. The area had been sealed to ensure that there was minimal dust and debris on the ward and a risk assessment had been undertaken.

The trust had policies in place to manage effective infection control and hygiene processes. Staff were able to access the policies on the trust’s electronic system.

Hand hygiene gel and personal protective equipment (PPE), for example gloves and aprons were readily available in the clinical areas and in appropriate quantities. There were checklists in each bay area which were signed daily by the nurse in charge of that group of patients to evidence that there was appropriate PPE. There was clear access to handwashing sinks in the bays and side rooms on the wards. Staff were aware of infection control issues. We observed staff washing their hands and using hand gel between treating patients and observed that staff adhered to being “bare below the elbow”. We saw that at the staff handover all staff were reminded about the importance of using PPE appropriately and to challenge staff if they were not adhering to the policy. In theatre we saw good and appropriate use of PPE at all stages.

The wards had side rooms available if patients needed to be isolated due to infection or risk of infection. Staff told us how they managed patients who needed to be isolated and how they would achieve this in an open ward if there were insufficient side rooms available. Following a patient being admitted with an infection and requiring isolation the trust had colour coded posters with clear guidance about the appropriate cleaning responsibilities, this included the appropriate solutions to use, nursing responsibilities and time frames. Any additional cleaning had to be authorised by the infection prevention and control team or on call microbiologist who would provide advice and guidance throughout the process. This ensured that there had been full compliance with the process and the correct time frames were imposed before the area was used for another patient.

Instructions and advice on infection control were displayed on the wards for patients and visitors including performance on preventing and reducing infection.

In each ward staff had audited their compliance with infection prevention and control measures. Handwashing audits were undertaken and indicated a compliance of 86% for both nursing and medical staff on ward 21 and ward 23 in July 2018. Results were reported to staff at team meetings and staff handovers. Observational trust hand hygiene audits between April 2017 and March 2018 demonstrated that nurse compliance was 90% to 98%, doctors were 70% to 95% with allied health professionals 86% to 90%.
There were infection control link nurses in the clinical areas. Link nurses act as a link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their ward and motivate staff to improve practice.

At our previous inspection in January 2016 we saw that the wards did not have cleaning schedules in place and “I am clean stickers” were not dated. At this inspection we saw that there were cleaning schedules in place. “I am clean stickers” were used and dated. However, we were told that “I am clean stickers” were not used in theatres as staff had taken a decision, with the involvement of the infection prevention and control team, not to use them. One staff member is dedicated to cleaning all equipment. We saw evidence that equipment was cleaned daily in theatres. Cleaning audits were undertaken on surgical wards monthly as a minimum. We saw that between February 2018 and July 2018 cleaning audits for all surgical wards were between 87% and 98% compliance.

Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, sharp bins. We observed these bins were not overfilled and there were risk assessments in place for needle stick injuries. Spills kits were readily available in each of the sluices we visited which allowed staff to safely collect and dispose of bodily fluids including blood and urine.

Theatre equipment was decontaminated and sterilised after use within the hospital. We saw that theatre tables and leg supports were clean and in good condition.

If a patient was admitted with an infection and required surgery, deep cleans were arranged following discharge. Infected patients were operated on as the last patient on the operating list. If this was not possible due to unforeseen operational issues colour coded cleaning protocols were followed which indicated staff responsibilities, the appropriate solutions to use and time frames for use. Advice would be sought from the infection prevention and control team.

There were procedures in place to reduce the risk and monitor for signs of surgical site infections (SSI) in line with the National Institute for Health and Care Excellence (NICE) CG 74 Surgical site infections: prevention and treatment. Infection control nurses assisted surgical teams in surgical site infection surveillance. Data was collected for inpatients, readmissions and at 30 days post-discharge.

Infection rates following knee surgery were higher than the national benchmark although improvements had been achieved. Data supplied by the trust indicated that the average surgical site infection rate (SSI) between 2013 and 2017 was 5.1% against a national benchmark of 1.4%. There had been six SSI for knees in 2017. As a result, SSI post knee replacement was monitored quarterly by the director of infection, prevention and control report to the clinical operational board and the clinical outcome, safety and quality committee (COSQ), a board sub-committee for quality. An action plan had been put in place to include the introduction of pathways and protocols, education and awareness for patients and staff which included a review of antibiotic usage, care of in-patients and care post discharge. In addition, the orthopaedic nurse practitioner monitored the use of antibiotics in particular groups of patients. The lower limb arthroscopy group met monthly to monitor the plans that were in place and to address any issues. Since the work had been undertaken there had only been one SSI declared in 2017-2018 compared to nine the previous year. The trust had further plans to create a dedicated clean joint ward which was due to open in October 2018.

The infection rates following hip surgery were in line with national rates. Hip replacement 2013-2017 SSI rate were just over 1% against a national benchmark of 1%. However, the service had reported three deep infections for hips from April to June 2018. Managers were investigating this.
but no single source had been identified. A final report was awaited. An action plan had been developed to address the concerns. This included ensuring that areas were restricted to scrubbed personnel only and door access in two areas was to have a restricted access swipe card facility.

Surgical site infection post knee replacement was monitored quarterly though the director of infection, prevention and control report to the clinical operational board and the clinical outcome, safety and quality committee (COSQ board sub-committee for quality). The average surgical site infection rate was 5% against a national benchmark of 1%. An action plan was in place to address the concerns, pathways and protocols had been developed, education and awareness for patients and professionals and post discharge advice was provided. Monthly meetings were held to discuss any issues. Improvements had been identified with one surgical site infection, less than 1%, declared between 2017 and 2018.

The infection control team and the trust had a zero target for cases of hospital acquired MRSA bacteraemia. Three cases MRSA bacteraemia have been reported in the period from April 2017 to March 2018 within the trust, however there had been no cases of MRSA reported in surgery. All patients were screened for MRSA pre-operatively so that if they were found to be carriers they could be treated before surgery. However, some patients were not screened until the day of admission and therefore screening results would not be available before their surgery. This meant that there was a risk that some patients would be operated on whilst MRSA positive and would be at an increased risk of developing a postoperative infection.

Following routine water testing in July 2017, legionella bacteria had been identified on Ward 21. Following our inspection, we requested the audit and the action plan to address the concerns. A risk assessment had been undertaken and an action plan and ongoing monitoring was in place to address the concerns and consider if any further actions were needed. The action plan included staff using only specific sinks for handwashing, patients in one area of the ward were to have urine samples sent for legionella testing and showers were taken out of use until further test results were satisfactory. Filters had been put on all showers in the surgical block.

A monthly patient led assessment of the care environment (PLACE) audit was undertaken at which trust representatives and members of the trust governors participated. A number of areas were audited each month which were representative of the organisation including surgical areas. The PLACE audit results for June 2018 reflected the most recent audit. Cleanliness scored between 68-100%.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The service had renovation and rebuilding plans in place due to the age and condition of the buildings which required high maintenance. Building work had been commenced on ward 22 to build a new discharge lounge which was due for completion in September 2018. This area had been sealed off to minimise disruption to the ward. A risk assessment had been undertaken. During the building works a temporary discharge lounge was located at the end of the corridor on ward 23. The lounge contained reclining chairs and was appropriately staffed, there was a strict criterion for patient use due to the temporary nature of the facility. Patients who required additional support or any teaching were not eligible to use the temporary discharge lounge. There was a medication trolley for this area which was stored securely and was locked.

The theatre suite had experienced difficulties with maintaining appropriate temperatures during the extreme hot weather conditions and breakdown of the chiller facilities. This had resulted in some
theatre closures and cancelled elective surgery. Between January 2017 and January 2018 there had been 100 to 300 patient cancellations per month, with a peak in January 2018, due to plant failure a lack of beds, or insufficient theatre time. This figure also included patients who did not attend for surgery but these were not clearly identified. Managers told us that difficulties had been experienced in one theatre in particular and that incidents were reported. Managers told us that some refurbishment had taken place and plans were in place to secure funding to build new theatres. Operating theatres were compliant with Health Technical Memorandum 03-01 Specialist ventilation for healthcare premises. This ensured there was adequate number of air changes in theatres per hour, which reduced the risk to patients of infection.

The theatre environments were visibly clean and tidy. Theatres had dedicated storage rooms for equipment and surgical instruments, however the storage space was limited. These areas were visibly clean and tidy. Theatre tables and leg supports were clean and in good condition. Anaesthetic and monitoring equipment was modern and well maintained.

Systems were in place to ensure that access to theatres and other areas was limited to specific staff. For example, access to theatres and the ward areas was restricted with a call bell system which only granted access to only those who were permitted entry.

Anaesthetic machines within the anaesthetic room and theatres conformed to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.

Waiting areas for patients were sufficient, both in the short stay surgical unit (SSU) and the surgical arrivals department. Patients told us that the waiting area were sometimes hot, fans were available to cool the area. There was no radio or television in the waiting area in the SSU, however staff told us that a television had recently been installed in the surgical arrivals department for patients who were waiting a long time. The main desk in the surgical arrivals department did not have a low accessible area for those patients with wheelchairs. Chairs were covered in wipe clean material.

The clinical engineering department provided the maintenance and repair of all medical devices except point of care testing and imaging either by in house or service contract. Point of care testing (POC) diagnostic devices are used to obtain diagnostic results whilst with the patient or close to the patient for example blood sugar testing. A database was maintained to record the devices history and identify when equipment was due for servicing and maintenance. Any equipment that broke down was recorded on the incident reporting system and reviewed at bi monthly medical equipment group meetings. Medical device alerts were also reviewed and acted upon at this meeting.

Equipment had been tested regularly. Electronic testing had taken place and equipment had stickers on them with appropriate dates of when they had been tested and when they were due for re-testing. Hoists and firefighting equipment had been regularly checked and was fit for use.

Resuscitation equipment for use in an emergency in operating theatres and ward areas was checked daily and documented as secure, accurate and ready for use. The trolleys were secured with tags which were removed weekly to ensure that the contents were all present and in date. A full check of equipment was also made after each use.

There was sufficient equipment to maintain safe and effective care. There was a hospital equipment store which staff used to access all necessary apparatus, this included items such as syringe drivers, drip stands, beds and specialist mattresses. Bariatric equipment was also readily available both on the wards and in theatre. Staff told us that they had no difficulty in obtaining items at any time and described the process. They also explained that specific equipment could be rented if it was not available through the hospital equipment store.
We saw that the clean and dirty utility areas were tidy, solutions were kept appropriately and all sterile equipment was in date. Chemical products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff. There was key pad entry to these areas so that no unauthorised entry could occur. During our last inspection in January 2016 sterile equipment had been stored in the ward sluice. During this inspection all sterile equipment was stored appropriately.

There were systems in place for the segregation and management of waste. We saw that bins were labelled to indicate the type of waste to be disposed of and bags were colour coded.

Processes were in place to provide feedback on product failure. We saw that the trust had contacted the manufacturer of a guidewire following an incident that had occurred when the tip of the guidewire had become detached.

The hospital had a policy and processes were in place to track and trace prosthesis and implants.

Piped oxygen and suction equipment was available at each bed space, as well as call buttons for emergency use and patient call bells. We saw that all bedside equipment was checked daily.

### Assessing and responding to patient risk

**Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Assessments were in place to alert staff when a patient’s condition deteriorated.** However not all patients had pre-operative assessments prior to surgery, which was not in line with national guidance.

The service did not always carry out pre-operative assessments prior to surgery in line with national guidance. Patients for elective surgery who required a general anaesthetic attended a pre-operative assessment clinic prior to their operation. During the assessment any tests required were undertaken, for example, MRSA screening and any specific blood tests. The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk, for example, ASA 1 was low risk. Staff told us that anaesthetists would also undertake either a face to face consultation or a notes review for some patients to assess their risk. However, we saw that not all patients had had a pre-assessment when they were admitted for elective surgery. Staff told us that the pre-assessment process was inconsistent and that they would not know until a patient arrived for surgery whether or not they had been pre-assessed. This was not in line with NICE guidance (NG45 routine preoperative tests for elective surgery). This meant that some patients had not been pre-assessed and required MRSA screening and blood tests to be taken on the day of surgery. If patients had MRSA screening undertaken on the day of surgery they may not have results back before their operation. In addition, there was a risk that some patients may be cancelled if they had been taking some medicines which were required to be discontinued prior to theatre, for example, anticoagulants (blood thinning drugs). Staff told us that patients may not have been pre-assessed if they had been called for surgery at short notice, for example, if their operation had been previously cancelled. The trust had a pre-operative assessment clinical guideline and a standard operating procedure, assessment hub role and tasks document, both documents were up to date. The purpose of the pre-operative assessment guideline was to outline the criteria for adult patient eligibility for pre-operative assessment and the length of validity of the assessment.

We saw that there were two pre-assessment forms, a pre-assessed form and a non-pre-assessed form.

Following our inspection, we requested further information from the trust about the pre-assessment processes. The trust had a criterion for pre-assessment the purpose of which was to:
- Identify all elective patients with a high perioperative risk
- Confirm patient’s suitability for day surgery
- Initiate and manage any actions needed in advance of, or the day of surgery
- Enable the theatre team to plan and prepare any special requirements
- Identify any post-operative needs and ensure patients understood their treatment.

The surgical division had commissioned an internal review into the pre-operative services in 2016. The aim was to reduce the number of patients cancelled on the day of surgery and identified a variation in pre-operative assessment practise across specialities and divisions and recognised the poor facilities for pre-assessment that were available. As a result, a pre-operative assessment (POA) project was set up with the aim of standardising the assessment process. The pre-operative assessment process had been re-designed, a new hub was being built and would be operational in September 2018. Data provided by the trust identified that there had been cancellations due to patients not having had a pre-assessment appointment.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients cancelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2018</td>
<td>7</td>
</tr>
<tr>
<td>March 2018</td>
<td>2</td>
</tr>
<tr>
<td>April 2018</td>
<td>17</td>
</tr>
<tr>
<td>May 2018</td>
<td>13</td>
</tr>
<tr>
<td>June 2018</td>
<td>10</td>
</tr>
<tr>
<td>July 2018</td>
<td>22</td>
</tr>
<tr>
<td>1-13 August 2018</td>
<td>27</td>
</tr>
</tbody>
</table>

However, managers told us that the increase in cancelled patients was driven by a reduction in pre-operative assessment capacity due to nursing staff shortages. Therefore, we were not reassured that all patients that required a pre-assessment had been offered an appointment. This did not comply with national guidance.

Two incidents had been raised for patients who had not had a pre-operative assessment, however these had both not attended their appointment and their surgery was cancelled.

The trust was not meeting the referral to treatment target of 18 weeks for patients who required admission. For these patients a notes review took place with the clinical teams. The aim was to ensure that the most appropriate actions were taken. Managers told us that highly complex patients did not breech these times. Such patients would receive treatment whilst those patients with more routine surgery waited longer. Following our inspection, we requested information from the trust about any harm reviews that had been undertaken as a result of patients exceeding RTT times. Managers told us that waiting list staff worked with the specialty teams to ensure patients had their surgery based on clinical priority. The trust did not have a standard escalation point at which a harm review would be completed for a patient exceeding the 18 weeks waiting time. However, no patients had been identified that had triggered for a formal harm review at the point of treatment. Managers told us that the trust had not had any patients breach the 52 week standard and no patients had been identified who had been found to be harmed as a result of their waiting time.

NICE guidance (NG89) for March 2018 states that all surgical and trauma patients should be assessed to identify the risk of venous thrombo-embolism (VTE) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review and that reassessments for
VTE and bleeding should be at the point of consultant review or if their clinical condition changes. Risk assessments were undertaken for VTE. The trust used an electronic medicine recording system, this system would not allow medical staff to prescribe any anticoagulant medicines until a VTE assessment had been completed. This system had been introduced in response to a VTE incident in the surgical division. The trust had introduced a ‘Stop the Clot’ campaign to raise awareness of the risks of hospital associated thrombosis. Risk assessments were documented in the patients records and included actions to mitigate the risks identified. The trust audited compliance with VTE assessments. Data provided showed that 99% of patients across the trust had had a VTE assessment in March 2018.

The trust had a hospital wide approach to managing deteriorating patients. There was a critical care outreach service, this team provided services to patients outside the critical care unit. These included visiting surgical patients on wards to help with interventions to stabilise them and prevent them becoming more unwell. Ward staff were able to access the critical care outreach team 24 hours a day for advice and support.

There was 24-hour access to emergency surgery teams which included theatres, doctors, endoscopy and xray. Daily medical handover meetings led by two consultant surgeons who had an overlapping weekday rota were held. These were well attended by all grades of medical staff. The discussions included detailed patient information including history, investigation results and treatment plans and was shared on an electronic screen and with a paper copy.

The national early warning score (NEWS) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: ‘Acutely ill adults in hospital: recognising and responding to deterioration’ (2007). Staff were competent in recognising deteriorating patients and used the national early warning score (NEWS). Electronic NEWS charts were used to identify if a patient was deteriorating. Staff had access to handheld devices to record patient’s physiological observations such as temperature, heart rate, respiration, blood pressure and oxygen saturation (the percentage of oxygen carried in blood) and to monitor a patient’s clinical condition. There were clear directions for actions to be taken when a patient’s scores increased. The nurse in charge and medical staff had oversight of all patient’s observations on a central electronic system. There were clear directions for actions to take when patients’ scores increased, indicating a deterioration and members of staff spoken with were aware of these. We reviewed 39 records and found that NEWS charts had been used to identify patient’s vital signs. The electronic system was a mobile clinical system that monitored and analysed patients’ vital signs providing clinicians with accurate, real-time information. A baseline audit has been undertaken which highlights that in terms of escalation, it was only clearly documented in 64% of cases. An improvement plan had been devised which the patient safety team were working with the clinical teams and the matrons and senior nurses to deliver.

The hospital had trust-wide, divisional and nursing leads for sepsis and had revised and implemented sepsis screening tools which provided clear management strategies for patients who triggered for sepsis. These had been re-designed to align with the updated requirements for NICE and the Commissioning for Quality and Innovation (CQUIN) national goals for 2017-19. The key objectives were compliance with sepsis screening and with the provision of antibiotics for patients diagnosed or presumed to be septic within one hour of diagnosis. The protocols for sepsis screening stipulate that any patient with a NEWS of greater than four and signs of infection should be screened for sepsis. This includes both emergency patients and those who developed signs and symptoms whilst in patients. Timely treatment for sepsis in acute inpatient settings stipulates patients should receive intravenous antibiotics within one hour of diagnosis of sepsis. The trust had provided training and education to the multi-disciplinary team in the recognition and
management of sepsis. Targeted ward rounds with a microbiologist and an antimicrobial
pharmacist had been introduced to provide guidance in line with best practice recommendations
and to raise prescribing queries at board rounds. Antimicrobial sensitivity overview flashcards had
been issued to all new doctors at induction. Patients who had been on antibiotics for over five days
were clinically reviewed in conjunction with the pharmacists. “Think Sepsis” signs were clearly
displayed on ward equipment so that staff would be reminded of the pathway and strategies. The
trust did not use a specialist sepsis box but staff told us they would use the resuscitation trolley.
However, staff on Ward 23 had developed a sepsis box but were unable to locate it during the
inspection.

A newly appointed sepsis improvement collaborative had been set up to lead this work in the year
2018-19.

Risk assessments were undertaken in areas such as falls, malnutrition and pressure ulcers using
standardised tools. Risk assessments were documented in the patients records and included
actions to mitigate the risks identified. The trust had implemented a “Baywatch” scheme to reduce
the risk of falls. A dedicated staff member was allocated to a bay where patients were at high risk
of falls, would wear an orange lanyard and would remain in the bay to observe and support
vulnerable patients to reduce the risk. Bed sensors were also available for patients who had been
identified as at a high risk of falls. A specialist falls nurse provided support for ward staff as
required.

We observed that patients identified at risk had care plans in place and were monitored more
frequently by staff to reduce the risk of harm. Information was available on notice boards on the
ward about the risk and management of hospital acquired complications for example pressure
ulcers.

The trust used the five steps to safer surgery, World Health Organisation (WHO) surgical safety
checklist, in line with National Patient Safety Agency (NPSA) guidelines. We saw two complete
WHO cycles in theatre. All paperwork was properly and fully completed at each stage and staff
were engaged in the process.

The trust recognised that staffing shortages would potentially impact on patient care and reduce
staff’s ability to recognise deteriorating patients early. The trust used regular agency and bank
staff to support permanent staff and had programmes in place to develop existing staff and
encourage staff retention. For example, in theatres operating theatre practitioners’ and health care
assistants were seconded to take associate nurse courses and staff across all areas were offered
leadership and development courses.

Information provided by the trust identified that they had introduced a mortality review process
using the Department of Health Structured Judgement Review documentation. A review of all
cardiac arrests was undertaken which reviewed the timeliness of vital sign observations,
escalation of concerns, medical response times, action taken to prevent further deterioration and
the appropriateness of treatment escalation plans was also undertaken.

We saw intentional care rounding was completed by healthcare assistants (HCAs) on the surgical
wards. Intentional care rounding is a structured process with staff carrying out regular checks
with individual patients at set intervals. For example, staff checked regularly whether patients
were in pain, we observed staff checking to see if patients had drinks. Patients told us that staff
were attentive and regularly checked on them.
Nurse staffing

Although there was a high number of vacancies for nursing staff the service ensured for each shift there were enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

There were systems and processes in place to assess, plan and review staffing levels, including staff skill mix. A staffing tool was used to calculate the number of nurses and health care assistants required for each shift based on the acuity (level of care a patient requires) and needs of the patients. The staffing tool was in line with NICE staffing guidance. Required and actual staffing levels were displayed in each surgical ward. During our inspection, although required staffing levels did not always meet the actual staffing levels, we saw the nurse in charge had restructured the ward to ensure staffing levels met the needs of the patients in the areas we visited. An annual review of staffing was completed. This involved using a triangulated approach which used a recognised acuity and dependency tool (Safer Nursing Care Tool), benchmarking findings with same speciality wards in other trusts and also professional judgement. Enhanced care requirements were monitored and reviewed at staffing meetings following risk assessments of patient requirements.

On a daily basis there was a modern matron bleep holder, responsible for safe staffing seven days a week and a hospital at night team out of hours. Staffing was reviewed twice a day in conjunction with matrons, the assistant director of nursing (ADON) and director of nursing (DON) and staff were redeployed to meet patient needs. Matrons reviewed the staffing needs of their areas and used a risk based approach to ensure that staff were moved to provide safe staffing cover as required. The response to staffing levels could include the moving of staff from one area to another or the moving of staff out of non-clinical shifts to support frontline activity. Clinical leadership and development nurses also worked in identified ‘hot spots’ to support leadership of the team. Managers told us that they tried not to move the same staff all the time.

New agency staff had an induction checklist completed to ensure they were familiar with the ward layout and processes. Most agency staff spoken with had worked on the wards previously and confirmed they had received a comprehensive induction and felt they had sufficient support from nursing staff. All of the agency staff we spoke to told us that they had had an induction to the clinical area. They said staff answered questions and provided guidance when required.

Daily safety huddles and board rounds were undertaken to highlight any patients that may be deemed at risk of deterioration and to ensure all patients had a plan for the day. We observed both theatre huddles and ward board rounds which were attended by all relevant staff. Discussions included what went well the day before, what could have gone better, staffing, sickness levels and any patients that may be a high risk of falls or other harm as well as plans for mobilisation and discharge home. Staff were also reminded about good practice issues including the appropriate use of personal protective equipment, wearing identifiable tabards whilst undertaking a medicine round to reduce the risk of being interrupted and to complete risk assessments.

The trust reported their registered nursing staff numbers as below as of March 2017 and March 2018.
<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
<th></th>
<th>March 2017</th>
<th>March 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Luton and Dunstable University Hospital</td>
<td>227.2</td>
<td>278.2</td>
<td>81.7%</td>
<td>249.5</td>
<td>285.4</td>
<td>87.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 23% for registered nursing staff in surgery. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The trust was looking at new roles and different ways to deliver services such as the introduction of nurse apprentice schemes, the development of new posts and was continuing with ongoing recruitment initiatives including international recruitment. Managers told us that following a recent recruitment drive many of the clinical areas would be fully staffed from September 2018. However, theatre managers told us that they continued to have significant staffing shortages but would ensure that they had sufficient staff for each theatre list. Managers told us that they would use regular agency or bank staff and had reviewed their establishment to ensure that they had appropriate levels of skilled staff.

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 12.2% for registered nursing staff in surgery. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Recruitment and retention plans were in place which linked with the lead nurse workforce, matrons and managers. The trust had joined cohort 3 of the National Health Service Improvement (NHSI) led retention programme which focussed on reducing the turnover of nursing staff and health care assistants (HCA’s).

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 3.2% for registered nursing staff in surgery. This was similar to the trust target of 3.25%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 29% for qualified nursing staff in surgery. This was made up of 19% bank staff and 11% agency staff.

Over the same period 3% of shifts were left unfilled by bank or agency staff to cover staff vacancies, sickness or absence.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Information provided by the trust indicated that operational pressures combined with vacancies meant that staff were busy, particularly if backfill temporary staffing could not be supplied. However, the trust used regular bank and agency staff to fill shifts. All agency staff had an induction and were orientated to the clinical areas to ensure that they were familiar with...
procedures and the environment. Overseas nurses had already been recruited and were working on the wards as health care assistants whilst going through objective structured clinical examination (OSCE) training.

Specialist nursing staff and practice educators also worked alongside the nurses in areas where bank and agency staff were used to support with delivery of quality care.

Recruitment and retention plans were in place linking with the lead nurse workforce, matrons and managers. The Trust had joined cohort 3 of the NHSI led retention programme which focussed on reducing the turnover of nursing staff and health care assistants (HCA’s)

Staffing was reviewed twice a day in conjunction with matrons, the director and assistant director of nursing and staff were redeployed to meet patient needs. Enhanced care requirements are monitored and reviewed at staffing meetings following risk assessments of patient requirements.

**Medical staffing**

*The service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.*

We saw the surgical assessment unit (SAU) had two allocated registrars who dealt with the admission of patients and another doctor allocated to dealing with theatres. Doctors were available to discuss any concerns or issues arising from patients attending the unit. This also assisted in the timely flow of patients in and out of the unit.

There was 24-hour access to emergency surgery teams, including theatres and doctors. During the night, there was a senior house officer present, who covered the surgical wards and was supported by the on-call consultant for surgery. Medical rotas were managed by specialties and planned in advance. Each sub-specialty within the surgery group had a consultant on-call rota covering 24 hours, seven days a week.

Surgery services were consultant led with emergency surgery being directed by the consultant. The trust employed an ortho-geriatrician. Daily multidisciplinary board rounds took place with the ortho-geriatrician in attendance.

We spoke with senior medical staff who reported that junior doctor staffing levels were normally adequate and that locum doctors were available if required. Surgical consultants were on call out of hours for all inpatient specialities. There was also onsite consultant presence at weekends and evenings during ward rounds. During the weekends on call consultants operated on emergency patients and an additional registrar was employed to undertake a full ward round of surgical patients. Consultants were available to review all patients with concerns or complications.

The trust reported their medical staffing numbers as below as of March 2017 and March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th></th>
<th>Fill rate</th>
<th>March 2018</th>
<th></th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td></td>
</tr>
<tr>
<td>Luton and Dunstable University Hospital</td>
<td>195.2</td>
<td>225.3</td>
<td>86.6%</td>
<td>216.4</td>
<td>244.1</td>
<td>88.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 16.9% for medical staff in
surgery. This was higher than the trust target of 10%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 8.0% for medical staff in surgery. This was lower than the trust target of 10%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 0.8% for medical staff in surgery. This was lower than the trust target of 3.25%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The trust were unable to provide the numbers of shifts worked by medical locum and agency staff over the most recent year as requested in the Routine Provider Information Request (RPIR). Instead they supplied the sums of money spent on temporary medical staffing in each area, and these have been used to calculate temporary staffing rates for medical staff in each core service area.

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 18.1% of total spending on medical staff in surgery. This was made up of 13.3% on bank medical staff and 4.8% on agency medical staff.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

As of December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 180 whole time equivalent staff working at Luton and Dunstable University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)
Records

Staff kept appropriate records of patients’ care and treatment. Not all patient records were kept in locked trolleys to maintain confidentiality.

We reviewed 39 sets of patient records and found these to be in good order. The trust used both electronic and paper records. Paper “skinny” medical records were kept on the ward for immediate use when patients were admitted to hospital, however the patient’s electronic record could be accessed for information about previous medical history. The service planned to have all records available electronically in two and a half years. All records were sent by ward clerks to be scanned into the patient’s electronic record on discharge. Paper nursing records were kept at the end of the patient’s bed and included care plans and risk assessments.

Not all records were stored securely in locked trolleys to maintain confidentiality. For example, medical notes were stored on shelves behind the nurses’ station. We raised this with ward managers during our inspection and were told that staff were present most of the time. We were not assured that patient confidentiality could be maintained.

There were a variety of different systems in place. Daily care records, such as fluid balance sheets, National Early Warning Scores (NEWS) were stored on an electronic system. We looked at a sample of both paper and electronic records and found these were up to date, completed and legible with entries timed, dated and signed. The nurse in charge and medical staff were able to oversee all of the records from a central system.

Records were clear, up-to-date and available to all staff providing care. Records were legible, and the entries, dated, timed, signed and the designation of the person making the entry was identified. Nurses and allied health professionals contributed to information in patients’ medical records and medical staff completed a review of the patient at least daily. The records also identified the input from the multi-disciplinary team such as therapists, dietitians and specialist nurses. There was a record of discussions held with the patient and/or their close relatives. However, these were not always fully completed. For example, we saw five records of patients who had a treatment escalation plan (TEP) but only one had been fully completed. A treatment escalation plan is a tool to assist with the delivery of appropriate levels of treatment to patients.

Records contained patient information and details of, for example learning disability, dementia or mental health needs. Support and advice was available for staff from specialist services to assist in the care and management of all patients with specific needs, for example learning disability and mental health nurse was able to support ward teams in providing appropriate care.

Nursing records were audited by ward managers on a monthly basis to ensure compliance with record keeping standards.

Patients individual care records were written and managed in a way that kept patients safe. The records included details of a patient’s admission, risk assessments, pre-assessment forms and treatment plans. However, nursing care plans were standardised and it was difficult to find information about individualised patient care. It was also unclear if the patient had been involved in their care plans to ensure they received the care that was appropriate to them.

Systems were in place to monitor the details of surgery, any implants or prosthesis used so that these could be easily identified and traced if necessary.

Medicines were prescribed and dispensed using an electronic system. This system incorporated the risk assessment for venous thrombo-embolism (VTE) to be completed. Electronic prescription charts were checked for accuracy, risk of allergies and anti-microbial treatments by the pharmacy department regularly.
We saw the wards used either electronic boards or hand-written information boards which were used to display patient names and location as well as some care and treatment information. These were visible to staff and visitors to the wards; therefore, we were not assured that patient confidentiality was always maintained.

Discharge summaries were sent to GP’s so that up to date information was shared.

**Medicines**

The service prescribed, gave, and recorded medicines appropriately. Patients generally received the right medication at the right dose at the right time. However, medicines were not always stored appropriately.

The hospital used an electronic prescribing and administration system which facilitated the safe administration of medicines. There had been one 12 hour occasion when the electronic system had broken down which necessitated paper prescriptions being printed by the pharmacy department. Staff told us that they received paper prescription charts promptly from the pharmacy department.

Pharmacy services were available on weekdays 09.15am to 5.30pm Monday Tuesday, Thursday and Friday, 9.30am to 5.30pm on Wednesday and 10.00am to 3pm on Saturdays, Sundays, and out of hours. There was an on-call pharmacist available on call for advice from 8pm to 8am seven days a week. The pharmacists or pharmacy technicians visited the wards daily and checked and reconciled medications. Prescriptions were also checked, for example they were checked for accuracy, drug interactions and allergy.

Antibiotics were reviewed periodically in line with Trust’s Antibiotic Stewardship policy.

Pharmacy staff participated in the assessment of patient’s own drugs and drug history gathering, they arranged the dispensing of monitored dosage systems when required and, where a prescribing pharmacist was in place, prescribed discharge medicines to facilitate the speedier discharge of patients. Pharmacists also provided high risk medication counselling, surgical pre-admission medication review, information and pre-operative medicines supply where required and advice and discharge counselling.

Arrangements were in place to ensure there were adequate supplies of emergency medicines and equipment especially out of hours from an emergency medicine cupboard and the on-call pharmacist.

Medicines, including intravenous fluids were stored securely with access to clinical drug storage areas restricted to authorised staff. Keys to medication trolleys and cupboards were kept securely by the nurse in charge of a group of patients. It was the responsibility of the nursing staff to top up medicines in the drug trolleys. We found liquid medicines did not have documented open dates or anticipatory expiry dates on them. On one ward we found a liquid controlled drug (CD) had expired. We also found three out of date medicines on the wards in the medicines trolleys. There were no systems for date checking medicines in the trolleys. Therefore, we could not be assured that all medications that were used would be in date. We raised this with the ward manager during our inspection who liaised with the pharmacy department who removed the medication.

We saw that medicine storage rooms had suitable preparation facilities for all types of medicines such as controlled drugs and antibiotics. Controlled drugs are medicines which are controlled under the misuse of drugs legislation. These were stored following good guidance procedures including daily checks by two nurses. However, on one ward the internal controlled drug cupboard was wooden which did not comply with standards. This was raised with the ward
manager who discussed the concerns with the pharmacy department. Pharmacists told us that a plan was in place to rectify this. During our unannounced inspection on 20 August 2018 we saw that the cupboard had been replaced.

Medicines were stored safely in theatres. There were three controlled drug cupboards which remained locked. In the anaesthetic room anaesthetic agents were stored in a locked cupboard, however these were unlocked when staff were present to allow quick access. Fluids were stored in fluid cabinets.

Members of the pharmacy team reviewed the patient’s medical history and commenced a medicine reconciliation to ensure patients’ medicines were available and up to date, however some medicines, including some controlled drugs were found to be out of date. This was raised with ward managers and the medication was removed by the pharmacy teams.

The pharmacy team had taken steps to manage clinical room temperatures when they were not in range across the trust. However, we found wards were not managing medicines fridge temperatures appropriately. On one ward we saw that the maximum and minimum temperature recordings for the fridge had been out of range for seven consecutive days since 29 July. On the day of inspection, we found the fridge was frozen and the actual fridge temperature was below the recommended range. The fridge had 13 different medicines stocked in it, including different types of insulin. There was a risk that frozen insulin could have been administered, which would not be effective at lowering peoples blood sugar levels. Staff told us that they had been advised to report to the pharmacy team when the actual fridge temperature was not in the recommended range. The pharmacy team was informed during the inspection and action was taken to quarantine the medicines. We were not assured that the trust had robust systems in place to monitor fridge temperatures consistently. We saw that fluids had been removed from fluid cupboards on one ward as the room temperature had risen above 30°. Another ward had moved the nutritional feeds to the medicines room which had air conditioning.

Pharmacy staff undertook a continuous program of intervention audits and took action to address some of the common themes identified. For example, “pop-ups” were introduced into the electronic prescribing system to support safer prescribing.

Medicines and equipment for use in emergencies were readily accessible to staff and was checked regularly. Emergency equipment (including oxygen cylinders, ligature cutters and an automated external defibrillator) was available. Oxygen cylinders were full and within date. The trust had employed a system that provided assurance that blood glucose testing kits were calibrated before use. Staff could access medicines supplies and advice throughout the day and out of hours. There was a clinical pharmacist available and a satellite dispensary on the ward Monday to Friday 9am to 5pm. Staff told us that electronic prescribing and medicines administration system (EPMA) helped with the patient’s timely discharge. Pharmacists attended ward rounds, conducted medicines reconciliation, and any medicines related activity. (Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct). Unwanted medicines were returned to the pharmacy department for disposal.

We checked a sample of electronic medicine records and saw that they were completed fully with no missing administrations. However, we saw that the electronic system did not alert staff if medicines were administered at incorrect intervals or when patients were on time specific medicines. Staff told us that this information would be shared during handover meetings. We saw insulin and fluid charts were kept on paper charts and reference to these was made on the electronic system to prompt staff. Staff told us that the electronic system had been very useful, however they did not have enough laptops especially during medication administration rounds.
Since electronic prescribing had been introduced there were no patient group directions (PGD’s) on the ward. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription, for example some types of pain relief. Staff told us that several senior nurses were undertaking a nurse prescribing course to enable them to prescribe from a small list of medicines.

All medicines were reviewed during consultant led ward rounds which were always attended by the clinical pharmacist. When required medicines were also reviewed during the ward rounds.

We saw that staff were not wearing red tabards when undertaking medicine rounds. The reason for wearing tabards is to stop staff being interrupted when dispensing medicines to patients and therefore reducing the risk of drug errors occurring. We raised this during our inspection and the following day we saw that when nursing staff were dispensing medication they wore red aprons to clearly highlight this. We also saw that staff did not always check patient wrist bands to ensure that they had the right patient. We raised this with senior staff and action was taken to ensure this was done. We heard staff being reminded of the importance of checking patient identity bands at the ward handover.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Lessons were learnt when things went wrong.

The trust recognised the importance of ensuring the safety of patients, staff and visitors and the opportunity that incidents presented for action, learning and quality improvement throughout the organisation. There was a collaborative approach in ensuring that lessons were learnt and shared within divisions, wards, departments and more widely across the organisation. Learning from incidents were shared and disseminated through newsletters, grand rounds, ward and departmental safety huddles, use of patient stories in training, talks and events, at trust-wide, divisional, departmental quality and risk meetings, audit meetings, induction, statutory and mandatory training and through staff briefings, emails and notifications. The trust managers also informed staff of incidents.

Most staff recognised incidents and reported them appropriately. Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff told us there was good communication about incidents through the safety huddles and discussion at ward meetings. Managers said they fed back to staff information from the quality improvement programme (QIP) meetings about incidents and learning from them.

The trust used an electronic incident reporting system and staff we spoke with knew how to report incidents. Staff understood their responsibilities to raise concerns and report incidents. Serious incidents were investigated following NHS guidance and learning was identified and communicated to staff. Actions were identified for the speciality and for the directorate. From June 2017 to May 2018 the surgery department had reported a total of nine serious incidents. Themes included sub-optimal care of a deteriorating patient, a surgical invasive procedure incident, a diagnostic incident including a delay in treatment, and a venous thromboembolism (VTE), when thrombo-prophylaxis had not been prescribed or administered. Actions were taken following serious incidents to reduce the risk of them re-occurring. For example, following the VTE serious incident the electronic prescribing system was reviewed to assist with the pathway, it was included in the trust induction for trainee doctors and a prompt was included on the pro-forma for prescriptions.
An incident had occurred in theatres when a specimen for analysis at the laboratory had been misplaced. Following an investigation, managers identified that processes had not been followed correctly. The policy was amended to ensure that the process was clear and that specimens were signed for when arriving at the laboratory. The specimen was found and managers told us that duty of candour had been applied.

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Nursing and medical staff understood their responsibilities regarding the duty of candour legislation. They said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology.

The fortnightly mortality board meetings included discussion of morbidity and mortality. Medical staff led the discussion of individual patients and their care and treatment to identify any issues in the management of the patient which could have been improved.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported two incidents classified as never events in surgery.

The first was of never event type “wrong implant/prosthesis” and concerned the insertion of the wrong type of lens during cataract surgery. This occurred in July 2017.

The second was of never event type “retained foreign object post-procedure” and occurred in April 2018.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type was as follows:

- Sub-optimal care of the deteriorating patient: four
- Surgical/invasive procedure incident: three
- Treatment delay: one
- Venous thrombo-embolism incident: one

The three SIs of type “surgical/invasive procedure incident” include the two never events described above.

The time taken by the trust to report these nine SIs to STEIS was variable:

- Within 14 days: two
• 15 to 30 days: three
• 31 to 60 days: three
• 90 days or more: one.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported seven new pressure ulcers, two falls with harm and three new urinary tract infections in patients with a catheter from May 2017 to May 2018 in surgery.

We saw data on display on information boards across the theatres and surgical wards. These included for example, the number of falls, pressure ulcers and complaints as well as detailed feedback from patients.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Luton and Dunstable University Hospital NHS Foundation Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of this effectiveness. They assessed staff compliance with guidance and identified areas for improvement. However, some policies were out of date.

A wide range of policies and guidelines were available for staff. They were based on national guidance and provided reference to these. However, we found that some policies were not up to date and were difficult to find on the trust intranet. For example, we saw that the clinical photography policy and the policy for the use of medicines were both due for review in November 2016 and August 2015 respectively. We raised this with the trust who told us they would review all out of date policies and the process of reviewing all policies.

The trust had an electronic database which recorded and tracked progress with the implementation of NICE guidance. Managers had developed a procedure which outlined the trust’s processes and how they dealt with new and updated NICE guidance. The trust’s clinical quality department ensured that each publication was allocated to the appropriate clinical lead, with declaration forms to be completed with information regarding compliance. NICE guidance was audited as part of the trust wide audit programme and through the completion of national audits. If further action was required by the trust before fully implementing new guidance for example, staff training or the acquisition of new equipment, action plans were developed and the issue was registered on the risk register. Audit support was provided by the quality department where needed. Audits of NICE guidance were reported bi-monthly to the clinical audit and effectiveness committee.

There was a systematic programme of clinical audit and local audit processes in place. Most audits scheduled had been completed or were in progress. For example, the national hip fracture database audit is an ongoing national audit to monitor the care of these patients and examine the quality and outcome of the care offered to frail and older patients. The surgical service had identified areas for improvement such as:

- Improved risk assessments for example nutrition and pressure ulcers
- Ring fencing beds for patients with fractured neck of femur (FNOF)
- The development of a golden patient policy to prioritise FNOF cases on the trauma lists for timely surgery.
- A fractured neck of femur lead was appointed in August 2017

Local ward and departmental audits were undertaken for example to monitor compliance with risk assessments such as the malnutrition universal screening tool (MUST) being undertaken within a specific time frame, record keeping and handwashing. Action plans were developed following local audits and staff were informed of outcomes and reminded of processes at safety huddles and ward meetings. An audit of do not attempt cardio respiratory resuscitation forms (DNA/CPR) was undertaken and identified that the forms were not easily accessible within the patients notes. Following the audit, a wallet was added to the front cover of the notes so that the documentation could be clearly seen and identified. The resuscitation team also undertook monthly audits of DNA/CPR to look at whether documentation and decision making was fully completed and revised action plans to address any concerns.

Surgery services used the American Society of Anaesthesiologists (ASA) grades as a guide regarding a patients’ fitness to undergo an anaesthetic. This was in line with NICE guidance. The
ASA physical status classification system is a simple scale describing fitness to undergo an anaesthetic. For example, ASA1 or ASA2 are relatively low risk patients. ASA3 patients have a higher risk of complications during anaesthesia due to other comorbidities they may have. We attended a team brief and noted that the order of surgery had been previously agreed at a theatre board meeting in accordance with the patient’s risk factors.

The pre-assessment clinic assessed and tested most patients in accordance with NICE guidance (NG45) for planned (elective) surgical operations, for example, MRSA screening was undertaken. However, we saw that eight patients had not had surgical pre-assessments carried out. We raised concerns about the inconsistency of pre-assessment with the trust who told us that the entire pre-assessment model had been reviewed. Managers told us that following a review of the pre-operative services provided by the trust, the new pre-assessment model, including a one-stop drop in service on the day of decision to list for surgery would be launched in September 2018. A new pre-assessment hub had been built and would be opening as the central location for pre-assessment in September 2018.

Venous thromboembolism (VTE) assessments were recorded on the electronic drug charts and were clear and evidence based, ensuring best practice in assessment and prevention. Pop up reminders had been added to ensure that risk assessments were undertaken and to prevent the prescription of specific medications without a risk assessment being done first.

Nutrition and hydration

Staff generally gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required. However, some patients were fasted prior to their operation for long periods of time which was not in line with national guidance.

Staff assessed patient’s nutrition and hydration needs using the validated malnutrition universal screening tool (MUST). Audits undertaken in April 2018 demonstrated that not all patients were screened within 24 hours of admission nor had a nutritional care plan. Individualised action plans were developed for each ward and agreed with ward managers. For example, data provided by the trust showed that trust wide compliance with MUST assessments being completed within 24 hours was 47%, data provided for Ward 20 demonstrated 55% compliance. Dietitians provided ward based MUST training for each ward on a quarterly basis; and records of all staff who had received training were maintained.

Patients waiting for surgery were usually kept “nil by mouth” in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. However, we saw that some patients had been fasting for long periods of time. For example, two patients had arrived at 10.30 but were still fasting at 4pm and waiting for surgery. One patient told us that she was hungry and thirsty. However, staff also told us that if a patient was waiting for a long time the anaesthetist would be contacted to check on the time of surgery and to see whether the patient could have a drink if surgery was delayed. The trust did not monitor fasting times. Following our inspection, we requested further information about fasting audit. Managers told us that the fasting audit was awaiting its formal assessment and presentation. Data had been collected between January and March 2018 and was to be presented to the general surgery and anaesthetic audit day. Findings and any recommendations were to be discussed at the audit meeting and presented at a governance half day.

The surgical wards operated a policy of ‘protected mealtimes’ which involved all none essential patient care and interventions being halted during the mealtime to enable patients to eat
undisturbed and maximise their nutritional intake. We observed a meal time and saw that interventions were minimised.

Patients with nausea or vomiting were prescribed antiemetic medicine (a drug effective against vomiting and nausea). Patients were given antiemetic medicine intravenously in the recovery area if they complained of nausea post operatively.

Patients had jugs of water within reach on their bedside tables. We observed these to be regularly refilled. Intravenous fluids were also prescribed and recorded appropriately.

A wide range of 'healthy' menu choices were available for all meals and patients could choose from a variety of foods including many cultural choices. There was a menu booklet at the end of each bed with dietary details included. We saw a patient information leaflet for diabetic patients 'controlling your diabetes while in hospital' available on all wards, the content had been due for updating in May 2018.

The trust sourced foods produced to higher sustainability standards, seasonal fresh food and paid attention to animal welfare and ethical trading conditions. Foods were procured and served to higher nutritional standards, this included reducing salt, saturated fat and sugar content and increasing the consumption of fibre, fish, fruit and vegetables.

Staff told us that during extremely hot weather conditions they had been provided with cold drinks in the clinical areas.

Patients that we spoke to were complementary about the standards and quality of the meals.

Pain relief

The service managed patients’ pain effectively and provided or offered pain relief regularly. Pain was risk assessed and recorded using the National Early Warning Score (NEWS) scale and we saw these were completed. We observed staff asking patients if they were in any pain. Staff had access to tools to help assess the level of pain in patients who could not express this verbally.

Staff could contact a nurse specialist in pain control by telephone for advice and to assess patients.

We saw staff ask patients if they had any pain. Patients that we spoke to told us that their pain was well managed. However, results of a pain audit indicated some areas for improvement around checking that pain relief had been effective after administration’.

A pain audit was undertaken by the nurse specialist pain team between October 2017 and March 2018. This showed that 92% of patients had had their pain score assessed and documented with every observation. This was the same as a previous audit undertaken in 2015. 69% of patients reported experiencing pain during their hospital stay, this was an improvement on the previous audit in 2015 when 75% of patients experienced pain. In the surgical division over half of patients asked, 57% reported that if they requested medicine for pain they received it straight away and 89% said that nurses and doctors came back to see them to see if the pain had improved.

Individual ward action plans were developed and shared with ward staff. Themes included evaluating analgesia effectiveness half an hour after administration, reviewing patients pain scores after receiving analgesia and informing the doctor if analgesia did not work. Action plans were shared and agreed with departmental staff at team meetings.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to
improve them. The trust participated in national audits for example the national emergency laparotomy audit and patient reported outcome measures and generally performed similar or better than the England average. We saw action plans were in place following the audits results

The service took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMs) programme and the National Emergency Laparotomy Audit (NELA). NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high quality comparative data from all providers of emergency laparotomy.

Data supplied between September 2016 and November indicated that in 85% of cases both consultant surgeons and consultant anaesthetists were both present in theatre when there was a risk of death, this was above the national average of 79%. However, the risk of death documented before surgery was 38% which was below the national average of 71%.

The trust participated in the national hip fracture database audit. This identified that there had been a reduction in 30-day mortality, improved nutritional risk assessments, falls and bone assessments and reductions in in-hospital pressure ulcers, re-operation, increases in pre-operative medical assessment and improved multidisciplinary team assessment.

The service participated in the CAN001 Bowel Cancer (NBOCAP) audit. Outcomes demonstrated that case ascertainment was 104%, above the national aggregate of 95 with post-operative length of stay after major bowel resection less than five days which was 55%, better than the national aggregate of 69%. Risk adjusted 90day post-operative mortality rate was 4%, which was within the expected range; whilst risk adjusted 30 day unplanned readmission rate was 15%, within the expected range (86 admissions). The risk adjusted 18 month temporary stoma rate in rectal cancer patients undergoing major bowel resection (removal of part of the bowel) was 56%, which was within the expected range.

The service had undertaken a re-audit of factors affecting non-compliance to venous thromboembolism (VTE) prophylaxis in August 2017 in general surgery following a decline in performance between February and March. This had resulted in correct VTE assessments being undertaken, the proforma was a good educational and audit tool which minimised errors in patient records. Staff awareness, confidence, accurate assessment and treatment of risks had increased which resulted in improved patient safety. The service planned to continue regular monitoring of assessments.

Relative risk of readmission

*Luton and Dunstable University Hospital – elective admissions*

From February 2017 to January 2018, patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average:

- Patients in general surgery and urology had higher than expected risks of readmission for elective admissions when compared to the England averages
- Patients in colorectal surgery had a lower than expected risk of readmission for non-elective admissions when compared to the England average
Luton and Dunstable University Hospital – non-elective admissions

Over the same period, patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average:

- Patients in general surgery had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Patients in trauma and orthopaedics and ENT had higher than expected risks of readmission for elective admissions when compared to the England averages.

Non-Elective Admissions – Luton and Dunstable University Hospital

The Trust has taken a number of actions in response to the readmission data including:

- An audit to review those patients who have been readmitted and their reasons.
- Implemented ‘hot clinics’ for any patients who were concerned to return to hospital to seek assurance about their care.
- Worked with the emergency department to ensure that the on call registrars were clear on the criteria for admission for these patients, including GP referrals post-operative.
- Established a telephone line for GPs to contact consultants, particularly lower limb, to seek advice and recommendations for patients.

The Trust will continue to monitor the re-admissions rates for elective admissions to review if the actions that have been taken are making the appropriate impact.

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the trust’s risk-adjusted 30-day mortality rate was
7.6% which was within the expected range. The 2016 figure was 7.9%.

The proportion of patients having surgery on the day of or day after admission was 63%, which failed to meet the national standard of 85%. This was within the bottom 25% of trusts. This was a deterioration from the trust’s 2016 performance of 72.9% for this metric.

The crude perioperative medical assessment rate was 93.9%, which failed to meet the national aspirational standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 98%.

The proportion of patients documented as not developing a pressure ulcer was 99%, which narrowly failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 100%.

The crude overall hospital length of stay was 22.6 days, which fell within the middle 50% of trusts. The 2016 figure was 16.1 days.

(Source: National Hip Fracture Database 2017)

In June 2018 the trust was one of the poorer performing trusts for high mortality in the first quarter of 2017. This high mortality was identified in January 2017 by the trust. In response the trust re-established a fractured neck of femur (NOF) steering group and mortality reviews and performance related to these actions were monitored monthly at the trust fractured neck of femur steering group. An action plan was in place and the service was working to develop a fractured neck of femur pathway. The trust had a process in place to have a fractured NOF bed available, which was included in the bed reports, or a step-down patient identified should a fractured NOF patient be admitted. This meant that since May 2018 patients could be transferred directly to ward 23. The trust also planned to re-launch a fast track protocol for direct admission to ward 23 for patients who met certain criteria. A lead nurse for fractured neck of femur had also been appointed. Since June 2018 the crude mortality for fractured neck of femur had reduced with low numbers of patient deaths in July and August. The trust planned to build two new operating theatres. The timetable for the new theatres included additional dedicated emergency operating time which was expected to reduce pre-operative length of stay for emergency surgery.

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 55.5% of the trust’s patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate of 69.5%. The 2016 figure was 67.9%.

The risk-adjusted 90-day post-operative mortality rate was 3.6% which was within the expected range. The 2016 figure was 3.3%.

The risk-adjusted two-year post-operative mortality rate was not reported for the trust in 2017. The 2016 figure was 18%.

The risk-adjusted 30-day unplanned readmission rate was 14.8% which was within the expected range. In 2016 this metric was not reported for the trust.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 56.1% which was within the expected range. The 2016 figure was 53.2%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not participate in the 2017 National Vascular Registry (NVR) audit as it does not perform major vascular surgery. The vascular service provided at the trust consists of four visiting
consultants from a local NHS trust who provide day case surgery and tertiary outpatient clinics. All emergency work and major procedures are referred to a local NHS trust, which provides the main elective and emergency vascular service for the whole of Bedfordshire.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer Audit the trust provided poor quality data for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The trust was not eligible for the 90-day post-operative mortality rate metric, either in 2015 or 2016.

The proportion of patients treated with curative intent in the Strategic Clinical Network (East of England) was 33.8%. This was significantly lower than the national aggregate of 37.6%.

This metric is defined at strategic clinical network level. The network can represent several cancer units and specialist centres and the result can therefore be used a marker for the effectiveness of care at network level. Better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The national Emergency Laparotomy audit (NELA) awards one of three possible ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 audit, the trust achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. Risk of death was documented in 36% of cases compared to the national aggregate of 71%. This was based on 187 cases.

The trust achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 109 cases.

The trust achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 94 cases.

The trust achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 55 cases.

The trust’s risk-adjusted 30-day mortality was within the expected range. This was based on 331 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 the trust performed worse than the England average for hip replacements according to two out of three indexes. However, the third index showed performance to be similar to the England averages for both the proportion reporting an improvement and those reporting that they felt worse after the procedure.

The trust’s performance for varicose veins was better than the England average according to two out of three indexes, but worse than the England average according to the third index.

The trust’s performance for groin hernias and knee replacements was in both cases similar to the England averages according to all indexes.

(Source: NHS Digital)

We saw that several audits results were discussed at the trauma and orthopaedic executive performance meeting for example readmission rates, fracture NOF audit results and elective hip and knee replacements audit results. Action plans were in place which included a review of staffing levels and gaps in theatre staff, additional weekend lists, a review of theatre case mix, a review of outpatient clinic start times and potential for an orthopaedic clean admissions ward. The results of audits and action plans were presented to the executive team in June 2018.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them, when required, to provide support and monitor the effectiveness of the service.

Staff told us they received a comprehensive induction when they commenced work at the trust. This included a trust wide induction and local induction. The local induction included orientation to the area and local competencies. Staff told us they found the inductions useful. Agency staff also received a local induction. The trust wide induction training included areas such as information governance, infection prevention and control and fire safety.

Nursing staff who were new to the clinical areas had a two-week supernumerary period so that they could familiarise themselves with the environment, processes, policies and procedures. During this time new staff would work with specialist nurses to support in the development of new skills. Newly qualified nurses underwent a six-month preceptorship programme with an identified preceptor. A period of preceptorship helps newly qualified nurses develop the confidence to practise competently. The preceptorship period also ensured the newly-qualified nurse was familiar with and met their obligations under the NMC code. Clinical supervision was also available to all staff.
Managers told us that ward rosters were arranged so that there were always senior staff to take charge of the ward and provide support to junior nurses. We saw that this had been achieved. Opportunities were provided however for more junior staff to take charge of the ward with support to develop their management and leadership skills.

Student nurses had practice placements in the clinical areas as part of their nurse training. They were supernumerary, worked alongside a registered mentor and had access to support from their link tutor at the university. We spoke with a student nurse who described the opportunities she had had to learn and the support she had had from her mentor.

The trust monitored the number of training places that were available to ensure that there was sufficient supply to meet the demand. E-learning was actively promoted. The number of e-learning courses had been increased and access for staff had been improved. This had been achieved through the provision of additional computers in the library so that individuals who required extra help or a quiet place to work could complete the relevant modules. An updated electronic record had also been developed where training could be accessed and recorded, and a programme for mobile devices had been introduced. Additional classroom sessions were provided when required. Educational sessions were either delivered internally through subject matter experts or were procured externally.

The trust had a wide range of specialist nurses and other professionals to provide guidance, education and support for staff in the clinical areas. For example, there were specialist nurses for diabetes, safeguarding, tissue viability, pain management, learning disabilities and infection control. In addition, clinical leadership and development nurses worked in identified 'hot spots' to support leadership of the team. Staff told us how they would access specialist nursing teams and we saw contact details on ward notice boards. Staff were able to access support for patients with mental health issues. If further psychiatric assessment was required staff could refer to the liaison psychiatry services who were based within the hospital.

The service had link nurses for a variety of specialities including nutrition, pain, continence, infection control, sepsis and an end of life champion. Link nurses are nurses with a special interest who have received additional training in specific areas. Link nurses shared information and provided formal, two-way communication between specialist teams and nurses in the clinical area.

There were practice educators in the clinical areas who provided support and training for staff, this included developing and assessing competencies. We spoke with a practice educator in theatres who described the process of staff development. For example, staff would be rotated through different theatres and specialities to increase their experience and to provide a flexible work force. Staff had the opportunity for access to supportive practice if, for example, they were having clinical difficulties or had been away from practice for a significant period of time such as long term sick leave. This provided the opportunity to complete an assessed supportive practice document to refresh skills and knowledge and increase confidence.

Specific training events were held. For example, there was open access to all nursing staff to a diabetes study day; a diabetes session was included in the preceptorship programme and took place on alternate months. A clinical skills day was also held on alternate months, and included training on the use of insulin including intravenous insulin infusions. An e-learning module 'The Six Steps to Insulin Safety' was available to all trust staff via the intranet. Diabetes e-learning modules were promoted at all teaching sessions but were not mandatory at present.

Secondment opportunities were available for staff of all grades. Managers and practice educators told us that in theatre, operating department practitioners (ODP’s) and health care assistants...
(HCA’s) had been seconded for additional training. Examples of this were to become a first assistant during surgery and to train as an associate nurse. In the surgical assessment unit staff told us they had attended an external pre-assessment course to develop skills within the role.

Senior staff on surgical wards told us that they were accessing nurse prescribing courses to enable them to prescribe from a dedicated list of medicines enabling them to enhance patient care.

Senior staff of all professions for example nurses, doctors, physiotherapists and speech and language therapists could access clinical leadership programmes to develop their leadership and management skills. Managers told us that this course had been very effective and had enhanced confidence. Action learning sets were utilised in the leadership development programmes for bands 7 and 8 staff. Senior staff also received coaching from the East of England leadership network list of coaches.

Trainee doctors were provided with a named clinical supervisor by the trust as outlined in ‘The Gold Guide- 6th edition’, Foundation Programme Reference Guide and standards for trainers outlined in the GMC publication “The Trainee Doctor”. In addition, they received support from senior medical and dental staff through supervision, teaching, training opportunities, completing supervised learning events and work based assessments and the receipt of immediate feedback to trainees during ward rounds, out-patient clinics, completion of procedures and theatre sessions. We saw that junior medical staff were provided with good learning opportunities at a medical handover meeting, they were given the opportunity to ask questions and that good consultant led case discussions were held.

All junior medical and dental staff were allocated an educational supervisor whose role was to support, guide and monitor the progress of a named trainee. They were also responsible for discussing the learning opportunities available in the post and developing a personal development plan. Pastoral care, support with their e-portofolio and curriculum completion needed for the level of the trainee was also provided, to enable progression to the next stage of training.

Medical staff received protected teaching sessions twice yearly on diabetes, insulin safety and the in-patient management of diabetes.

The service had received complaints from surgical trainee doctors that they did not have appropriate work schedules and were not being enabled to access all of the training opportunities that they could to complete their core training requirements. Junior doctors had reported these concerns to the medical deanery who carried out an investigation and produced a report. An action plan had been developed by the service to address the issues, which included a junior doctors committee which held regular meetings. All junior doctors are allocated an educational supervisor whose role is to support, guide and monitor the progress of a named trainee.

Medical staff that we spoke to reported being happy with the exposure and training that they were receiving.

Overseas nurses had been recruited and were working on the wards as unregistered nurses. These staff were going through their objective structured clinical examination (OSCE) training to register as nurses in the UK. The OSCE is based on UK nursing pre-registration standards. Candidates must work through scenarios that nurses would be likely to encounter when assessing, planning, delivering and evaluating care.

The majority of bank shifts were filled by permanent staff members or regular bank staff.

Agency nurses also worked on the wards and in theatres. The trust used agency nurses from a
specific agency and many of the same agency staff worked on a regular basis and were familiar with the clinical areas. Specialist nursing staff and practice educators also worked alongside the nurses on these wards to support with the delivery of quality care.

Recruitment and retention plans were in place linking with the lead nurse workforce, matrons and managers. The trust had joined cohort three of the NHS Improvement (NHSI) led retention programme which focused on reducing the turnover of both nursing staff and health care assistants (HCA’s).

Staffing was reviewed twice a day in conjunction with matrons, the interim director of nursing and the assistant director of nursing. Staff were redeployed as necessary to meet patient needs and to ensure patient safety.

Enhanced care requirements were monitored and reviewed at staffing meetings following risk assessments of patient requirements.

**Appraisal rates**

Staff received an annual appraisal which they told us was constructive and provided a formal opportunity to review their progress and identify further training needs.

Appraisal rates for nursing and ward based staff were 81% against a trust target of 90%. However, during our inspection we saw that appraisal rates had increased to 96%. Some staff that we spoke to had not had an appraisal as they had not been in post long enough but had received feedback and was awaiting an appraisal.

Staff said they understood the areas required for development which were discussed in their annual appraisal. Staff said the trust provided them with development opportunities and there was an agreement with the local university for staff to undertake continuing professional development courses. Staff told us they could identify areas of education or development that they wished to pursue in their appraisal for consideration by managers. Staff also confirmed the trust had enabled them to develop their career through the attendance of relevant educational courses.

Managers told us that they would raise an incident if there were problems with planning appraisals due to work schedules. Managers had arranged to do some appraisals out of working hours so that they could be completed, staff then claimed the time back.

Divisional reports and reports to cost centre managers, were sent on a monthly basis, both of which contained information about appraisal compliance for individual staff. Staff were also contacted to remind them that they needed to book an appraisal with their line manager. A further system had been introduced to inform staff in advance, that their appraisal was due so that there was sufficient time to book the meeting with their line manager.

From June 2017 to May 2018, 83% of staff in surgery at the trust received an appraisal compared to a trust target of 90%.

The breakdown by staff group is shown in the table below. Please note that the trust was unable to provide separate appraisal completion data for registered nursing staff. In the trust’s appraisals data these staff are included in the staff group “nursing and ward based staff”.

As well as registered nursing staff, this group also includes healthcare assistants, health care support workers, modern matrons and nurse managers, dental surgery assistants and play specialists.
<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>103</td>
<td>118</td>
<td>87.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>40</td>
<td>50</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing/ward based staff</td>
<td>246</td>
<td>303</td>
<td>81.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>389</td>
<td>471</td>
<td>82.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Effective multidisciplinary team working practices were established and teams generally worked well together to improve the effectiveness and timeliness of care. Relevant staff teams and services were involved in assessing, planning and delivering patient’s care and treatment and worked together to understand and meet the range and complexity of patient’s needs. We observed that patient care on surgical wards was supported by a variety of teams. This included pharmacists, an infection control team and physiotherapists. Consultants felt they had good support with difficult cases from colleagues.

We were made aware of some interpersonal difficulties between one group of consultants and poor working relationships with a potential impact on patient safety. The trust invited the Royal College of Surgeons (RCS), the Invited Review Mechanism (IRM) and a representative of the Association of Surgeons of Great Britain and Ireland to carry out an internal review. Following the review, a number of recommendations were made including the trust facilitating a mechanism to improve relationships, a review of the role of the clinical director and general manager and a review of clinical governance processes in order to monitor performance more robustly. Although the performance was within an acceptable range for most clinical outcomes, concerns had been raised about the collection and use of data.

Twice daily ward rounds were undertaken seven days a week on all surgical wards, these were performed by both consultants and registrars, however, registrars would perform the ward rounds at weekends. Medical and nursing staff were involved in these together with physiotherapists, and/or occupational therapists. We observed good multidisciplinary working between these teams of staff.

We observed good multidisciplinary team working within the wards to ensure that patient care was co-ordinated, the nurse in charge was aware of patients care and any concerns and that staff were aware of patient’s needs.

Care pathways were multi-disciplinary and staff of all disciplines developed and supported the enhanced recovery programme. Each professional group recorded their assessments in patient’s medical notes. It was therefore easy to access information about outcome of the valuation and the ongoing care of the patients from each professional’s perspective.

Staff could access practice development nurses, safeguarding teams and the critical care outreach team who were able to provide support and advice when required. Staff liaised with patients, their community and the specialist learning disability nurses at the hospital. Staff explained how they had accommodated patients prior to surgery to alleviate their fears and worries enabling patients to attend their procedure.
Daily board rounds were held that included members of the multidisciplinary team (MDT). For example, extended role nurses and allied health professionals worked as part of the surgical team. The surgical service had an ortho-geriatrician (a consultant who specialised in elderly care patients) who attended the board rounds. An ortho-geriatrician is involved in the care of patients over 65 years of age who require an orthopaedic review. The service for fractured neck of femur had an active steering group, we saw reports of cases discussed which demonstrated a good level of review. The service also held a monthly mortality review. Patient care was planned in several specialities through MDT meetings for example in cancer care and trauma and orthopaedics.

Staff reported good daily working arrangements. This included good liaison between theatre and the ward to enable discussion about theatre timings and theatre delays so that patients may have oral fluids if time permitted. However, we also saw that two patients had been fasting for long periods of time without this communication occurring.

Services had introduced monthly MDT meetings to minimise clinical variation. For example, in orthopaedics, as a result of the getting it right first time (GIRFT) review, the team identified that a lower limb MDT to review complex case management would help ensure consistency of application of the treatment thresholds across the group of consultants.

Daily huddles were held on each ward with nursing staff and members of the multi-disciplinary team attending, including the lead nurse, occupational therapists and physiotherapists. During the huddles, important information was shared to ensure each patient received the required level of support for that day, staff were appropriately allocated for patient care and key messages were shared.

We saw evidence of good communication with care homes around the admission of patients. A new system had been introduced which involved that patients admitted from a care home had a special red bag which contained a lot of patient information including medications, any do not resuscitate paperwork (DNA/CPR), and clothing.

Discharge planning was commenced prior to admission and was part of the surgical pre-assessment. This meant that patients requiring additional support would be identified early so that care packages could be arranged as necessary. However, managers told us that some patients discharges were delayed due to a lack of availability of local authority care packages.

Letters were sent to GP's when patients were discharged from hospital.

**Seven-day services**

The service was working towards seven-day services.

The trust was committed to the delivery of seven-day services across four priority clinical standards to 90% of patients by 2020 and the results of the national seven-day services audit were used to monitor progress on the trust’s delivery. There was executive sponsorship and regular board oversight for the seven-day services project.

The survey demonstrated that some standards such as access to diagnostic tests and consultant directed interventions were being consistently delivered.

The surgical services provided consultant cover on site seven days a week. Theatres, anaesthetics and recovery had staff on duty 24 hours a day. There was a rota for out of hours and weekends to cover emergencies. There was a consultant on-call 24 hours a day, seven days
a week for emergencies.

Ward rounds at the weekend were often run by registrars with consultants available for advice as necessary. This meant that the service did not always meet the target of patients being seen by a consultant within 14 hours of admission.

The last national audit of seven day working in September 2017 showed that the proportion of patients reviewed by a consultant within 14 hours of admission to the hospital was 63% overall compared to 73% compliance at the previous audit. Results were variable across the divisions with one of the biggest challenges being in surgery. In general surgery for example 40% of patients were reviewed within 14 hours during the week with 38% being reviewed within 14 hours at the weekend. In trauma and orthopaedics 57% of patients were seen within 14 hours in the week, no figure was provided for the weekend. The surgery department were reviewing processes to ensure that the appropriate resources were in place.

Diagnostic services including interventional radiology services were available 24 hours a day, seven days a week. Interventional radiology refers to a range of techniques which rely on the use of radiological image guidance (X-ray fluoroscopy, ultrasound, computed tomography (CT) or magnetic resonance imaging (MRI) to precisely target therapy.

Pharmacy advice and support was available seven days a week from 8am to 8pm with access to a pharmacist for advice or supply of medicines out of hours through the hospital switchboard.

The physiotherapy and occupational therapy (OT) team worked seven days a week. At weekends the service was reduced to two physiotherapists, one technician and one assistant.

The surgical assessment unit (SAU) provided 24-hour cover seven days a week. The SAU service is an acute unit where they assessed patients for emergency surgical problems.

Nursing staff were supported with the deteriorating of care in a patient by the critical care outreach team.

**Health promotion**

**Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and as appropriate for individuals.**

The enhanced recovery programme provided patients with information on how they could ensure they were as fit for their procedure as possible. It reminded patients of the importance of eating a balanced diet and stopping smoking.

Staff identified patients who may need extra support. We saw health promotion information and materials on display on the wards. Examples included; eating a healthy diet, moderating alcohol intake, increasing physical activity and smoking cessation. We also saw post-operative dietary advice displayed.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff understood their roles and responsibilities in relation to consent and under the Mental Health Act (MHA)1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care**

The trust had a consent policy which was in date. The policy stated that when written consent was being sought there was a two-stage consent process to discuss treatment options, this should be in advance of the procedure being carried out. The second stage was confirmation that the patient...
still wanted to continue and may be signed in the out-patient’s department, pre-admission clinic, or when they arrived for treatment.

There were three versions of the standard consent form: form one for adults or competent children, form two for parental consent for a child or young person and form three for cases where it was envisaged that the patient would remain alert throughout the procedure and no anaesthetist would be involved in their care.

For procedures in theatre, staff performed a series of safety checklists during which time staff could review the validity of capacity to consent, and alter the format of the consent obtained if necessary. If capacity was deemed to be lacking, staff utilised the recommended consent form (type four) designed for the purposes of sanctioning procedures in the best interests of the patient, on medical grounds. If capacity was considered present, a standard type one consent form (form two for children) was used, allowing the patient, or individual with parental responsibility, to provide written confirmation/evidence that the process of consent had been undertaken.

When patients were admitted for surgery and confirmation of consent was sought, this could not be documented in the patient record as the consent form had been scanned into the electronic record. This had been identified at the previous inspection in 2016.

There were no consent forms available in other languages but staff that we spoke to said they would access an interpreter from the trust’s interpreting service to gain informed consent.

Patients we spoke with told us they were given all the information they needed to make a decision about their treatment. They said medical staff had fully explained the procedure at their initial appointment, they were given further information at their pre-operative assessment and when they were admitted to the ward it was explained again. This meant that when a patient was due to sign their consent form they had been provided with clear, concise information about the procedure and the associated risks.

We saw that consent was checked prior to theatre, theatre staff told us that there was a policy that “if there was no consent there was no theatre”.

The trust screened all patients over 75 years for dementia within 72 hours of admission, this information was held on the electronic recording system. There was also an identification symbol for people with a known diagnosis of dementia on the bed management electronic system and the information technology system (IT) system was being updated with a list of patients known to have had a diagnosis of dementia on previous admissions to hospital. This allowed a visual alert to be held against their information.

The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. We saw four records for patients with MCA documentation, however of these only one was fully completed and signed. For example, we saw that not all parts of the form, stage one and stage two, had been dated or signed. Although families had been involved in decisions there was nowhere on the form for their views to be documented. We raised this with the trust, who told us that they had reminded staff to complete forms and that matrons would be carrying out daily audits to check compliance.
The deprivation of liberty safeguards (DoLS) protect people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). During the inspection we saw two completed DoLs forms, however there was no record of family involvement on one record.

Staff we spoke with told us that they would provide additional support dependent on the patients’ needs, for example support was available from the learning disability nurse for patients with dementia or a learning disability when they attended for the pre-assessment clinic. Theatre staff told us that they would ensure that additional support was provided for patients living with dementia or a learning disability, for example the patient may be walked to theatre rather than go on a theatre trolley. The order of the operating lists was also prioritised according to need.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) levels 1 and 2 training was completed by 83% of staff in surgery compared to the trust target of 80%.

This included 93% of registered nursing staff and 65% of medical staff. Therefore the 80% target was not met for medical staff in surgery.

Deprivation of Liberty Safeguards training is covered under the trust’s Safeguarding Adults Level 1 and 2 and Safeguarding Adults Level 3 training modules.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. Patients universally praised staff for their kindness and their understanding of their needs. Staff promoted privacy, and patients were treated with dignity and respect. Staff members spent time with the patients, and interacted with them during tasks and clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.

We observed staff treating everyone with kindness and respect. They welcomed people onto the ward and to theatre and put them at their ease. We saw staff explaining what they were proposing and responded well to people’s questions and concerns. They quickly recognised when someone might need some extra reassurance or support and provided it tactfully.

Feedback from patients confirmed that staff treated them very well and with kindness. Staff respected patients’ privacy and dignity both on the wards and in theatres. We observed staff maintaining patient’s dignity prior to going into theatre and during surgery. Nursing staff pulled curtains around the bed space during personal care.

Surgical wards visited displayed many thank you cards which they had received from patients and relatives. Patients we spoke to told us that “the care is excellent” and said that staff had been “kind, caring and chatted to them” and that when they were woken up for observations staff were courteous.

Staff in individual services had commissioned their own surveys, which included services such as the discharge lounge. Key findings included communication issues, being given conflicting information and lack of communication. Communication from nursing staff was reported to be slightly better than doctors. Staffing levels, staff attitude and the environment, including privacy and dignity, cleanliness of the clinical area and noise levels were other themes.

Friends and Family test performance

From May 2017 to April 2018 the Friends and Family Test (FFT) response rate for surgery at the trust was 43%. This was based on 3,974 responses. This was higher than the England average of 28%.

A breakdown of FFT performance by ward for surgical wards at this hospital with total responses over 100 for the period from May 2017 to April 2018 is below. All the wards scored 90% or above for the 12 month period overall.

The lowest monthly score was for ward 22 in June 2017 (78%). However this was based on only 18 responses. Otherwise all four surgical wards scored 86% or higher in every month.
Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and they were able to talk openly with them and discuss any concerns.

Patients’ spiritual needs were taken into account irrespective of any religious affiliation or belief. The lead chaplaincy service supported spiritual care across all services and ensured that the delivery of spiritual, pastoral and religious care was adequate and appropriate. The trust had a team of chaplains, volunteers and faith community leaders, drawn from the diverse local communities who worked in partnership to provide spiritual care and support to patients, visitors and staff to ensure that religious and cultural needs are met. A Muslim Chaplain had recently been appointed. The Chaplaincy team visited the wards regularly, had visitors that visited generically as well as teams that offered support to particular patient groups.

The hospital had recently refurbished the Chapel and Faith Centre which had facilities for people of all faiths, with a Christian Chapel, a shared space and a prayer space as well as the Sacred Space Prayer Room that had washing facilities, religious literature, prayer mats and the ability to section off parts of the room.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients said they felt involved in their care and had been asked for permission and agreement first which meant that the views and preferences of patients were taken into account. Patients and relatives had been given the opportunity to speak with the consultant looking after them. Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. Most patients were very complimentary about the way they had been treated by staff. We observed most staff introduced themselves to patients, and explained to patients and their relatives about the care and treatment options.

All of the patients we spoke to could explain their procedure and they had received all relevant information during their pre-assessment appointment. Most were clear about what was expected of them post-operatively and the exercises, if applicable, they should continue.

Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. Staff said that the pre-assessment clinic identified the communication needs of patients. This included access to language interpreters, specialist advice or advocates. This meant the service was compliant with the Accessible Information Standards (2015). These standards direct and define a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

Feedback from patient surveys showed that patients were sometimes unsure of who was looking after them and who they could talk to if they were unsure or worried about their care. Some
relatives visited PALS to voice concerns. As a result of this managers introduced the ‘Nurse in Charge’ initiative which included the nurse in charge wearing a distinctive red badge so that patients, visitors and other staff knew who they could approach to find out vital information.

We saw that staff had responded to patient concerns, for example some patients had complained that the wards were too noisy at night. Staff had responded by offering patients ear plugs and ensuring that the call bells were set to night mode.
Is the service responsive?

Service delivery to meet the needs of local people

The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services.

The service used a model for delivering needs based care and recognised the need to allocate patients to specialty beds based on clinical presentation and need irrespective of age. For example, the service had dedicated beds and a clinical pathway for patients who had suffered a fractured neck of femur to ensure that they were admitted to the appropriate ward.

An enhanced recovery programme was in place to support patients prior to and during their procedure. The aim of the programme was to:

- Ensure patients were as healthy as possible for their treatment
- Ensure patients received the best care during their surgical procedure
- Ensure patients received the best care while recovering post-operatively
- Encourage early mobilisation to avoid complications such as pressure tissue damage or a chest infection.

The service also had re-design plans for the pre-assessment service which would ensure that any patients cancelled on the day of surgery would be kept to a minimum which would benefit patient outcomes and experience. This service was due to commence in September 2018.

The trust was a regional centre for bariatric patients and took patients from a wide catchment area. The service had systems in place to support the needs of patients who required additional support. For example, there were specialist nurses in a variety of clinical specialities. This included a learning disabilities team and dementia champions who, in collaboration with ward staff identified patients who needed support, risk assessed individual needs, and supplied patient centred care.

The red bag scheme had been implemented for patients admitted from a care home. This ensured that patients vital information was brought to hospital, for example medications, clothing and do not resuscitate documentation (DNA/CPR). Staff told us that they had found this system to be working well.

A “Baywatch” scheme was also in place for patients who had a high risk of falls. We saw that a designated member of staff wore an orange lanyard and remained in a bay of patients whilst engaging with all patients and performing care. Any items required were brought by other staff so that the dedicated staff member did not leave the area. We saw PIPA healthcare signs on the wards. PIPA healthcare signs are healthcare cards used to identify specific needs for example specific nutrition needs, these signs were pictorial and therefore suitable for use with patients of all ethnicities, cultures and languages.

The trust had an interpretation policy and provided an interpreting service to reflect the needs of the diverse local population. The interpreting service provided interpreters for 36 languages, this was either by telephone, face to face or translation services. The trust planned to further improve how this service was delivered to include literacy, comprehension, vision, hearing and other ability support as well as language. Staff we spoke to told us that they could access the interpretation service easily.

Ward layouts had been designed to ensure bays were single sex. The trust did not report any single sex breaches between July 2017 and July 2018. New policies were being developed to
Meeting people’s individual needs

Services were planned to take into account the individual needs of patients.

Standardised care plans were used and whilst care planning was individualised and based on the needs of each patient, it was sometimes difficult to find information about individualised patient care. An assessment was taken by the multi professional team either before a planned admission or on admission ensuring that patients were safe. Where patients lacked capacity, the trust used the ‘this is me’ and ‘all about me’ resource. Patient preferences were identified which included information about their family, likes and dislikes and eating and drinking preferences. We saw that in some records this documentation had not been fully completed.

Some adjustments had been made for patients living with a physical disability. The surgical wards had wide corridors and nursing station desks were low so that they were at an appropriate height for patients in wheelchairs. However, in the surgical admissions department access was limited, the area was long and thin with low tables and chairs which would limit access for patients with a disability and the desk was high therefore not appropriate for patients in wheelchairs to access staff easily.

The service used a flagging system for patient care needs. all patients had PIPA boards cited above their beds, which included the patients name and allocated consultant as well as magnetised symbols. We saw these boards in use on the wards. PIPA healthcare signs are healthcare cards used to identify specific needs for example nutritional needs, these signs were pictorial and therefore suitable for use with patients of all ethnicities, cultures and languages. Other symbols were used, for example for patients suffering from dementia a butterfly was used. A butterfly sticker was also placed on the patients notes. “John’s campaign”, where carers had a 24-hour pass to enable them to remain with patients with learning disabilities had been implemented.

There were arrangements in place for patients with complex social health and social care needs. Staff said patient’s individual needs were identified during their pre-operative assessment and the theatre lists were arranged to reduce the amount of time patients waited. A specialist nurse for learning disabilities was available to provide support and advice if required. However, staff told us that some patients with complex needs who required local authority sourced care packages had their discharge from hospital delayed because of a lack of availability of carers.

Open visiting was in place which enabled family members to engage in patient care.

The wards protected patient mealtimes to ensure patients could eat their meals without interruption. The policy of ‘protected mealtimes’ which involved all none essential patient care and interventions being halted during the mealtime enabled patients to eat undisturbed and maximise their nutritional intake. We observed a meal time and saw that interventions were minimised.

A wide range of ‘healthy’ menu choices were available for all meals and patients could choose from a variety of foods including many cultural choices. There was a menu booklet at the end of each bed with dietary details included. We saw a patient information leaflet for diabetic patients ‘controlling your diabetes while in hospital’ available on all wards, the content had been due for updating in May 2018.
The trust sourced foods produced to higher sustainability standards, seasonal fresh food and paid attention to animal welfare and ethical trading conditions. Foods were procured and served to higher nutritional standards, this included reducing salt, saturated fat and sugar content and increasing the consumption of fibre, fish, fruit and vegetables.

Patients that we spoke to were complementary about the standards and quality of the meals.

Patients with complex needs were discussed at a daily trust wide senior nurse safety huddle. This was attended by the dementia, safeguarding and learning disabilities clinical nurse specialists. Any specific interventions were planned and actioned, this included “Baywatch” for patients at high risk of falls. Patients with mental health needs were assessed and support provided as necessary, enhanced one to one care was also provided as required. We observed staff discussing patient specific care needs at a ward daily safety huddle.

The trust had an interpreting service which staff told us was easily accessible and provided translation services in 36 languages. Staff told us that they could access the interpreting service easily. Interpreters could be pre-booked, for example for pre-assessment appointments. There were also hearing loops in place for the hard of hearing.

There were a variety of patient information leaflets available with a range of information including community services, healthy diets, pre-and post-operative advice and exercises. However, these leaflets were not available in a variety of languages.

There was a menu booklet at the end of each bed with dietary details included and a wide range of foods available to suit a variety of cultural tastes. We also saw a patient information leaflet for diabetic patients 'controlling your diabetes while in hospital' available on all wards.

Patients who were admitted as emergencies frequently did not come prepared. A patient essential care pack pilot project funded by charitable funds had been introduced. The pack contained essential items for personal care along with eye shields and ear plugs. The feedback from patients had been very positive and the trust were working on accessing permanent funding.

The red bag scheme had been implemented for patients admitted from a care home. This ensured that patients vital information was brought to hospital, for example medications, clothing and do not resuscitate documentation. Staff told us that they had found this system to be working well.

A private ambulance service for discharging selected patients had been introduced as delays in discharges had been encountered. Staff told us that this service had had a positive impact. A new discharge lounge was being built. Patients would be discharged from the ward to the lounge. A satellite pharmacy department was planned to enable ease of access to take home medications. Patients would also receive their discharge letters there. A temporary discharge lounge was located on a corridor on Ward 23, it contained comfortable chairs and was appropriately staffed. However due to the temporary nature of the facility there was a strict criterion for the patients who were able to access it. No hot food was served and patients who required additional support would not meet the criteria. Discharge medication was available and appropriately stored.

The trust had a spiritual care policy. Staff ensured that patient's religious and spiritual needs were taken into account irrespective of any religious affiliation or belief held by other patients or staff. The lead chaplain supported spiritual care across all services and ensured that the delivery of spiritual, pastoral and religious care was adequate and appropriate. The chaplaincy liaised with communities to ensure they accommodated the faith and beliefs of patients. A faith centre was available for all patients and staff at the hospital where services and prayers were held regularly.
Access and flow

Waiting times from referral to treatment were longer than the England average. The national standard target was 92% of patients waiting no longer than 18 weeks for treatment. From May 2017 to April 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average in 11 out of 12 months. As of April 2018, RTT data was improving, the trust was 4% below the national average overall.

The trust had systems and processes in place to manage patient waiting times from referral to treatment. The national standard target was 92% of patients waiting no longer than 18 weeks for treatment. From May 2017 to April 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average in 11 out of 12 months. The trust is building two new operating theatres scheduled to open in March 2019 which will significantly improve the capacity for planned procedures.

The trust had an action plan in place which was monitored by the deputy chief executive. A referral to treatment (RTT) recovery plan was put in place in February 2018 and was reviewed monthly by the board sub-committee responsible for quality, the clinical outcome, safety and quality committee (COSQ). RTT performance was also reported to the board through the quality and performance report.

To address the backlog, waiting list initiatives were implemented. Eight additional surgical operating lists were booked for weekends with 42 patients having their surgery, and day case surgery was increased. The trust optimised theatre operating lists and filled and re-booked new cases into any short notice cancellation slots. These bookings were undertaken by the waiting list office. In addition, the trust arranged “super Saturdays” when nine surgeons, theatre and nursing staff ran additional theatre lists. Managers told us that staff were not paid at premium rates for working on "super Saturdays”.

The trust reported that high numbers of planned elective cases were cancelled over the winter months due to lack of beds, having to use theatres recovery areas as contingency beds for emergency patients, which impeded theatre flow and meant fewer numbers of procedures were completed. Clinical safety was maintained by protecting capacity for cancer and urgent operations. This meant that some specialties were more greatly affected than others for example orthopaedics and bariatrics. Following our inspection, we requested information from the trust about the number of patients who remained in the recovery area overnight. Managers told us that no post-operative patients were kept in recovery overnight but if additional surgical capacity was required a contingency area would be opened and appropriate patients would be transferred to that area to allow post-operative patients to be moved from recovery to a suitable ward area.

The trust was exploring opportunities to outsource to the private sector and other local providers to reduce the waiting times for large numbers of clinically appropriate patients as quickly as possible. Additional clinics were also being run to address the waiting lists of day-case patients.

Theatre managers told us that their greatest risks were the ventilation in the operating theatre, fabric of the building and the recruitment of scrub nurses. Ventilation and high temperature issues had resulted in the one theatre being out of use which had resulted in the cancellation of patients. High numbers of vacancies within the theatres team had also negatively affected the sustainability of the level of Saturday working.

Managers told us that a business plan had been developed for two new operating theatres and were they were awaiting the outcome of this. Following our inspection this £6.2m business case had been approved with the new theatres scheduled to open in March 2019.
During periods when theatre lists had been cancelled due to bed pressures, theatre staff had been redeployed to work in other clinical areas.

The numbers of surgical outliers and medical patients taking up surgical beds were recorded in a bed report on a daily basis. This identified where patients were within the hospital. Managers held three bed meetings a day and an additional meeting when the trust was in an escalation situation. A medical director was also on call daily and liaised with the control room to ensure that all patients were reviewed by the appropriate medical, surgical, nursing, allied health professionals, and discharge planning teams. This ensured that any health care or safety issues were escalated and managed appropriately.

The hospital had a nurse led pre-operative assessment clinic. Most patients had a pre-operative assessment which included for example testing for MRSA, however there were some patients who had not been pre-operatively assessed and were assessed on the day of surgery.

Patients admitted for surgery were admitted to the surgical admissions department. The surgeon and anaesthetist saw the patient pre-operatively in the admissions area which was separate from the wards and theatres. Patients were escorted directly to theatre from this department and relatives were asked to telephone the hospital to find out what ward they were on as beds were allocated dependent on availability. Patients that we spoke to said that the system had worked well, although some patients said that they had waited a long time. All patients arrived at the same time and could wait four to five hours in the waiting room for surgery as there was no staggered admission times.

Two patients that we spoke to in the surgical day unit told us that they had waited for surgery all day and had been fasted since the morning. They had been admitted at 10.30 but had not been to theatre at 4.30pm. Staff told us that they would check with anaesthetists if theatre lists were delayed to see if patients could have a drink, however this had not happened. Patients were discharged home directly from the recovery area and we saw staff from the day-case unit discussing discharge arrangements with patients.

Referral to treatment (percentage within 18 weeks) - admitted performance

From May 2017 to April 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average in 11 out of 12 months.

There was a deteriorating trend in performance from 69.2% in May 2017 to 54.6% in February 2018 (England average 67.5%). This was followed by an improvement to 66.2% in April 2018 (England average 64.6%). This was the only month in the whole 12-month period when the trust outperformed the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

The NHS Constitution set out that patients wait no longer than 18 weeks from GP referral to treatment (RTT). From May 2017 to April 2018 three specialties were above the England average.
for admitted RTT (percentage within 18 weeks):
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>95.8%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>79.8%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>76.2%</td>
<td>70.2%</td>
</tr>
</tbody>
</table>

Over the same period four specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>68.7%</td>
<td>77.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>60.9%</td>
<td>72.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>54.1%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>40.0%</td>
<td>62.2%</td>
</tr>
</tbody>
</table>

The RTT was included in the corporate risk register and we saw this risk had been regularly reviewed. As of April 2018, RTT data was improving, the trust was 4% below the national average overall.

A notes review took place for patients waiting over 18 weeks and were reviewed with the clinical teams. The aim was to ensure that the most appropriate actions were taken. Managers told us that highly complex patients did not breech these times and were identified by the getting it right first time review (GIRFT). Complex patients would receive treatment whilst those patients with more routine surgery waited longer. Following our inspection, we requested information from the trust about any harm reviews that had been undertaken as a result of patients exceeding RTT times. Managers told us that waiting list staff worked with the specialty teams to ensure patients had their surgery based on clinical priority. The trust did not have a standard escalation point at which a harm review would be completed for a patient exceeding the 18 weeks waiting time. However, no patients had been identified that had triggered for a formal harm review at the point of treatment. Managers told us that the trust had not had any patients breach the 52 week standard and no patients had been identified who had been found to be harmed as a result of their waiting time.

Cancer waiting times targets were largely met, however there were five two week wait breeches for gastroenterology/surgery with performance at 85%-92% against a target of 93%. The earliest available appointments had been offered to these patients. Other breaches across all specialities were due to complex diagnostic pathways, late referrals and patients rescheduling appointments.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two-year period from quarter 1 (Q1) of 2016/17 to Q4 2017/18, the percentage of last-minute cancellations at the trust where the patient was not treated within 28 days was consistently lower (better than) than the England average.

There was a deterioration in trust performance from Q2 2017/18 to Q4 2017/18.

In Q2 2017/18, the trust cancelled 87 operations. Of the 87 cancellations, 0% weren’t treated within 28 days.

In Q3 2017/18, the trust cancelled 199 operations. Of the 199 cancellations, 3% weren’t treated within 28 days.
In Q4 2017/18, this trust cancelled 361 operations. Of the 361 cancellations, 7% weren’t treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Luton and Dunstable University Hospital NHS Foundation Trust**

Over the same two-year period, the percentage of cancelled operations at the trust was worse than the England average in five out of eight quarters. Again, there was a deterioration in trust performance from Q2 2017/18 to Q4 2017/18. In Q2 2017/18 the trust’s performance for this metric was 0.8% compared to the England average of 0.9%. By Q4 2017/18 this had deteriorated to 3.3% compared to the England average of 2.1% in that quarter.

*Source: NHS England*

Managers told us that the numbers of cancelled operations reflected unprecedented winter pressures. This had led to the trust cancelling significant volumes of elective operations.

**Average length of stay**

*Luton and Dunstable University Hospital - elective patients*

From March 2017 to February 2018 the average length of stay for elective patients at Luton and Dunstable University Hospital was 2.7 days, which was shorter than the England average of 3.9 days.

Average lengths of stay for elective specialties:

- Average lengths of stay for general surgery, trauma and orthopaedics and urology elective patients were shorter than the respective England averages
Elective Average Length of Stay - Luton and Dunstable University Hospital

Note: Top three specialties for specific site based on count of activity.

Luton and Dunstable University Hospital - non-elective patients

The average length of stay for non-elective patients at Luton and Dunstable University Hospital was 3.7 days, which was shorter than the England average of 4.9 days.

Average lengths of stay for non-elective specialties:

- Average lengths of stay for general surgery and ENT non-elective patients at Luton and Dunstable University Hospital were similar to the respective England averages
- Average length of stay for trauma and orthopaedic non-elective patients was shorter than the England average

Non-Elective Average Length of Stay - Luton and Dunstable University Hospital – elective patients

(Source: Hospital Episode Statistics)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, complaints were not always managed in a timely way.

The service had a complaints procedure and processes in place to manage complaints. However, there was a delay in the service response to complaints which was not in line with the policy which stated that complaints should be responded to in three working days and resolved within 35 working days. Managers told us that this was because of staffing issues and the time taken for statements to be written as the process of receiving statements and complex complaints took longer than 35 days to resolve.

Summary of complaints
From April 2017 to March 2018 the trust received 139 complaints about surgery. The trust took an average of 47.5 working days to investigate and close these complaints. This was not in line with their complaints policy, which states that complaints should be responded to within 35 working days.

The breakdown of complaints by subject is shown in the table below. Because one complaint can have multiple subjects, the total below exceeds the total number of complaints.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>115</td>
</tr>
<tr>
<td>Appointments</td>
<td>33</td>
</tr>
<tr>
<td>Communications</td>
<td>17</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>12</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>12</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>4</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>2</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td>Commissioning</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>203</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Complaints were assigned to the divisional complaints lead who ensured the general manager and clinical director were aware of the complaint and a full investigation was carried out. There was a complex process for reviewing complaints prior to responses being sent to complainants. Between January 2018 and February 2018 only 31% and 38% respectively of complaints had been completed within 35 working days. The trust was planning to reorganise the complaints process to manage all complaints centrally and introduce a triage system to enable faster responses. However, managers expressed concerns that a centralised process may reduce the level of ownership at local level and therefore impact on sharing and learning. No new complaints had been referred to the ombudsman within the last 12 months.

Staff told us that some verbal complaints were managed on the wards or in theatres and were not always reported. Staff told us that these complaints were dealt with as soon as they occurred by the ward sister or matron.

Staff would direct patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly.

There was information within the hospital about how patients could make a complaint. Information leaflets and posters were also displayed within the ward areas, advising patients and their relatives how they could raise a concern or complaint, either formally or informally. Notice boards on the wards included ‘You said’ ‘We did’, in response to patient comments.

Patients we spoke with told us they had not had a reason to complain during their stay, but they would feel confident in raising a concern or complaint if necessary. Staff said that if a patient raised a concern or wanted to make a complaint they would listen to the issue, see if they could resolve the matter immediately and report it to the ward manager or nurse in charge.
Learning from complaints took place through various forums at local divisional level and across the trust. These included ward meetings, safety huddles, divisional governance meetings, newsletters, grand rounds, patient safety breakfasts, and patient stories to the board. We saw action taken following complaints for example complaints had been received around communication and handover. Staff had not been aware that a patient was deaf or blind and had approached them inappropriately. As a result of this, PIPA boards were in place on the wards with icons that are able to identify patients with specific needs.

A red flag system had been introduced in the surgical division as a result of complaints for clinic letters to be typed urgently when a patient needed imaging prior to a scheduled appointment or procedure. This meant that patient experience was improved and delays in treatment were prevented.

**Number of compliments made to the trust**

From April 2017 to March 2018 the trust received 64 compliments about surgery.

In their RPIR the trust did not provide a breakdown by subject or theme for compliments in each core service. However, they noted that the overall theme identified from compliments received across the trust over the period above was excellent care from staff in various teams.

*Source: Routine Provider Information Request (RPIR) – Compliments tab*

We saw that there were a number of thank you cards from patients displayed thanking staff for the care they had received. Most of the patients that we spoke to were complimentary about the care and treatment they had received.

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Senior leaders were visible and demonstrated commitment.

The surgical clinical leadership team was being strengthened and speciality based clinical directors were being appointed for each speciality. Each speciality and the theatre department had a matron who was supported by the ward and theatre manager.

Senior leadership was visible, staff told us that the chief executive officer and the chief nurse were visible and was described as approachable.

We saw strong leadership within the surgery division which demonstrated commitment, and support for staff. The senior management team including the lead nurse and matrons were responsive, accessible and available to staff at all times. Ward managers said they were supported by the matrons and surgical divisional leads. Staff gave us examples of how they had been individually supported by senior management.

Service leaders had the necessary skills and knowledge required to lead the service effectively. They understood the challenges to quality and sustainability such as financial pressures and bed capacity.

We met with the ward managers and registered nurses during the inspection and found they were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward’s performance against the trust priorities and the areas for improvement. When we raised issues with them, they responded to address them immediately.
Band six and seven nurses and other allied health professionals had completed leadership and development programmes which included undertaking staff appraisals. Theatre managers told us that staff who had undertaken these programmes demonstrated clear leadership skills which were vital to working in a busy and challenging department. Band five nurses had opportunities to develop their leadership and management skills, for example they had opportunities to take charge of the ward with support from senior staff.

Ward staff told us that matrons and ward managers were supportive and approachable. Staff knew how to contact the medical and nursing lead for their area. Staff told us that ward managers and matrons were approachable and supportive and offered advice and training.

The surgical wards had a daily nurse in charge who managed the daily running of individual wards. When a member of staff was the nurse in charge they wore a red badge which clearly identified them and were supernumerary which enabled them to manage and fulfil the requirements of the role.

Managers held departmental meetings to keep staff informed of updated information within their ward or department. These meetings were minuted and shared with staff. There were various methods of communication across the teams, including meetings, newsletters, notice boards and e-mail. Areas covered included; patient safety, staffing and staff vacancies and ward performance.

Junior medical staff that we spoke to reported that they were happy with the exposure and training they received. However junior medical staff had previously raised concerns about the level of support they were receiving. This was being addressed by managers and an action plan was in place.

Leadership within one surgical speciality was compromised due to poor interpersonal relationships. An external review had been undertaken and recommendations had been made to address the concerns.

Theatre managers told us that they worked together closely and were supportive of each other. However, they also told us that there had been limited engagement with clinical directors to address the challenges that had been identified in theatres such as the impact of ventilation issues and cancelled theatre lists.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action. Staff understood and demonstrated the trust's vision and values.

The surgery divisional strategy was aligned with the trust’s annual plan. Service developments were planned which included:

- the launch of a new referral process for oral maxillofacial and orthodontics patients to reduce inappropriate referrals
- the recruitment of a new bariatric clinical fellow due to the high demand of the service,
- to implement a designated elective orthopaedic ward which would reduce patient stay and enhance outcomes for patients
- implement a new model for preoperative assessment

We saw that the vision was displayed on noticeboards within the wards. Staff understood and demonstrated the trust's vision and values of the trust and they felt the service adhered to the trust’s aims daily. Staff told us that they enjoyed working at the trust and had good training opportunities, felt supported by their managers, teamworking was effective, they were kept
updated and felt that they were listened to. Staff were positive about the forthcoming merger with a local NHS trust.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Both theatre staff and nursing staff on surgical wards reported a good culture.

Staff felt supported by their colleagues and matrons in their individual areas. They told us they were proud to work within the trust. Staff said their line managers looked after them well. We also observed positive and supportive interactions between matrons and ward managers. Matrons described having an open-door policy where any member of staff could see them privately. This was confirmed by staff spoken with who felt they could address any concerns with the matrons and managers.

Service leaders spoke highly of staff in theatres and on the wards and how hard they had worked and adapted to the winter pressures. When asked what they were most proud of, they replied, “their staff”.

Throughout the inspection, staff told us they were happy with their work and their immediate team. There was a culture of collective responsibility between teams and services. Staff felt listened to and said they worked well as a team. Openness and honesty was encouraged at all levels and staff said they felt able to discuss and escalate concerns. Staff knew and understood the role of the trust’s freedom to speak up guardian although they did not all know their name. The role of the freedom to speak up guardian is to ensure that staff have the capability to speak up effectively and are supported appropriately. There were posters of who to contact available and the freedom to speak up guardian had attended meetings and trust wide events to introduce themselves.

All the staff we spoke with talked about an open and transparent culture within the hospital and the trust. Staff told us that there were “good people around, very supportive”, “this is an excellent place to work” and it was a “caring hospital”. This was confirmed by patients that we spoke to.

Managers told us that new staff rotated so that they learnt skills in all surgical specialities and this also introduced them to the wider surgical division. Most theatre staff rotated to cover recovery, scrub and anaesthetic nurse duties regularly.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The service had systems in place to improve quality. The senior management team described the governance structure for the surgical division. There were a variety of meetings which took place. Governance meetings for the division included the (COSQ), the surgical risk and governance meeting, and the quality performance meeting (QPM). Divisional performance was reviewed by the executive team monthly. This covered financial reporting, quality and human resources issues. A nursing and midwifery board meeting took place monthly and the minutes were shared with the COSQ. The senior nursing team also met weekly to discuss current issues and for peer support. This was an informal meeting and was not minuted.

All staff spoken with confirmed there was a good governance structure in place across the surgical services with meetings being attended by both divisional leads and senior staff. Staff confirmed governance meetings included feedback from the board as well as input from ward staff. These
were disseminated to staff via team meetings. Anything urgent was discussed at the safety meeting each day and put on display on the staff board.

Monthly meetings were held for a variety of staff groups including ward managers, band six, ward sisters and charge nurse forums. We saw minutes of these meetings and that a variety of topics were discussed and the action plans and review dates were in place to address them. Examples of these included staff knowledge of the mental capacity act and deprivation of liberty standards (MCA/DoLS) and an improvement in teamworking. Action plans had been put in place to provide additional MCA/DoLS training on the wards and processes on the ward had been amended which had enhanced team working.

Nursing staff said they attended ward meetings and we saw meeting minutes were available for staff to read in the staff room. Staff also confirmed learning from incidents, complaints, audits and other quality improvement initiatives were communicated to them in a variety of ways such as; handover meetings, quality safety meetings, e-mails and information on the notice board.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Each clinical group had a risk register which was reviewed at monthly surgical clinical risk and governance meetings. Control measures were in place; they were regularly reviewed to ensure they remained current and additional control measures were added as relevant. Risks identified included the risk of failing the 18-week referral to treatment time target as a result of rising demand and fixed capacity. A high level action plan was in place to address this.

The lead nurse for surgery told us that they had oversight of incidents and met with matrons and ward sisters to discuss these. We saw minutes of meetings where incidents and complaints had been discussed. Complaints were discussed at team meetings. Staff told us that they received feedback from incidents and complaints in team meetings, safety briefings and on a staff only social media group.

Matrons and ward managers had daily meetings to discuss staffing levels, patient safety concerns and bed occupancy.

The trust had completed local as well as national audits. For example, audits had been undertaken to ensure compliance with full completion of risk assessments in relation to falls and nutritional within the time frames identified in the trust policies.

The trust had a major incident and mass casualty plan developed by the clinical risk and emergency preparedness manager. This had been developed in 2015 but had been extended until March 2018. Staff could access the plan on the intranet.

The trust had a business continuity plan released in May 2016 which provided guidance on maintaining services and dealing with business interruptions which might disable services or require special arrangements to be put in place to allow them to continue.

The adult safeguarding team had a governance pathway in place to ensure appropriate information and learning from enquiries were disseminated to the internal risk management team, Care Quality Commission (CQC) lead, risk and governance team, local authority adult safeguarding teams and clinical commissioning groups (CCGs) to ensure appropriate governance internally.

**Information management**
The service collected, analysed, managed and used most information well to support all its activities, using secure electronic systems with security safeguards.

Leaders had a holistic understanding of performance. Information was used to measure improvements. There were clear and robust service performance measures in place, which were monitored at monthly governance meetings.

The service had a wide range of information available to them to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.

The information department used benchmarking reports to improve the accuracy of patient level information and identify any data quality issues which were reviewed at data quality (DQ) meetings. The trust had an information management and technology strategy and an information system steering board to oversee the administration of all systems. There were effective arrangements in place, which ensured data was submitted to external providers as required such as serious incidents and RTT performance.

During the inspection we observed appropriate use of computers with no screens detailing patient information left unattended.

**Engagement**

The service engaged well with patients, the public and local organisation to plan and manage appropriate services, and collaborated with partner organisations effectively.

Patients views were sought and acted upon. For example, patients with chronic pain could join the integrated pain management service user group, which was set up in September 2017. The group had reviewed the pathway for the management of chronic pain. This was a multidisciplinary meeting which included staff from acute and community services. Feedback and suggestions made to the group have resulted in information being shared with the Clinical Commissioning Group (CCG) to improve and develop the service.

Staff attended the twice yearly “good, better, best” events which was used for sharing information with staff. Staff said they found it a good opportunity to receive updates, meet new staff and share learning. Staff were aware of the proposed merger with a local NHS trust. Communication had commenced within the surgical division on both sites around planning and development of future services.

Engagement surveys had been conducted with staff through engagement events for example in relation to the vision and the values and their opinions on the engagement process for the merger with a local NHS hospital. Managers ensured that there were regular communications and reports back to staff at team brief which aimed to raise awareness, and encourage involvement, support and feedback for the merger proposal.

Staff had also reported good communication between senior management and staff, high staff motivation at work, and the good quality of appraisals. However, staff reported that they had experienced harassment, bullying or abuse from patients, relatives or the public. An action plan was in place to address this.

The trust had implemented a mobile staff “app” to give staff better access to the information they needed. These included news alerts, links to important information, access to the e-roster, e-mails and major incident alerts.

**Learning, continuous improvement and innovation**
The service was committed to improving services by learning from when things go well and when they go wrong, promoting innovation.

The urology service had been doing holmium laser enucleation of the prostate (HoLEP) instead of trans-urethral resection of the prostate (TURP). HoLEP is a modern alternative to the standard transurethral resection of the prostate with a reduced hospital stay. The trust was a reference centre for this procedure and had regular visits from units from around the country who wanted to develop the services. Two masterclasses a year were run for consultants and senior registrars from the UK and Ireland who could watch live operations and attend lectures on how to set the service up.

Areas of improvement since the last inspection included:

- Feedback to staff following incidents.
- Availability of record of consent.
- Staff awareness of trust values.

Areas that had not improved since the last inspection included:

- Despite a focus on recruitment the vacancy rate for nursing staff had increased from 16% to 23%.
- Information was not readily available in other languages than English.
Luton and Dunstable University Hospital had 42 critical care beds as of May 2018. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Luton and Dunstable University Hospital NHS Foundation Trust and England.**

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>48.7%</td>
<td>23.9%</td>
</tr>
<tr>
<td>Adult</td>
<td>43.6%</td>
<td>68.2%</td>
</tr>
<tr>
<td>Paediatric</td>
<td>7.7%</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

There were 17 open adult critical care beds split between the intensive therapy unit (ITU) and the high dependency unit (HDU):

- The ITU had six open beds for level three patients as of May 2018. There was an additional bed, which could be used in the event of excess demand. As of March 2018, there were 35.0 whole time equivalent (WTE) registered nursing staff and one member of additional clinical services staff. The ITU received approximately 350 patients from April to 2016 to March 2017.

- The HDU, including the respiratory HDU, had nine open beds for level two patients and two level one beds as of May 2018. As of March 2018 there were 33.8 WTE registered nursing staff and 1.8 WTE additional clinical services staff. The HDU received approximately 600 patients per year from April 2016 to March 2017.

Level two beds are for patients who need higher level of care and more detailed observation than that provided on a general ward. These patients usually have a single failing organ or require post-operative care. Level three beds (in ITU) are for patients who require advanced respiratory support, or complex support for multi-organ failure.

As of May 2018, there were 19 open neonatal critical care cots. These services are covered in the children and young people section of this report.

The critical care service also provides a critical care outreach (CCO) team, which supports patients at risk of clinical deterioration on the wards of the hospital. As of March 2018 this service employed 6.7 WTE registered nursing staff.

As of March 2018, the trust employed eight intensivist medical staff in adult critical care.

(Source: Acute Routine Provider Information Request (RPIR) Context acute tab; NHS England)

During our inspection, we spoke with 28 members of staff, which included consultants, doctors,
different grades of nursing staff, allied health professionals, care support workers and staff in supportive roles. We also spoke with six patients and their visiting relatives and friends.

We checked the clinical environment, observed ward rounds, nursing and medical handovers and reviewed patients' health records.

The service was rated as requires improvement following our January 2016, with a rating of good for effective, caring and responsive and requires improvement for safe and well-led.
Is the service safe?

Mandatory training

Whilst the service provided mandatory training in key skills to all staff, not all staff had completed all the mandatory training required. Medical staff compliance was substantially below the trust target.

Staff were expected to complete mandatory training in seven topics as outlined below. In January 2016, 95% of staff had completed mandatory training, against a trust target of 80%. Data provided for this inspection showed that compliance was above the trust target for six out of seven topics for nursing staff. The exception was for staff trained in immediate life support (ILS). However, data provided by the trust at the time of inspection showed that 100% of nursing staff had completed basic life support training and 79% had completed intermediate life support training. On ITU 95% of nursing staff had completed basic life support training and 72% had completed ILS training.

Medical staff compliance was below the trust target for all topics. Overall compliance had also reduced since our previous inspection.

Staff compliance with training is detailed below.

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for registered nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult basic life support (ABLS)</td>
<td>65</td>
<td>71</td>
<td>91.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>65</td>
<td>71</td>
<td>91.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control - level 1 and 2</td>
<td>65</td>
<td>71</td>
<td>91.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>64</td>
<td>71</td>
<td>90.1%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling (practical)</td>
<td>63</td>
<td>70</td>
<td>90.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling (theory)</td>
<td>62</td>
<td>71</td>
<td>87.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Immediate life support (ILS)</td>
<td>45</td>
<td>70</td>
<td>64.3%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care, the 80% target was met for six of the seven mandatory training modules for which registered nursing staff were eligible.

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling (theory)</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control - level 1 and 2</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support (ABLS)</td>
<td>1</td>
<td>8</td>
<td>12.5%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the 80% target was met not met for any of the five mandatory training modules for which medical staff were eligible. All five modules had been completed by half or fewer of the
eight eligible medical staff. In particular, only one member of medical staff, out of eight eligible, had completed adult basic life support. There was an action plan in place to improve medical staff basic life support and advanced life support training which was implemented following a trust wide training review. We were told that pop up training sessions were being provided locally to capture staff whilst at work and prevent medical staff having to attend training classes.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Patient’s notes reflected recent referrals and documented actions taken locally to support patients through this process.

We saw that staff were aware of their roles and responsibilities to report any concerns relating to abuse or potential harm. We saw that staff had recently referred patients to the safeguarding team and openly discussed what actions were being taken to maintain the patient's safety. We saw that nursing records clearly outlined discussions with patients and relevant safeguarding staff. The nursing handovers ensured that delicate information was not generally discussed and was only discussed with the nurse maintaining that patients care.

We saw that staff could access safeguarding information on the trust intranet if they needed to make a referral. Staff could also access the trusts safeguarding team to support or advice. We saw that contact details were displayed across both units.

Staff were expected to complete safeguarding training, relevant to their roles. Similarly, to mandatory training, nursing staff compliance was above the trust target, and medical staff compliance was below the trust target. Details of compliance can be found below.

**Safeguarding training completion rates**

The trust set a target of 80% for completion of safeguarding training. Nursing staff told us that band 6 and 7 nurses were trained to safeguarding children level 3, whereas all other nursing staff were trained to level 2. Nursing staff training was in line with the trust target, whereas medical staff training was below the target for both adult and children’s safeguarding training. Details of level three training for medical staff was not shared during the inspection process.

**Trust level**

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for registered nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - level 1 and 2</td>
<td>69</td>
<td>71</td>
<td>97.2%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 and 2</td>
<td>68</td>
<td>71</td>
<td>95.8%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In critical care, the 80% target was met for both of the safeguarding training modules for which registered nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for medical staff in critical care is shown below:
<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - level 1 and 2</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 and 2</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care, the 80% target was not met for either of the two safeguarding training modules for which medical staff were eligible. In particular, four out of eight eligible medical staff had completed safeguarding adults’ level 1 and 2.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Throughout common areas, we saw posters relating safeguarding and sexual exploitation, which provided names and contact details of appropriate services. Nursing staff told us they would refer to these in any case where additional support was required.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Nursing staff generally kept themselves, equipment and the premises clean. However, medical staff did not always wash their hands before or after the point of care and audits in HDU showed poor compliance with hand hygiene for medical staff.

During our January 2016 inspection, we saw that the provision of handwashing basins did not comply with the Department of Heath 2013 best practice guidelines for critical care facilities (Health Building Note HBN 04-02) standard, of a minimum of one washbasin per bed space. Similarly, in HDU, there was one washbasin in each side room, and three located in the main department for 13 bed spaces. This posed a risk to effective hand decontamination. This concern was raised and the HDU was reconfigured to reduce the number of beds to nine within the main ward area.

Within the main ward area there were two pods used for patients with suspected communicable infections and seven beds. We spoke with the clinical leads who informed us, that the team were awaiting confirmation of a building proposal for a new HDU and ITU, which was expected around November 2018. It was envisaged that the new build would be in place in five years’ time, and the team were working on plans to make both ITU and HDU suitable until the new build was completed. The plans were in discussion amongst senior leads at the time of inspection.

Staff were observed to have arms bare below the elbows and used personal protective equipment when completing patient care. We saw that hand washing was completed appropriately and hand sanitiser was available and used regularly by nursing staff. This met the safe hand washing guidance from the National Institute for Health and Care Excellence (NICE). However, handwashing and sanitising gel use was not as prevalent by medical staff. During inspection, we did not see consistent use of hand hygiene by the medical staff, particularly in the high dependency unit. This was discussed with the team locally and staff reminded to wash or sanitise their hands.

Handwashing audits were completed monthly and results showed that nurses were more compliant than doctors. Hand hygiene audits were undertaken to measure compliance with the World Health Organisation’s ‘Five Moments for Hand Hygiene.’ These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene, to reduce risk of cross contamination between patients. Results of the most recent
audits were displayed on boards on the entry to the units. ITU showed a compliance rate of 83.35% for medical staff and 98.67% for nursing staff. The HDU information board showed 52% compliance for medical staff and 78% for nursing staff. We saw that hand hygiene audit results were communicated to staff through their staff meetings with reminders to sanitise hands after the point of care. Clinical leads were aware of audit results and were working with medical staff to improve handwashing. Following our inspection, the trust implemented additional weekly handwashing audits and refreshed the infection control programme in response to concerns raised regarding handwashing.

All areas were visibly clean and tidy. In ITU, staff cleaned their work area during each shift to complete damp dusting of equipment in use. We also saw that bed spaces were cleaned between patients. This included the changing of bed space curtains at regular intervals and following soiling or when patients had communicable infections.

There was a cleaning schedule, which was displayed on the unit. Domestic staff were employed through a separate provider and were dedicated to each unit. Ward cleaning compliance was also displayed on entry to the unit. ITU compliance showed a cleaning score of 98.37% and HDU 98% for July 2018. We saw that domestic and housekeeping staff were involved with ward activity, which included safety huddles. This process enabled them to keep informed of any changes in patients’ conditions, admissions and discharges.

There were side rooms available within ITU and HDU for the isolation of patients with communicable infections or patients with reduced immunity. Rooms did not have controlled airflows, or a lobby to assist with infection control isolation. This meant that there was a risk of cross contamination. However, this was cited on the critical care risk register. Staff were observed trying to reduce the risks of potential cross contamination by wearing appropriate protective equipment and removing them prior to leaving rooms.

Data reported by both units to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) showed there had been no unit acquired Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia (infection in the blood) or Clostridium difficile in the last twelve months (December 2017). This information was displayed locally on each clinical area as part of their quality performance data.

We saw that equipment, including the blood gas analyser was cleaned regularly, and free from dust, staining and blood spillage.

Environment and equipment

The service had suitable premises and equipment and looked after them well. Environments were adapted to suit the needs of the service, and staff ensured that equipment was maintained and stored appropriately to ensure it was easily located.

The ITU was located on the second floor of the main hospital building and HDU was located the floor below. There was easy access with public stairs and elevators close by. Both units were signposted from the main entrance. Upon arrival to the units, there was a secure door, which was accessed by intercom.

During the January 2016 inspection, we found that the units did not meet many of the national recommendations of building guidelines for modern critical care units (Health Building Note HBN 04-02). On HDU, there was insufficient space around the patient’s bed; monitoring equipment was not on ceiling-mounted pendants and there were no isolation facilities with specialised air
handling. During the unannounced inspection on 27 January 2016, the HDU was found to have undergone urgent reconfiguration, including reducing the number of available beds by four. Beds and bedside equipment had been removed and curtain tracks adjusted for the new configuration. During this inspection, we found that the reconfigured beds had remained in place. Although the unit was not purpose built, there was sufficient space for equipment and attending to patients.

There was sufficient equipment to enable staff to complete their roles. Additional equipment, such as infusion pumps, specialist beds and hoists were available on request. For example, we saw that a pressure relieving chair cushion was requested and was delivered the same day. Nursing staff told us that externally sourced specialist equipment was easily accessible and usually delivered within 24 hours.

Storage of equipment was an issue for the high dependency unit, with items located in several areas across the unit. Some storage areas were cramped, but all appeared to be tidy, well organised and maintained. Staff were aware of the location of each item, so did not spend time searching for the right item. Storage within ITU was well organised and clearly labelled. All storage rooms were locked or not directly accessible to non-authorised persons.

Equipment was cleaned before and after use and labelled with “I am clean” stickers, which were dated. We saw that equipment was maintained by the trust’s engineering department or the manufacturer, depending on the item. The manufacturer maintained specialist equipment under warranty agreements whilst trust engineers completed annual checks and portable appliance testing. Equipment labels showed that they had been serviced and maintained appropriately.

We saw that there was suitable equipment for use in an emergency for each unit. We checked the intubation trolley and resuscitation trolley on ITU and HDU and found that equipment was not checked daily on HDU. Daily checks had not been completed with seven omissions in March 2018, three omissions in April 2018, two in May 2018, three in June 2018, six in July 2018 and two up to the 22 August 2018. The resuscitation trolley and difficult airway trolley were checked daily and after use on both units. On ITU, we saw that all equipment had been checked daily and a record maintained.

Resuscitation equipment was stored in trolleys, which were secured with tamper evident tags, which were checked daily to ensure that they had not been tampered with. During inspection, the difficult airway trolley was not sealed with a tamper evident tag on HDU. Staff reported that this was an error and ensured that this was corrected. The trolley was located adjacent to a desk, which was staffed for long periods, which would prevent non-authorised persons tampering with the equipment.

Single use and disposable equipment was used where necessary, and staff used appropriate disposal methods to ensure safety. This included sharps bins and appropriately coloured waste bags for segregation of clinical and non-clinical waste.

Since our previous inspection, HDU had acquired a blood gas analysing machine, which meant that staff did not have to attend another department to obtain these results. We saw that on both units, staff were appropriately trained to use the analyser and were issued with a unique barcode once training had completed. We were told that the analyser captured usage and could remind staff when competencies or training were required.

We were told that equipment was replaced using capital bids. This process meant that the units were able to replace either large pieces of expensive equipment, or large numbers of smaller equipment at the same time to prevent a variety of equipment being used. The service was in the process of replacing some high flow devices and was awaiting the replacement of patient monitors at the time of inspection. We saw that training on new equipment was completed by the
manufacturer, which ensured that all staff were trained to the same standard.

Staff were trained on unit specific devices as part of their induction to the units. Practice development nurses maintained a device training record, which showed that in July 2018, 77% staff had been trained in clinical devices, compared to 35% in April 2017.

Assessing and responding to patient risk

The service planned for emergencies and staff understood their roles if one should happen. Patients admitted to ITU were monitored closely to enable safe management and identification of deterioration.

Bedside monitoring was completed across all the service, which included clinical observations, electrocardiogram (ECG) monitoring and oxygen saturations. We saw that monitors were set according to the patient with alarm settings adjusted according to the individual's parameters. We saw that alarms were responded to swiftly. This included alarms from within the side rooms on HDU that were located a short distance (approximately 20 meters) away from the main ward area. Patients cared for within these rooms confirmed that staff were responsive and alarms did not sound for very long.

We reviewed nine sets of nursing notes and saw that nursing risk assessments were completed and reviewed regularly. National assessment tools were used to assist with the identification of risks in malnutrition, falls, pressure areas, bedrail use and manual handling and these were completed on admission and at intervals throughout the patient's stay in hospital. For example, those risk assessments, which identified a higher risk, were repeated more frequently than those where no risk was identified. Each assessment, recorded the frequency of reassessment required.

We saw that the service used the National Early Warning Score (NEWS) to track patient’s clinical condition, which enabled the identification of any deterioration. Records were clear and accurately recorded. There was an escalation process in line with the NEWS score, which was observed to be followed by staff.

Since our last inspection, the critical care outreach (CCO) team had commenced a 24-hour service. The team had 6.7 whole time equivalent nurses. The CCO team assisted with the management of the unwell or deteriorating patient across the hospital and trust wide training. We saw that staff could access support from the outreach nurse by bleep. In addition to the CCO bleep, we were told that the CCO nurse on duty would also carry the non-invasive ventilation (NIV) bleep from 16.00 daily, ensuring that there was a suitably trained nurse available to assist with the management of NIV. Staff reported that one nurse on duty was often insufficient to meet the demands of the service, and they would like to increase numbers to two nurses.

The role of CCO also included the follow up of patients discharged from ITU and HDU. However, we found that there was no formalised system for the follow up and not all patients were tracked by the team. Clinical leads and nursing staff told us that the nurse responsible for discharging the patient would make the decision as to whether CCO follow up was required. This meant that there was the potential that patients at risk of deterioration would be discharged to a ward with no follow up.

CCO workload was not easily auditable, with records of clinical assessments being paper based. The outreach lead was looking at systems that could be used to enable accurate data collection at the time of our inspection.

There was an 11.30am safety huddle completed on HDU, which was attended by nursing staff, physiotherapist, domestic/ housekeeping and ward clerk. We saw that this meeting was geared to
focus on any safety aspects relating to the patients care and treatment. For example, we saw that any changes to the patient’s condition and resuscitation status were discussed. The meeting followed a clear process and was inclusive of all staff disciplines, lasting for approximately 15 minutes. There was a similar process used on ITU.

The respiratory consultant responsible for HDU reviewed patients under their care a minimum of three times daily. We saw that consultant reviews concentrated on ensuring care was appropriate to the clinical condition, checking of any tests or investigation results and the planning ongoing care. The respiratory consultants managed a week on rota, which meant that there was consistency in managing patients. ITU patients on HDU were reviewed by an ITU consultant a minimum of twice daily.

The treatment and management of sepsis was overseen by the trust wide lead. Nursing staff were aware of the signs and symptoms of sepsis and were able to demonstrate that they would take appropriate action. We were told that the trust used sepsis stickers in patient’s notes. However, critical care did not routinely use these and we did not see any in use during our inspection. Staff were able to access the trust policy, toolkit and advice through the intranet. Trust data showed that compliance with timely administration in antibiotics in suspected sepsis cases was currently below the trust target, with approximately 70% compliance.

The risks of venous thromboembolism (VTE) assessments were completed using the electronic medicine charts. Doctors were required to complete the assessment prior to prescribing any preventative medicine or treatment. Service data showed that compliance with VTE assessments was between 83% and 100% on HDU from April 2017 to December 2017, with 100% achieved for four months during this period. Performance on ITU was from 82% to 100% for the same period, with 100% compliance for five months.

We saw that the fire exit for HDU consisted of a narrow staircase at the end of the ward. Staff told us that they had been trained in the use of evacuation equipment and completed an exercise to ensure that they could assist patients in the event of an emergency.

**Nurse staffing**

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from potential harm. Nurse staffing numbers were sometimes maintained at the expense of the supernumerary nurse in charge, or through the movement of staff across HDU and ITU.

During our January 2016 inspection, we found that patients on HDU were not always monitored closely and HDU nursing staff levels did not meet the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. This placed patients at risk and was escalated to the trust, and immediate actions were taken to address the concerns. The recommended level of care was one nurse for two HDU patients, plus a supernumerary nurse in charge (NIC). During this inspection, we saw that HDU staffing levels were maintained as per guidance. Staffing rosters confirmed that staffing numbers were maintained as planned. Guidelines for ITU staffing are one nurse to one level three patient, with one nurse to two level two patients, plus a supernumerary nurse in charge. During inspection, we saw that this was maintained through the flexible working of staff.

Both units reported that the nurse in charge sometimes worked clinically, being responsible for patients care, when activity increased. During inspection, we saw that on ITU, although a supernumerary nurse in charge was planned for each duty, they were not always able to refrain from managing a patient due to clinical workload. Although this meant that an appropriately skilled
nurse cared for patients, it was not in line with guidance. Staff told us that they would usually complete an incident form when this occurred, but confirmed that this may not always be the case.

Nurse staffing numbers were displayed on entry to both units, with a record of the planned numbers and the actual numbers on duty. During inspection, HDU staffing was as planned, however, ITU staffing was short by one nurse during the days. This was due to sickness and the inability to cover the shift with substantive staff, bank or agency staff. The impact of this meant that if an additional patient required ITU level three care, a nurse would be moved from HDU to ITU to cover. We saw that this occurred on our second day of inspection, where there was additional staff on HDU due to a number of empty beds.

We saw that daily staffing levels were flexed across both units, with sickness, lack of cover for vacant shifts and variable workload affecting the ability to maintain a supernumerary NIC. On 22 August, there were five ITU nurses on duty, with six patients within the department. Two patients were level two, which meant that the supernumerary NIC was maintained. However, as the day progressed, one patient was transferred to another acute provider, one patient was discharged to HDU and another level three patient admitted. This resulted in the NIC managing a patient for the last section of their shift. Similarly, on the 23 August, there were eight potential level three patients requiring care with five ITU staff on duty (including the NIC). We saw that the NIC prepared contingency plans for obtaining staff from HDU to support and creatively used practice development staff and matrons to support activity. The practice development nurse remained on duty after the end of their shift to support the team. Whilst the situation was maintained safely, the variable activity and lack of availability of suitably skilled staff could affect patient safety if the situation reoccurred. We saw that the clinical leads had plans and had started to integrate both HDU and ITU to enable further flexibility of the service.

During our January 2016 inspection we found that the ITU and HDU staffing was organised as separate departments, with two off duties and training. During this inspection, we saw that this was unchanged. Both units were managed by a ward manager as two departments; however, there was an obvious cross over of staff with nurses covering each unit according to activity. We were told that some staff were rotating through each clinical area as part of an integration of critical care services.

Nurse staffing rotas were generated using an electronic system. Qualified nursing staff worked 12.5-hour shifts and rotated through day and night duties. Off duty showed that staff worked no more than two consecutive long days, although some staff had three or four consecutive days with a combination of short shifts (either management or training days) and clinical shifts.

We saw and were told that ward managers, and practice development nurses assisted with staffing shortfalls across both units where necessary.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Luton and Dunstable University Hospital</td>
<td>70.7</td>
<td>86.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates
Both units reported minimal vacancies, with recruitment activity in progress. Details of staffing numbers and vacancies are detailed below. Band 5 nurses were being actively recruited, with an advertisement recently being closed. Staff told us they had attempted to recruit staff from a
number of sources including the local universities and overseas.

HDU reported a more established team, with a number of staff who had been recruited since our last inspection.

From April 2017 to March 2018, the trust reported a vacancy rate of 12.6% for registered nursing staff in critical care. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 8.6% for registered nursing staff in critical care. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 3.5% for registered nursing staff in critical care. This was similar to the trust target of 3.25%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Locally ITU reported that sickness was 2.6%, which was below the trust target.

**Bank and agency staff usage**

The core standards for critical care units (GPICS 2015) stated that agency staffing should not make up more than 20% of the trained nursing cover for a shift. From April 2017 to March 2018, the trust reported a bank and agency usage rate of 14.0% for qualified nursing staff in critical care.

This was made up of 11.4% bank staff and 2.6% agency staff.

Over the same period, 5.1% of shifts were left unfilled by bank or agency staff to cover staff vacancies, sickness and absence.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Agency staff were used in both units, following the completion of a risk assessment to justify additional staffing to management. Staff told us that on ITU it was difficult to fill vacant shifts during the week, with agency staff preferring to work weekends. On HDU staff reported that the most frequent requests for additional staffing related to the need to supervise patients more closely with one to one care. The Matron, ward managers and nurse in charge on both units considered and managed any potential risks of using agency staff by reviewing staffing across both units.

Agency staff were required to complete a local induction, which included the explanation of duties, location of emergency equipment, and fire safety. We reviewed the induction checklists for agency nurses and found that they had been completed fully.

The nursing handover was completed at the commencement of each shift using a pre-printed record of patients on the unit. We saw that the process included a detailed account of each patient, their clinical condition and any outstanding care and treatment. This started with a full nurse team handover, with the nurse in charge from the previous shift handing over to the whole nursing team. The handover also enabled any key messages to be shared amongst the team, prior to allocation of patients. For example, during our inspection, we saw that safety information was shared relating to incidents. The full team handover was followed by a bedside handover from the named nurse to each allocated nurse. This process was followed on ITU and HDU. We
observed the handover on ITU and HDU and found that these were thorough, well planned and fully prepared the oncoming nurses to care for their patients.

**Medical staffing**

**Whilst the service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.** Consultants were available for advice and assistance, although we saw one occasion and were told of two recent previous occasions where the ITU consultant was not immediately available due to clinical demands outside ITU.

During inspection, we found that the day ITU consultant was also the bleep holder for all cardiac arrest calls, to offer support to the first responders. This occurred during our inspection, and the consultant did not immediately return to the department to assist with the management of ITU patients, for up to one hour. The registrar was in attendance on ITU and ensuring patients safety, however, assistance was required to intubate a patient. Staff reported that although this does not happen frequently, it does occur. We were told that there had been at least two occasions in the last two weeks where this had happened. This was escalated to the service as an area of concern and the service provided additional evidence to confirm consultant responsibilities.

Medical staffing on ITU was in line with the following professional standards and recommendations:

- 24 hour a day, seven days per week consultant on call. All consultants were required to live within 30 minutes travel time of the hospital.
- Specialist intensive care anaesthetist cover. Six out of seven consultants were fellows of the faculty of intensive care.
- Consultant to patient ratio of one consultant to a maximum of seven patients. This was better than the one to 15 maximum standard.
- Continuity of consultant cover, with the day consultant working 8am to 10pm.
- Twice daily consultant ward rounds, on both units.
- 24-hour resident medical staff.

High dependency unit medical cover consisted of a designated respiratory consultant from 8am to 6pm with an on call service out of hours. There was a designated ITU consultant allocated to HDU from 8am to 1pm, with cover from ITU outside these hours. The unit had a designated respiratory registrar (senior doctor) and designated ITU registrar during the day, with overnight medical cover maintained by the on call medicine team, for respiratory patients and the ITU registrar for ITU patients.

There were some medical vacancies with shifts covered by locum staff. This equated to one registrar out of three within ITU. Staff told us that cover was provided by regular locum staff, which assisted with continuity of care. The medical cover rota was provided by the medical secretaries on a weekly basis. Staff reported that there were seldom changes and they knew whom to contact.

**ITU medical staffing levels are detailed below.**

The trust reported their medical staffing numbers as below as of March 2017 and March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual staff</td>
<td>Planned staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Site</td>
<td>March 2017</td>
<td>March 2018</td>
</tr>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
</tbody>
</table>
Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 9.6% for medical staff in critical care. This was lower than the trust target of 10%. The service reported that this equated to one consultant for ITU. There were two vacancies within respiratory medicine; however, the recruitment process was in progress at the time of inspection.

(SOURCE: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 11.6% for medical staff in critical care. This related to a single member of medical staff leaving the trust. This was higher than the trust target of 10%.

(SOURCE: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 0.6% for medical staff in critical care. This was lower than the trust target of 3.25%.

(SOURCE: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The trust were unable to provide the numbers of shifts worked by medical locum and agency staff over the most recent year as requested in the Routine Provider Information Request (RPIR). Instead, they supplied the sums of money spent on temporary medical staffing in each area, and these have been used to calculate temporary staffing rates for medical staff in each core service area.

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 20.0% of total spending on medical staff in critical care. This was made up of 19.9% on bank medical staff and 0.1% on agency medical staff.

(SOURCE: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

Staff reported that the nine ITU consultants were all intensivists. Intensivists are doctors who specialise in the care of critically ill patients. This was thought to be a positive mix of skills as the intensivist had a background in accident and emergency care.

As of December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 161 whole time equivalent staff working at Luton and Dunstable University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Luton and Dunstable University Hospital</th>
<th>(WTEs)</th>
<th>(WTEs)</th>
<th>(WTEs)</th>
<th>(WTEs)</th>
<th>(WTEs)</th>
<th>(WTEs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9.0</td>
<td>10.4</td>
<td>86.6%</td>
<td>8.0</td>
<td>9.0</td>
<td>88.7%</td>
</tr>
</tbody>
</table>

(SOURCE: Routine Provider Information Request (RPIR) – Total staffing tab)
Medical handovers occurred daily between consultants when cover changed in mornings and around 5pm to 6pm in the evenings. The ITU consultant responsible for HDU also attended the ITU handover to ensure that staff were aware of patients’ conditions, treatment and any planned activity. The respiratory and ITU consultants responsible for HDU, held a meeting to discuss all HDU patients at midday. We saw that handovers were thorough and offered the opportunity to discuss any ideas or learning about different clinical conditions.

Service leads told us that ITU did not currently have junior doctors allocated to the unit as placements, however this was planned to change in October 2018, when there would be allocated junior doctors. Staff saw this as a positive change as reported that sometimes the activity warranted additional staffing.

Records

**Staff kept appropriate records of patients’ care and treatment.** Records were clear, up-to-date and available to all staff providing care. Patient’s records were stored securely in paper-based files in drawers at the bedside or at the nurse’s station.

We reviewed five patients’ notes on ITU and four on HDU. We found that they were comprehensive with detailed accounts of care provided and regularly updated nursing assessments. All staff disciplines wrote in the medical notes, which ensured that all staff were informed of any changes to the patient’s condition.

Observation charts were located at the patient bedside and were completed hourly unless clinically indicated otherwise. We saw that the National Early Warning Score (NEWS) was completed, which enabled staff to identify if the patient was deteriorating.

We were told that respiratory patients discharged from HDU did not have discharge letters generated if being transferred to the respiratory ward. This was due to the local knowledge of the medical team of the patients and the patient’s care continuing under the same consultant team. Nursing handovers were completed as part of the HDU discharge checklist.

We were told that the IT system did not always support effective working. We were given an example of when computers needed to “reboot” and how this slow process affected the ability to
complete timely reviews, as results were not always accessible. We saw this during inspection, when a doctor waited over 20 minutes to obtain the results of an investigation. This delayed the ward round and caused considerable frustration for staff.

**Medicines**

The service prescribed, gave and recorded medicines well. Medicines were stored securely and patients received the right medicine at the right dose at the right time. However, medicines were not always kept at the correct temperatures.

During our January 2016 inspection, we identified concerns with the safe prescribing and administrating of medicines. Patients had multiple charts and prescriptions were not always clear. This was escalated during the inspection and actions immediately taken to address concerns. During this inspection, we found that safe prescribing had improved following the implementation of an electronic medicine prescribing system. Medicine charts were now electronic, with the exception of intravenous fluid charts and warfarin charts, which were amended daily according to the patients’ blood results. The paper prescription charts for fluid and warfarin, were kept at the patient’s bedside, with an electronic note attached to the electronic prescription to remind staff that there were additional charts.

Staff were required to use a portable laptop to prescribe and record the administration of medicines. Each member of staff was allocated an individualised log in, which enabled them to complete tasks relevant for their role. For example, nursing staff could only access patients on their unit (ITU or HDU). The laptop was required during medicine rounds to identify which medicines were required and record the dose given. We saw that both units had sufficient computers to enable patients to receive their medicines at the correct time. Where possible staff ensured consent was obtained from patients for medicines prior to administering them.

We checked four prescription charts on the electronic system and found that the majority of medicines had been signed when the medicines were administered. However, we found one patient whose medicines had not been signed for. The nurse responsible for that patient’s care told us the medicines had been given. However, they had been unable to sign for them as another member of staff took the computer away. The nurse signed for the medicines retrospectively. This meant that there was a potential risk that the medicines could have been re-administered by another nurse, if they were unaware of the administration. All written prescriptions were signed and dated with recording when medicines were administered. Medicines were discussed as part of the nursing handover.

Medicines and intravenous (IV) fluids were stored appropriately. On the 22 August 2018, we found that IV fluid boxes were placed on the floor in the HDU IV fluid store. We spoke with staff who told us they had just received a delivery. We checked the area the following day and found that all boxes were neatly stored on shelving. The IV fluid on HDU was stored in a locked cupboard inside a locked equipment store. We saw that the equipment store was small and could pose a trip hazard to staff accessing IV fluids in a hurry. The temperature of the IV storeroom was recorded daily and was found to be above the recommended 25 degrees Celsius due to very high air temperatures during a period of heatwave. We spoke with the pharmacy team, who told us that there was a plan to reduce the expiry dates of the fluids to ensure that they were used within the adjusted recommended timescale following storage outside recommended levels and that there was a long term plan to relocate storage. We saw that all medical gases were stored appropriately, and secured.

Some prescription medicines under the Misuse of Drugs legislation are controlled drugs (CDs). We found the CDs were managed in line with legislation and NHS regulations. We saw that CDs
were booked into the stock record upon arrival to the department, signed out by two nursing staff and notes made when items were removed for destruction. Stock was accurate against the records in all those we checked at on both units.

The clean utility room on HDU was accessed by a keypad to ensure secure storage of medicines, which were also in locked cupboards. The ambient temperature of this room was being monitored daily and documented by staff. The temperatures within the clean utility room were in line with guidance as a result of air conditioning units. Medicines on ITU were located in locked cupboards and accessible only to authorised persons.

Medicine fridges were checked daily with minimum, maximum and actual temperature reading logged. We saw that temperatures were regularly outside the recommended two to eight degrees Celsius in both units. Records showed that thermometers had been reset and that pharmacy had been informed of the temperature variances, but it was unclear if appropriate action had been taken to ensure the efficacy of the medicines being stored. Staff told us that pharmacy were aware of the temperature variances but were not aware of any actions taken in response. Records of checks were reviewed by the ward manager and stored in a file.

Some of the critical care outreach team were nurse prescribers. This enabled them to implement key treatment to deteriorating patients without waiting for a doctor to prescribe medicines. We were told that three nurses had completed the relevant training, whilst the remaining staff were waiting funding.

Both units had a designated clinical pharmacist who provided clinical input to ensure that medicines were optimised. In addition, pharmacists provided medicines counselling to patients, to ensure that they fully understood the medicines prescribed. This was particularly relevant to patients being discharged with high-risk medicines.

We saw that details of any medicine errors were displayed on information boards, ensuring that staff were aware of any learning from the error. Service information stated that there had been 12 errors from April 2017 to July 2018. No medicine error had resulted in patient harm. Staff we spoke with were able to talk about individual errors and outlined what had happened in response to prevent reoccurrence.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

During our January 2016 inspection, we found that staff were actively encouraged to discuss incidents and regularly received feedback on any concerns raised. During this inspection we saw that an electronic reporting system was used across the service and staff continued to discuss incidents. Incidents were investigated locally and escalated to the appropriate divisional leads as part of regular governance meetings.

Service records showed that there were 270 incidents reported on ITU and HDU from March to September 2018, which were rated as low or no harm. During this period there was one reported incident where the harm was recorded as a patient death, however, the outcome was not a result of the incident. Records showed that this incident occurred in September 2018 and was under investigation to identify any learning during the inspection. There was one incident recorded as resulting in moderate patient harm during the same period. This related to a possible delay in
diagnosis of clinical condition by a GP and was being investigated and discussed with the relevant staff. This indicated that staff were reporting proactively to prevent avoidable harm to patients. There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported one incident classified as a never event in critical care. This occurred in December 2017 and was of never event type “misplaced naso- or oro-gastric tube”.

(Source: Strategic Executive Information System (STEIS))

Staff were aware of the reported never event and there was evidence that the investigation had led to learning across the service. We found that all staff spoke openly about learning from incidents and the investigation had been shared with the team. Staff across HDU and ITU were able to describe the recent never event and outlined what had changed following the investigation. We also saw that the investigation and action plan were shared with each staff member.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care, which met the reporting criteria set by NHS England from June 2017 to May 2018.

This was the never event described above. The SI type was “surgical/invasive procedure incident”.

The trust reported this SI to STEIS within 14 days.

(Source: Strategic Executive Information System (STEIS))

In January 2016, we saw that the mortality and morbidity meetings had commenced in November 2015, but were not established and meeting minutes did not reflect a standard agenda. During this inspection, we saw that these were now established with detailed minutes taken and a standard agenda.

Mortality and morbidity meetings were completed with all staff invited to attend for ITU patients (level two and three). The meetings were attended by the ward managers, clinical leads and any available staff and included a full review of the patients past medical history, treatment, identifying any areas for learning. Patients admitted to HDU under the respiratory consultants, were reported through the medicine division, with all deaths being reviewed at their mortality and morbidity meetings. Medical consultants told us that the review process was robust, and that they had been allocated protected time to complete mortality reviews. A clinician reviewed every death and staff reported that this was now part of the medical job plan. Minutes from both meetings showed that cases were presented and discussed, identifying any area where practice could have improved. For example, we saw that there were discussions about opening a second emergency theatre, in
response to a short delay in operating on a patient admitted in an emergency, due to multiple time critical operations being listed.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers or falls with harm and one new urinary tract infection (UTI) in a patient with a catheter from May 2017 to May 2018. The one UTI in a patient with a catheter occurred in September 2017.

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and had evidence of its effectiveness. Managers checked to make sure staff followed guidance and tracked performance to identify areas for improvement.

Services, care and treatment were delivered and clinical outcomes monitored, in line with and against the National Institute for Health and Care Excellence (NICE) requirements. Patients’ care and treatment was assessed during their stay and delivered in line with national and best-practice guidelines. For example, the National Early Warning Score (NEWS) with a graded response strategy to patients’ deterioration complied with the recommendations within NICE Guidance 50 Acutely ill patients in hospital. Trust compliance audits were completed regularly and included environmental, infection control and patient care audits, such as hand hygiene.

During our last inspection, ITU was working towards the NICE Guidance No: 83 – Rehabilitation of the Critically Ill Patient, with a review of documentation to improve the ability to audit relevant information. During this inspection, we were told that information relating to rehabilitation has been collected since April 2018, which feeds into the quality reports and dashboards. This information was reviewed regularly to identify trends and performance.

The service introduced a follow up clinic in January 2018. We were told that this was still in development; however, the team had a dedicated consultant and nurse lead. Follow up appointments were offered to a set criteria of patients, for example, those who had been ventilated on ITU for over 24 hours. We were told that there had been a positive response to the clinic with 23 out of 33 patients accepting the offer for an appointment during the initial calls. As a result, the division had agreed to free up additional consultant time, to facilitate additional clinics as necessary. The current plan was for one clinic every two weeks. At the time of inspection, the full multidisciplinary team were not included in follow up clinics, with physiotherapy not participating with appointments. Physiotherapy staff reported that they would like to be involved with the clinic as they could provide additional advice for ongoing recovery.

ITU and HDU submitted data to the Intensive Care National Audit and Research Centre (ICNARC) an organisation reporting on performance and outcomes for intensive care patients nationally. The exception was patients admitted to HDU under the respiratory consultants. We were told that this was due to patients being cared for by the respiratory consultants and that this had been discussed with ICNARC. Please see ICNARC section for further information.

Patients were ventilated using recognised specialist equipment and techniques, including mechanical invasive ventilation and non-invasive ventilation. Appropriate airway devices were used where necessary according to the patient’s clinical condition. All ventilated patients were reviewed and checks made and recorded hourly.

ITU staff used the Richmond Agitation Sedation Scale (RASS) scoring tool, in line with NHS guidance for monitoring sedated patients. The assessment enables identification of patient responses, such as alertness (scored as zero) and then behaviours either side of that from levels of agitation (positive scoring) to levels of sedation (negative scoring). RASS scores were part of administering the Confusion Assessment Method, which is a tool used to detect delirium in intensive care unit patients. We saw that staff recorded these scores on the ITU observation charts.

We saw that there were a number of reference guides located at nurse’s stations relating to processes to be followed and best practice. Staff could also access the intranet for local policies.
and procedures. During this inspection, we were told that there was no critical care outreach policy in place, although staff reported that they were in the process of writing one. The critical care outreach team did not complete or participate in any regular audits relating to their work. This was largely due to there being limited facilities to record or measure activity with written notes.

The service participated in the national care bundle audits regarding ventilator and central line care and associated infection rates. Information relating to the audits was displayed on information boards as part of the information sharing process. Data displayed showed that the ventilator care bundles audits for March to August 2018 had 88 to 100% compliance, and central line audit showed 89 to 99% compliance for the same period.

The ITU team belonged to the East of England critical care operational delivery network, which was in line with the core standards relating to engaging, and participating in operational delivery. A senior nurse and doctor attended network meetings, and shared information with the network and the local team as necessary.

The ITU met best practice guidance by promoting and participating in the programme of organ donation, led nationally by NHS Blood and Transplant. There was a specialist nurse for organ donation who was employed by NHS Blood and Transplant and was based on ITU. They directly supported the organ donation programme and worked alongside the unit staff. The specialist nurse also supported a regional and community programme for promoting organ donation and submitted data to the national audit regarding potential organ donors.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Patient nutrition and hydration needs were assessed using a national nutrition-screening tool. Any needs were effectively responded to, patient records showed that nutrition, and fluid intake was measured, recorded and analysed regularly. We saw that nutrition support was adjusted according to the patient’s condition, and ability. For example, when patients were awake, they were encouraged to eat and drink normally.

Patients told us that food was of good quality and they had access to a broad menu. We saw that the menu on HDU included specialist diets and advice for people who required diet variations, such as soft or pureed foods. On HDU, we saw that breakfast was prepared for each individual patient, which meant that they had hot food and drinks when they required it.

On HDU, we saw that water jugs were replaced during the day to ensure that water was fresh for those patients who were able to drink. Water jugs and cups were always left within easy reach.

Artificial nutrition was assessed daily and relevant prescriptions made. There were protocols for nursing staff to commence enteral feeding for critical care patients before discussion with dietitians and out of hours.

Staff were competent in administering intravenous (IV) fluids. The trust policy was for all trained nurses commencing employment at the trust to attend IV administration training as part of their induction or as part of the preceptorship programme for newly qualified staff. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 Statement 2: intravenous therapy in hospital. Locally the practice development nurses monitored competence and assessed agency staff who had completed intravenous competencies at another trust to ensure that they were safe to administer medicines whilst working on the units.
Pain relief

Patient’s pain was well managed. The presence of pain was assessed regularly and patients were provided with appropriate pain relief on both ITU and HDU areas. A pain assessment tool was used on both units. This included the use of a scale out of 10 for severity of the pain and a pictorial scale for patients who were unable to communicate verbally. Pain assessment scores were documented on the observation charts. Patients told us that their pain was managed effectively.

Staff could refer to the pain specialist team if necessary and HDU received regular pain team visits.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Data collected was within the expected limits.

Locally, the service collected data relating to delayed admissions, night time discharges as well as participating in the trust wide audit programme. The clinical leads reviewed this information as part of their monthly governance review.

ICNARC Participation

The trust submitted data for its critical care service to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide.

Data collection was completed by two dedicated administrators who had received specific training in the process. A nominated consultant oversaw the audit.

ICNARC data collection had been commenced in the high dependency unit in October 2016. Patients admitted to HDU were cared for by either a respiratory consultant or the ITU team depending on their clinical condition. Data was collected on all ITU level two patients and all level three patients. Patients under the care of a respiratory consultant were not reported through ICNARC, despite them being a level two patient and placed in the HDU. This along with the fact that ICNARC data referred to 11 level two beds, when there was nine level two and two level one beds within HDU, raised some concerns as to the accuracy and validity of the data. This was raised with the trust who informed us that discussions with ICNARC had taken place.

Following our inspection, we were informed that the service had contacted ICNARC to clarify the reporting responsibilities for the respiratory patients. ICNARC indicated that all level two patients should be reported and the service had asked for confirmation from them.

We saw that the ICNARC data was shared with the service and displayed on ITU. We were told that the respiratory consultants did not use this data for the management of respiratory patients on HDU, capturing audit data, which was reported to the medical division. Data relating to respiratory patients on HDU was collected and reported through the critical care network. Data for April to August 2018 showed that patient outcomes were measured in relation to readmission rates, out of hour discharges, out of hour transfers between wards, delays in admission and delays in discharge from four to 24 hours and those over 24 hours. The report also considered activity within ITU giving supportive information for findings. For example, the number of ITU admissions, cancelled elective operations and delayed discharges as a result of no bed.

We used data from the 2016/17 annual report. Locally, ICNARC quarterly reports showed that
performance was in line with expected limits.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (all patients)
The risk adjusted hospital mortality ratio for the ITU was 1.2 in 2016/17. This was within expected limits.

The risk adjusted hospital mortality ratio for the HDU was 1.0 in 2016/17. This was within expected limits.

In 2015/16, the trust reported a single figure for its ITU and HDU for this metric. The overall risk adjusted hospital mortality ratio across both units was 1.2 in 2015/16. This was within expected limits.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)
The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% admitted to the ITU was 1.4 in 2016/17. This was within expected limits.

The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% admitted to the HDU was 1.1 in 2016/17. This was within expected limits.

In 2015/16, the trust reported a single figure for its ITU and HDU for this metric. The overall risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% across both units was 1.3 in 2015/16. This was within expected limits.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Standardised competencies were used to monitor progress and practice development nurses worked collaboratively to ensure standards across both units.

The service had recruited two practice development nurses (PDN), approximately 18 months prior to this inspection. There was one designated to each area although they worked closely to ensure that processes across both units were compatible. All staff were aware of both PDNs.

On commencement in post within critical care, the new staff member was allocated up to six weeks supernumerary time. This was in line with core standards (GPICS 2015) and gave staff the opportunity to work alongside a buddy to learn the specifics of the post. The supernumerary period was monitored and adjusted according to experience and progress. For example, a new member of staff with critical care experience was likely to have a shorter supernumerary period.

New staff were provided with an induction pack, basic and advanced drug calculation booklets and step one, two and three of the national competency framework competencies; a standardised three staged approach to development of critical care nurses. We reviewed five staff files and saw that competencies were assessed at intervals and signed off when deemed competent. All newly qualified staff also participated in the trust wide preceptorship programme, with support from the local team.

Staff’s skills and competency were assessed annually in line with their appraisals. Trust data showed that the majority of staff had completed appraisals, and compliance was higher than the
trust target across all disciplines. Staff reported that the appraisal process was positive and enabled development in areas of interest. Some staff reported that access to additional training was sometimes difficult due to funding and availability of courses. For example, one member of staff had transferred a request for specific training to the following year’s appraisals due to the inability to access the popular course. A breakdown of appraisal rates can be found below.

Staff were able to access the critical care course through a local external provider and staff on HDU could access an introduction to critical care course. We saw that several members of staff were about to commence courses during our inspection. Core standards state that a post registration award in critical care should be held by at least 50% of trained staff and the ITU met this with 63%. Some staff, who held a post registration award were working or rotating through HDU, which meant that the service was meeting the core standards for both areas.

The service promoted the use of link nurses who were staff members with an interest in specific topics, this enabled staff to gain additional skills and share this learning amongst the team. We saw that link nurse training was updated regularly.

We spoke with students who had been working within critical care as part of their nurse training. They had been provided with an induction booklet and worked with a named mentor or associate mentor. This ensured that they were supported throughout their rotation. Students were positive about their experiences, however, it was noted that students did not rotate through critical care outreach or the other department to see how the service worked. For example, the student on ITU had remained on ITU for the duration of their placement.

**Appraisal rates**

From June 2017 to May 2018, 94.0% of staff within critical care at the trust received an appraisal compared to a trust target of 90%.

The breakdown by staff group is shown in the table below. Please note that the trust was unable to provide separate appraisal completion data for registered nursing staff. In the trust’s appraisals data these staff are included in the staff group “nursing and ward based staff”.

As well as registered nursing staff, this group also includes healthcare assistants, health care support workers, modern matrons and nurse managers.

<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing/ward based staff</td>
<td>70</td>
<td>75</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>84</td>
<td>94.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Medical and nursing staff completed revalidation in order to remain registered with the General Medical Council (GMC) or Nursing and Midwifery Council. The trust had established processes and procedures to support staff through the revalidation process. Service records showed that all medical staff had completed revalidation.

**Multidisciplinary working**

Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care and were able to refer to specialists for support when necessary.
Critical care services maintained a multidisciplinary approach to managing patients care and treatment. We saw that physiotherapists, pharmacists, dietitians, speech and language therapists, speciality consultants and doctors were involved with managing care. Teams were inclusive. Staff reported that there were positive working relationships.

Weekly multidisciplinary team (MDT) ward rounds were held on Wednesday mornings for ITU patients. When capacity allowed, these were attended by the critical care outreach nurse and the practice development nurses. On HDU, we were told that the pharmacist attended ward rounds, and advice was sought from physiotherapists and specialist practitioners such as dietitians when necessary. Consultants felt that working relationships were positive and had improved over the last two years; they were also complimentary about staff they worked with. Staff were able to refer for specialist advice through a telephone referral process.

On HDU, there was a planned daily joint board meeting planned for midday. This was the forum for the respiratory and ITU consultants to meet and discuss patients; however, we did not see this during our inspection as the ITU consultant was unable to attend the meeting due to capacity demands. The respiratory doctors told us that this meeting was beneficial and improved coordination of patients.

We were told some conflicting views of effective MDT working; with some staff stating that they could not implement any changes and were not listened to when making suggestions about patient’s care. We were told that physiotherapy staff did not attend MDT meetings. However, we did see them attend the nurse handover at 11.30am during inspection.

Seven-day services

The service provided a 24 hour, seven days a week service with admission to both ITU and HDU available following referral. There was a dedicated senior doctor available for both units with out of hours and weekend on call. Consultants were available for advice and assistance, although we saw one occasion and were told of two recent previous occasions where the ITU consultant was not immediately available due to clinical demands outside ITU. The clinical lead consultant confirmed the on call consultants could be available within 30 minutes and this formed part of the terms of the consultant’s employment.

Staff told us that the consultant was available whenever they required assistance. However, we saw that the availability of the consultant was dependent on workload outside the units. The ITU consultant attended emergencies to assess patients following referrals and carried the paediatric emergency bleep, which meant that they spent time off the unit when patients became unwell. This affected their availability to cover the unit, and we saw this during inspection.

The critical care outreach team provided a seven day a week service covering the whole trust. The 24-hour service had been introduced since our previous inspection and provided one nurse on duty at all times.

An on call physiotherapist was available overnight, through the on call rota. Designated physiotherapist would visit ITU/ HDU daily, providing support to staff and performing specialist therapies. We saw that physiotherapy reviews were completed regularly and patient notes reflected the treatment given and planned. Local audit data showed that patients on HDU received just under the recommended 45 minutes physiotherapy per day. Service leads told us that the physiotherapy team had planned to complete a therapy review in critical care this year, and since April 2018, activity had been reported as part of the service dashboards, enabling the identification of any trends or areas for closer monitoring.
Pharmacy support was provided weekdays, with on call advice available out of hours. Where possible, either a pharmacist or pharmacy assistant would attend the ward round to offer advice. We saw this during our inspection of HDU when a pharmacy assistant accompanied the consultant.

Other specialist support, such as dietitians, pain specialists and pharmacists and were available during weekdays.

Health promotion

Where possible, staff encouraged people to have healthier lives, offering advice and services relating to aspects such as smoking cessation and healthy diets. There were a large number of information leaflets available for patients and their relatives relating to specific clinical conditions and how to access support. These were located in the relatives’ rooms’ in both units.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the policy and could easily locate a copy on the trusts intranet.

When able, patients gave their consent to treatment. We saw that patients were asked to confirm that they were happy for treatments, and nursing and medical notes recorded that consent had been obtained. For patients who were unable to provide consent, staff acted in accordance with Mental Capacity Act 2005 when treating an unconscious patient, or in an emergency.

Staff received training regarding the Mental Capacity Act 2005 as part of their mandatory training at the trust.

Mental Capacity Act and Deprivation of Liberty training completion

Staff received training regarding the Mental Capacity Act 2005 as part of their mandatory training at the trust.

Deprivation of Liberty Safeguards training was covered under the trust’s Safeguarding Adults Level 1 and 2 and Safeguarding Adults Level 3 training modules.

The trust reported that from May 2017 to April 2018, Mental Capacity Act (MCA) levels 1 and 2 training was completed by 92.0% of staff in critical care compared to the trust target of 80%.

This included 95.8% of registered nursing staff and 50.0% of medical staff (four out of eight medical staff). Therefore, the 80% target was not met for medical staff in critical care.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We spoke with six patients and without exception; they told us that staff were attentive and caring. Without exception, patients and their relatives were positive about the care they received. We saw that staff attended people in a timely manner, and buzzers and calls for help were responded to quickly. We were told that staff provided “empathetic personal care” and dignity was maintained at all times.

We observed multiple interactions between staff and patients, and all were caring and compassionate. Staff introduced themselves, described their role, and went onto explain what would happen next. Staff spoke to patients and their relatives in a friendly manner, engaging in conversations relating to topics other than their health or care being provided. During the ward round, medical staff talked to patients (including those that were sedated), and explained what was happening to them.

We observed that staff were careful to maintain patients’ dignity at all times. This included speaking at a level so conversations could not be overheard, the drawing of curtains and closing of doors where possible. All curtains were labelled with a do not enter sign, when they were closed.

Patient feedback was captured at regular intervals, and we saw that feedback forms were easily accessible. Information gathered was shared with the teams. We saw that there were multiple thank you cards and positive comments from patients and relatives displayed.

Emotional support

Staff provided emotional support to patients to minimise their distress. It was clear that staff working across both units appreciated the anxiety of patients and their relatives when they were admitted to critical care services. Staff were friendly and attentive when offering support. We saw that nursing staff spent time talking to relatives as well as patients updating them on any changes to care or treatment. Staff were observed encouraging relatives to use quiet areas to gather themselves whilst waiting to visit patients.

We saw that there was a chaplaincy support system, which included regular visits and contact details displayed in common areas.

The critical care follow up service offered support to patients following discharge from ITU. The clinics had been introduced in January 2018, and were well subscribed, with consideration for additional clinics. The critical care team acknowledged that the service was in development.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Staff communicated with patients and their relatives sensitively to ensure that they understood their care, treatment and condition. Where possible, patients were involved with their care and decisions taken and we saw that plans were inclusive of patient’s wishes. Patients told us that they were kept informed of their progress and were encouraged to talk about anything worrying them. We observed staff, including doctors and nurses talking inclusively with patients and their relatives.
Relatives we spoke with told us that their views were listened to and respected and we saw that patient records reflected conversations held. We also saw that difficult conversations had been held with some relatives and notes reflected that time was given to ensure that the information shared was understood and to allow for questions.

We saw that ITU staff promoted the use of patient diaries. These are records completed by relatives of sedated patients detailing the patients’ progress or anything that may be relevant to the individual when they regained consciousness. This helps with patients understanding of what happened to them whilst they were sedated.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people. However, both the high dependency unit and intensive therapy units were limited in functionality by the estate. This included the provision of washing facilities for patients.

Limitations of the estate affected the ability of the units to meet the recommendations of the Department of Health guidelines (HBN04-02) for modern critical care units for meeting patient needs and those of their visitors. These included:

- There were no facilities for patients who were well enough to have a shower on HDU
- Lack of separate entrances to the units from within the hospital corridors to ensure visitors did not observe patients arriving and leaving the unit
- Relatives’ facilities were limited on the HDU, with a small waiting room and no access to drinks or toilet facilities. There were also limited facilities for private discussions, such as breaking bad news.

Clinical leads were aware of the limitations of the building and were in the process of waiting for confirmation of a new build. In the interim, the leads were looking at areas that could be worked on to improve the patient and staff experience. For example, the ward was prone to high temperatures due to the number of windows and its location. Staff were looking at air conditioning and temperature control units that could be used to help reduce the temperatures in warmer weather.

Both units provided visitors facilities. On ITU, this included two relatives’ rooms, one with kitchen facilities for hot and cold drinks and a refrigerator and the other that was used predominantly for private discussions. There was also a visitor’s toilet provided. Visitors attending HDU were directed to the public toilets outside the unit and café as necessary.

Visiting times were displayed across both units, which were 2.15pm to 7.15pm daily. There was information relating to visiting outside these times following discussion with the nurse in charge. Relatives confirmed that staff had been flexible with visiting times, particularly during the initial admission phase.

Meeting people’s individual needs

The service took account of patients’ individual needs. There were a variety of service provisions on both units, which assisted patients’ needs to be addressed. Patients were reviewed a minimum of twice daily and a daily plan was completed by consultants during ward rounds. This process ensured that patients’ treatments were individualised and timely.

Patients had access to call bells, which were seen to be in reach and answered promptly. There was one exception, on ITU, where one patient told us that staff rarely ensured that the call bell was within reach which meant that they needed to capture someone’s attention if they needed something. This made the patient feel anxious about the speed of staff’s responses, particularly when needed something in a hurry, although we were told that staff responses were usually timely.

The service used a variety of communication aids for people who were unable to communicate verbally and for those whose first language was not English. For example, we saw pictorial charts
with common words or phrases in use. The units had access to information in a variety of languages. Staff told us that they could access translation services if necessary.

Staff told us that the trust used the “This is me” information booklets to support people with learning disabilities. These booklets contained details of individuals’ preferences, likes and dislikes which can be used to support the patients care. We did not see these in use during our inspection as there were no patients with a learning disability on either unit.

Both units displayed posters relating to the units being mixed sex wards, explaining that this was due to the type of care provided. Posters also gave the name and contact details of the matron if there were concerns relating to this.

The relative’s room within ITU provided items to distract or occupy relative whilst they were waiting to see their loved one. This included magazines and a television. There were also refreshments available, which were replenished daily.

**Access and flow**

Patients could access the service when they needed it. The waiting times for treatment and arrangements to admit, treat and discharge patients were largely in line with good practice. However; there were a high number of out of hour’s transfers between ITU and HDU and from HDU to main wards.

Admission to ITU and HDU was through agreement with the consultant on call and arranged by the nurse in charge, supported by the trust wide bed management team. The referral for care was always made by the consultant responsible for that persons care during their admission. During our inspection, we saw that the nurse in charge on ITU spent considerable time arranging patient’s transfers, both within the hospital and to other acute or specialist trusts. This meant that admissions were arranged in a controlled manner and that staff were available to care for the new admission.

Patients requiring ITU should be admitted within four hours of the decision to admit in order to comply with core standards for critical care (GPICS 2015). Service data showed that from April 2017 to March 2018 HDU admitted 773 patients with 759 (98%) admitted within four hours of referral. For the same period, ITU admitted 417 patients and 413 (99%) were admitted within four hours of referral.

When patients were transferred, we saw that there was a clear process for maintaining patient safety. Nursing staff ensured that patients were stable and informed the transfer destination of any special requirements. A nurse accompanied the patient on their transfer and handed over care to the receiving nurse. There was a discharge checklist, which was used to ensure that all tasks had been completed prior to the transfer. This process was followed for both ITU and HDU patients.

Elective admissions were planned in advance with details relating to the patient’s name, operation and consultant placed in the unit’s diary. Staff told us that the consultant responsible for the unit reviewed all elective admissions on that day to ensure that they were being admitted to the right location. Staff were also limited to the number of elective admissions that could be scheduled for each day, which ensured that there was sufficient capacity to meet demand.

**Bed occupancy**

There were seven physical beds within ITU, with six funded and staffed for level three (intensive care) patients. The seventh bed was used for major elective surgery and was staffed as needed. There were 11 beds within HDU, which were used flexibly to meet the demands of the respiratory
and ITU level two patients. We saw that there was an operational policy outlining the elective and emergency admission procedure to both units.

From May 2017 to April 2018, the trust’s adult critical care bed occupancy was lower than or similar to the England average in 11 out of 12 months. The exception was February 2018, when bed occupancy in the trust was 88.2% compared to the England average of 85.4%. This was the highest adult critical care bed occupancy reported by the trust over this 12-month period.

Over these 12 months the trust’s bed occupancy varied between 52.9% in August 2017 and (as noted above) 88.2% in February 2018.

Service data showed that there had been no elective surgery cases cancelled due to lack of availability of a post-operative critical care bed on HDU for the last 12 months ending August 2018. There were no cancellations, of this type, due to lack of ITU bed availability in the same period.

Adult critical care bed occupancy rates, Luton and Dunstable University Hospital NHS Foundation Trust.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Delayed discharges

Staff reported some difficulties in the obtaining beds on general inpatient wards due to capacity demands across the hospital. This resulted in delays in some transfers as outlined below. During inspection, we found that there were no delays in obtaining beds on main hospital wards and HDU were able to discharge patients enabling admissions from ITU. Staff told us that the two side rooms on HDU enabled flexibility with level one patients. This meant that they rarely had to report mixed sex breaches due to level one patients waiting for a main hospital ward bed. We reviewed the incidents reported for HDU and found that there were 51 incidents reported relating to patient transfers, bed management and discharge processes from March to September 2018. There were no mixed sex breaches reported for the same period.

Staff within ITU told us that the lack of a ward bed rarely affected the ability to admit a patient, although they could recall occasions where a level three patient was held in the admitting location (usually the emergency department (ED)) until a bed became available. We saw this during inspection, when a patient was held in ED whilst a bed was made available on the unit. The consultant usually accompanied patients awaiting admission to ITU and/or the outreach nurse on duty who supported the local team to ensure the patient was safe until transfer.

We saw that there was one reported mixed sex breach reported from August 2017 to August 2018. This incident occurred in August 2017 and related to the inability to move a patient from HDU to a main ward. There were no other mixed sex breaches reported for HDU or ITU.
Luton & Dunstable Hospital ITU

For the ITU at Luton and Dunstable University Hospital, there were 2,555 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed by more than eight hours was 3.2%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,555 available critical care bed days</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>3.2%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>

Luton & Dunstable Hospital HDU

For the HDU at Luton and Dunstable University Hospital, there were 2,002 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 10.6%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,002 available critical care bed days</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>10.6%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>

In 2015/16, the trust reported a single figure for its ITU and HDU for this metric. The overall percentage of bed days occupied by patients with discharge delayed by more than eight hours was 4.4% in 2015/16.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-clinical transfers

Luton & Dunstable Hospital ITU

For the ITU at Luton and Dunstable University Hospital, there were 387 admissions in 2016/17, of which 0.3% had a non-clinical transfer out of the unit. This was within the expected range.

In 2015/16, none of the patients admitted to the ITU had a non-clinical transfer out of the unit.

<table>
<thead>
<tr>
<th>Number of cases 2016/17</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>387 admissions</td>
<td>Crude non-clinical transfers</td>
<td>0%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

Luton & Dunstable Hospital HDU

For the HDU at Luton and Dunstable University Hospital, there were 379 admissions in 2016/17,
of which none had a non-clinical transfer out of the unit. This was within the expected range.

In 2015/16, it was also the case that none of the patients admitted to the HDU had a non-clinical transfer out of the unit.

<table>
<thead>
<tr>
<th>Number of cases 2016/17</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>379 admissions</td>
<td>Crude non-clinical transfers</td>
<td>0%</td>
<td>0%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Non-delayed out of hours discharges to the ward**

During our inspection, we saw that there was a number of out of hour’s transfers, particularly between the ITU, HDU and main wards. The core standards for intensive care units (GPICS 2015) stated, discharge should occur between 7am and 10pm. Discharge overnight has been highlighted as an event that adversely affects patients’ experience (East of England Critical Care Network, Quality Data Definitions 2015).

Staff told us that ITU and HDU were exempt from incident reporting due to patients being classed as level two, and the transfer being in response to clinical needs. However, we reviewed the patient registers for July and August 2018 and found that there were a number of discharges out of hours that did not appear to relate to a clinical need. For example, patient registers showed that:

- On 2 July 2018, a patient was discharged from HDU to a ward, at 03.30; with the next admission at 02.40 on 3 July 2018.
- On 8 July 2018, records showed that a patient was transferred from ITU to HDU at midnight; the next admission to ITU after 7am on the 9 July 2018.
- On 12 August 2018, a patient was admitted to HDU from ITU at 02.55, with no admission to ITU until 19 August 2018.
- On 12 August 2018, a patient was discharged from HDU to a ward at 22.19 with no admission to HDU until 15 August 2018.
- On 14 August 2018, a patient was discharged from HDU to a ward at 06.05 with no admission until the following day (15 August 2018) at 09.15.
- On 15 August 2018, a patient was discharged from ITU to HDU at 00.15, with no admission to ITU until 19 August 2018.

Nursing staff told us that there were sometimes delays in the availability of a ward bed due to increased capacity demands, but could not give details relating to any specific transfer.

Staff told us that out of hour transfers were reported using the trust incident-reporting tool. A review of incidents reported from March to September 2018 showed that 23 incidents related to out of hour transfers.

**Luton & Dunstable Hospital**

For the ITU at Luton and Dunstable University Hospital, 9.4% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm
and 6:59am. This was within the expected range.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>128 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to ward proportion</td>
<td>9.4%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

Luton & Dunstable Hospital

For the HDU at Luton and Dunstable University Hospital, 3.7% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>296 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to ward proportion</td>
<td>3.7%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

In 2015/16, the trust reported a single figure for its ITU and HDU for this metric. The overall percentage of admissions that were non-delayed, out-of-hours discharges to the ward across both units was 8.7% in 2015/16.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Staff was aware of any complaints made and what actions had been taken in response.

Staff were aware of the complaints procedure and knew how to signpost patients or their relatives if there were concerns raised. Staff predominantly attempted to resolve issues locally, but would escalate concerns to the nurse in charge or the trust complaints team as necessary. We saw that concerns were discussed with the local team to ensure awareness and assist with preventing repeated concerns.

Details of critical care complaints can be found below.

Summary of complaints

From April 2017 to March 2018, the trust received nine complaints about critical care. The trust took an average of 31.8 working days to investigate and close these complaints. This was in line with their complaints policy, which states that complaints should be responded to within 35 working days.

The breakdown by subject is shown in the table below. Because one complaint can have multiple subjects, the total below exceeds the total number of complaints.
<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>14</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From April 2017 to March 2018, the trust received no compliments about critical care.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*
Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Critical care leaders were visible and maintained regular contact with staff within each area, offering support and advice where necessary. Nurses in charge of units were good role models.

Critical care services belonged to the surgery division, with leadership for HDU being split between the surgical division for ITU patients and the medicine division for respiratory patients. Both divisions had similar structures with a clinical lead consultant and lead nurse supported by matrons and ward managers. This was in line with the guidelines for the provision of intensive care services (GPICS 2015).

Each unit had a ward manager, who worked alongside the team to provide effective care and treatment. HDU staff reported that the unit was well managed and staff felt supported, however, on ITU nursing staff were less satisfied. Some staff reported that senior nurses were not open to change and that they were not always effective in managing concerns raised. This meant that some staff were reluctant to discuss any concerns with their line managers. The unit was in a period of transition following the appointment of a new matron and staff were hopeful that this would have a positive impact on staff satisfaction.

We saw that in the absence of the matron, the senior directorate nurse assisted with the management of ITU. They regularly attended each unit offering support to staff. From interactions, this was not unique to the inspection period. We also saw that when the ward manager was absent from one unit, the ward manager from the opposite unit would also offer support to staff.

Again, observed interactions indicated that this was normal practice.

During inspection, we saw a number of band six nurses managing the units during busy periods. All showed excellent skills, professionalism and dedication to providing care to acutely unwell patients. Staff were respectful of each other and supported each other through difficult periods.

ITU and respiratory consultants were observed leading the teams during ward rounds, clinical procedures and when planning workload. They listened to staff views and teams collectively worked to address any issues, such as new patient admissions and bed management.

Nursing staff told us that although they did not see the chief nurse regularly, they were confident that they could speak to her directly if they wished.

Vision and strategy

Service leads had a clear vision for what it wanted to achieve. It was not clear if the service vision was developed with involvement from staff, patients, and key groups representing the local community. There was limited feedback collected.

There was a vision for a “hot block” which would include theatres and a 30-bedded ITU. The team were expecting a decision as to whether the plans were successful in November 2018. This development would enable HDU and ITU to be co-located. Leads told us that there had been some discussions to relocate the services to enable a more fluid approach to the model of care, as the current estate did not facilitate this. Staff we spoke with did not refer to these plans, however, did openly speak of working across units. In the interim, service leads told us that they were trying to be creative with roles to promote retention of staff and the quality of the service. This included the possible rotation of staff through ITU, HDU and the critical care outreach team.
We did not see evidence to suggest that patient feedback was used for plans to develop the service. The feedback sought was generally at the point of care; however, with the introduction of follow up clinics, it was evident that feedback collected from discharged patients could assist with service development.

The trust was in the process of merging with another acute NHS trust. This had been postponed until April 2019. All staff we spoke with were aware of the planned merger and the changes to the proposed timescale. Senior leads told us that there were no current work streams in place, however they were working together to review processes to ensure that they were compatible. For example, they were in the process of comparing data relating to the use of critical care beds following specific surgeries.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff on HDU reported a positive culture that promoted the development of staff and the service and although we heard some negative comments about the support of staff on ITU, the team worked collaboratively in a positive manner. Staff reported that they were aware of the challenges and there was clear communication when things went wrong.

HDU staff spoke positively about their service and were happy in their roles, reporting that HDU was an excellent place to work. Staff stated they felt empowered to make suggestions, make changes and improvements and this was actively encouraged. The team had been nominated for team of the year and were proud to have been runners up in the award.

On ITU, staff appeared to have a good rapport and were observed ensuring breaks were taken and that assistance was available when needed. There was positive communication across all team members. ITU staff used a notice board to display positive messages to each other. For example, we saw that staff were named and thanked for their support during specific incidents or days.

Staff told us there were good opportunities for continuing professional and personal development in the organisation. However, on ITU, some staff told us that they “had been overlooked for external courses” and “they had given up asking for training, because it wasn’t available”. Minutes from team meetings corroborated that external training courses were restricted to staff who had completed their competencies and that funding was limited.

Staff reported a positive and supportive relationship between the ITU and respiratory consultants, with open communication. This enabled them to work collaboratively to meet the needs of level two patients cared for on HDU.

Governance

Governance for ITU and respiratory patients fell under two divisions, although the surgical division and medical division used the same processes to manage governance within their teams. This meant that there was systematic approach to continually improving the quality of its services for all patients.

There was an effective corporate and local governance framework, which oversaw service delivery and quality of care. There were operational policies in place with guidance to support staff to complete their roles and an audit framework that measured compliance.

Governance within critical care services was discussed as part of the surgical risk and governance meetings. In preparation for the meetings, a comprehensive report was produced detailing
performance across all areas. This included incidents, mortality reviews, speciality performance, compliance against standards, duty of candour, complaints and patient feedback. We saw that these were discussed and any actions recorded in an action log, which was updated at the beginning of each meeting.

There were no joint governance meetings with critical care relating to the respiratory patients on HDU. Any concerns, data collection or compliance results were reported through the separate divisions. Critical care leads reported that both divisions had the same reporting structure and responsibilities, which ensured that all patients were captured. Although the ITU consultants did not attend the medical division governance meetings, the ward manager for HDU attended the respiratory divisions’ multidisciplinary governance meetings and had oversight of any incidents, complaints and action plans, which related to the unit.

We were told that the frequency of board oversight meetings was dependent on performance, with a minimum of quarterly meetings, and maximum of fortnightly meetings. These were designed to hold the service lines to account for their own business and ensure that performance was on target. The critical care and surgical division leads reported that they had meetings every quarter, and presented to the board on the current risks, financial position, mortality rates and outliers. Intensive Care National Audit Research Centre data was a key component along with results from trust audits in the analysis of performance.

The senior nursing teams (cross both units) met monthly as part of their internal governance process. Minutes showed that a set agenda was followed, with discussion on recruitment, training, and performance. We did not see an action log associated with the meetings; however, actions were clearly allocated and discussed at the next meeting. Information from the team meetings were escalated to the divisional governance meetings as necessary. This process enabled a board to ward and ward to board oversight of the service.

Staff told us that team meeting minutes were emailed to all staff to ensure that they were kept informed of service changes and news.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There was a robust risk assessment system in place locally with a process of escalation onto the corporate risk register. The local risk register was reviewed and updated monthly and new risks added regularly.

We saw that the risk register was reviewed at every quality and governance meeting and updated with any mitigating actions and risks adjusted according to changes. The risks associated with both units were displayed on ITU. There were two areas identified as high risk, the lack of ITU consultants and lack of side room facilities. There were eleven medium risks, which included, out of hours discharges, outreach resilience, recruitment, split ITU/ HDU location and discharge within four hours. There was one identified low risk, which was rehabilitation.

Risks and incidents were openly discussed in multiple forums. For example, we saw that the June and July 2018 newsletters included a featured article on a theme from the previous months reported incidents. The June 2018 issue featured the importance of wearing personal protective equipment and July 2018’s issue featured information on medicine errors.

There was a patient safety board on ITU, which displayed the number of incidents reported the previous month. We saw that the number of incidents were broken into themes. The nurse in charge was able to talk us through the incidents and detailed what had occurred in response.
example, additional training being completed in response to a medicine error. This suggested that staff were made aware of any issues relating to performance and what was needed in response.

Nursing staff were allocated into teams within each unit. This enabled roles and responsibilities to be shared amongst senior nurses and ensured that all staff had an identified team lead to monitor their progress.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The service collected performance related data from clinical audits and the Intensive Care National Audit Research Centre (ICNARC) for ITU patients. This was used to inform decisions about how the service was performing and used to benchmark against peers.

However;

Respiratory patients on HDU were audited through the respiratory medicine team and not through ICNARC.

We saw that the regional network was used to share information. Staff represented the service at the East of England critical care education group meetings. Minutes from these meetings showed that that competencies, policies and projects were discussed openly, to share learning and discuss new guidance. Minutes for the meetings were shared amongst attendees and staff locally. The action log associated with the meetings showed that information was shared across the area to enhance consistency across the speciality.

There was good communication in the service both from a local managers perspective and at a corporate level. Staff stated they were kept informed by various means, such as newsletters. We saw that ITU used a communication book to share key messages to staff. This included training sessions arranged, jobs for the day, booked admission details, audits required and any pharmacy requests. There was also a nurse in charge checklist, which was used as an aid memoire for tasks that were required on a daily basis, for example, checking resuscitation equipment and arranging breaks.

Engagement

The service engaged well with staff and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. Staff were generally engaged. Frequent staff moves and perceived lack of support affected job satisfaction within ITU. Frequent moves had been raised as a concern during ward meetings, and were being addressed by ward managers.

There was a clear difference in the staff morale between ITU and HDU. Nursing staff within HDU felt listened too, supported and engaged with changes to the service. They spoke positively of the changes since our last inspection and reported team working and a positive camaraderie. In contrast, staff on ITU expressed poor morale, with staffing numbers, lack of local vision and the lack of support for professional development being the main reasons for dissatisfaction with their roles. ITU nursing staff also expressed that they were frequently moved from the unit to provide nursing cover on other clinical areas. Whilst staff understood that this was a decision made relating to patient safety, the move could leave the unit with just enough staff to manage and the nurse in charge caring for a patient. Staff also expressed that when a patient needed to be admitted, they were unable to get the nurse back to care for the new admission. This meant that patients were potentially placed at risk and there was a lack of recognition of the GPICS 2015 guidance relating to the supernumerary nurses. The duty rota confirmed this, with some staff
recorded as being moved to another area on four occasions in several weeks. There were no incidents reported relating to the inability to retrieve staff from other wards for March to September 2018.

Physiotherapy staff across both units also expressed varied engagement, with some negative comments referring to the inability to raise concerns to some senior clinicians due to an expected poor response, and lack of feedback with projects or work completed.

We saw that a newsletter was used to share news with staff. We saw that newsletters covered topics such dates of meetings, guidance on specific topics such as how to manage a medicine error, trainings news and celebrating staff successes, such as achieving qualifications and team social events. Newsletters were shared across the team and displayed on the units, to capture as many members of staff as possible.

The service worked collaboratively with the critical care network to review services and offer peer reviews. This process enabled staff to visit other intensive care units to observe how they worked, reporting their findings and enabling shared learning across the speciality.

Learning, continuous improvement and innovation

Whilst the service was committed to improving services by learning from when things go well and when they go wrong, there were limited opportunities reported for innovation within ITU.

We found the following improvements since our last inspection in January 2016:

- Clear roles and responsibilities for respiratory and ITU consultants when managing patients within HDU
- Increased substantive staffing numbers particularly in HDU reducing the use of agency staff and promoting continuity of care
- Introduction of practice development nurses implementing standardised practices and training for staff working in both units
- Promotion of cross unit working, improving flexibility of workforce to meet the clinical demands of patients requiring level two and three care
- The provision of 24 hour outreach services ensuring that unwell and deteriorating patients across the hospital have access to critical care skilled assessments and staff have additional support in the event of emergencies

Although the service participated in some research, staff told us that ITU was not very innovative. Nursing staff reported that it was difficult to implement change within ITU, with some resistance from established staff. This affected staff ability to promote change, which affected negatively on their job satisfaction. It was clear, however, that staff were dedicated to the continuous improvement of the service and shared learning. All staff were fully aware of incidents, complaints, and any issues and were open about what they had learned in response to these.

The introductions of practice development nurses had promoted a consistent approach to training and consequently care for acutely unwell patients. Staff received training consistent with guidelines and standardised for the service.

The area of the service that was undergoing the most changes was the high dependency unit. Following our January 2016 inspection, HDU had designed a poster relating to “learning since the last CQC inspection”. This was displayed on the ward and showed changes in several areas:
• Pharmacy- introduction of electronic prescribing and dedicated HDU pharmacy cover.
• Equipment- increased number of ventilators including non-invasive ventilators and provision of a HDU arterial blood gas machine for blood analysis locally.
• Staff- introduction of a designated ITU and respiratory consultants as bleep holders for HDU.
• Data- introduction of ICNARC data capturing for HDU patients. The capture of bed allocation transfers and reporting of escalation/ flow concerns impacting capacity.
• Training- redesign of HDU observation chart, the introduction of practice development nurses, delirium assessments and introduction of Confusion Assessment Method.

Staff were proud of the changes that had taken place on HDU and referred to the poster as “how far they had come”.

There were two other areas under development; one was the critical care outreach team who were in the process of completing a business case for additional staffing. The team had found that having one nurse on duty was not always sufficient to meet the demands of the role. The outreach team were also in the process of reviewing IT systems, which would support the capture of patient data. Currently there was no system in place to capture the number of patients or the time spent with them and the care given. All auditing was completed by a review of any paper records.

The other area under development was the ITU follow up service, with service leads agreeing that additional time was required to promote an effective follow up programme.

ITU had participated in the East of England Peer Review, as part of the critical care operational delivery network. We saw that a review was completed in January 2017 and a report completed with findings shared with the team. The report detailed areas for improvement, such as out of hour’s transfers, as well as areas of good practice such as rehabilitation prescriptions. In response, the team developed an action plan, which was also displayed on the unit.
Services for children and young people

Facts and data about this service

Luton and Dunstable University Hospital has 54 inpatient beds on the paediatric admissions unit and paediatric wards:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Inpatient beds/cots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric assessment unit</td>
<td>5</td>
</tr>
<tr>
<td>Ward 24 (Squirrel ward)</td>
<td>17</td>
</tr>
<tr>
<td>Ward 25 (Rabbit ward)</td>
<td>17</td>
</tr>
<tr>
<td>Ward 26 (Hedgehog ward; day case surgery unit)</td>
<td>15</td>
</tr>
</tbody>
</table>

In addition the hospital’s neonatal intensive care unit had 37 cots as of May 2018:

- 11 intensive care cots
- Eight high dependency cots
- 18 special care cots

The unit provides care for local and regional new born babies as part of the East of England Neonatal Network. It is one of three units in the East of England that provide intensive care for premature and sick newborn babies.

The paediatric assessment unit provides 24 hour access to children referred from the emergency department and primary care and children with complex healthcare needs on open access. The unit also provides ‘consultant connect’ which allows immediate direct access for a primary care practitioner to a paediatric consultant for advice and guidance.

Wards 24 and 25 provide medical, surgical and high dependency care for children.

Ward 26 is for children undergoing day case surgery and other treatments including computerised tomography (CT) and magnetic resonance imaging (MRI) scans under sedation or general anaesthetic and dynamic endocrine tests. The trust has subsequently informed us that Ward 26 is also used as additional capacity for children’s emergency medical and surgical cases when required.

The trust also has a level 1 paediatric oncology shared care unit (POSCU).

The trust’s outpatients department sees over 11,000 children each year. There are also a number of subspecialist outreach clinics from tertiary paediatric specialists.

(Source: Universal Routine Provider Information Request (RPIR) Sites tab and Acute RPIR Context tab; trust website)

The hospital’s services for children and young people had 10,863 attendances from March 2017 to February 2018.

Emergency spells accounted for 87.2% (9,469 attendances), 11.1% (1,203 attendances) were day case attendances, and the remaining 1.8% (191 attendances) were elective.
Percentage of attendances in children’s services by type of appointment and site, from March 2017 to February 2018, Luton and Dunstable University Hospital NHS Foundation Trust

Total number of children’s attendances by Site, Luton and Dunstable University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton &amp; Dunstable Hospital</td>
<td>10,863</td>
</tr>
<tr>
<td>England total</td>
<td>1,103,628</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and most staff were compliant. The trust target of 80% completion was met for the majority of mandatory training courses. Nursing staff were meeting the trust standard of 80% for mandatory training modules for the eight mandatory modules they were eligible for. However, medical staff were not meeting the 80% standard for any of the four modules they were eligible for.

The trust provided a structured induction and mandatory training programme for staff. Training was allocated to individuals according to their individual job role and clinical/non-clinical status. Mandatory training topics included moving and handling, fire safety, infection prevention and control, resuscitation, safeguarding children and vulnerable adults, health and safety, equality and diversity and information governance.

Staff we spoke with told us they had completed their mandatory training through face-to-face sessions and online courses and had been allocated dedicated time to complete their training. Staff we spoke with told us their managers monitored staff attendance and ensured staff were meeting their mandatory training requirements.

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for registered nursing staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety</td>
<td>153</td>
<td>175</td>
<td>87.4%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control - level 1 and 2</td>
<td>150</td>
<td>175</td>
<td>85.7%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling (theory)</td>
<td>145</td>
<td>175</td>
<td>82.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>145</td>
<td>175</td>
<td>82.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling (practical)</td>
<td>71</td>
<td>88</td>
<td>80.7%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In services for children and young people the 80% target was met for all five mandatory training modules for which registered nursing staff were eligible.

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 at trust level for medical staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety</td>
<td>47</td>
<td>71</td>
<td>66.2%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling (theory)</td>
<td>45</td>
<td>71</td>
<td>63.4%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control - level 1 and 2</td>
<td>44</td>
<td>71</td>
<td>62.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>42</td>
<td>71</td>
<td>59.2%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In services for children and young people the 80% target was not met for any of the four mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During the inspection nursing and medical staff in children’s services told us they were up to date
with their mandatory training requirements. Monthly divisional reports identified compliance against core mandatory modules reported to the board. Reports were sent to service managers identifying individual staff who were not compliant with their mandatory training requirements.

In the workforce board report for July 2018, (June data) the Women’s and Children’s divisional mandatory training compliance for medical staff had increased to 74%. However, this meant medical staff were not meeting the 80% trust target for mandatory training.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies. The trust target of 80% completion was met for the majority of safeguarding training courses.** Nursing and medical staff were meeting the trust standard of 80% for level 1, 2 and 3 safeguarding training for children. However, medical staff were not meeting the trust standard of 80% for safeguarding adults training levels 1 and 2.

Staff were aware of the different types of abuse and the procedure for reporting a concern. Appropriate arrangements were in place to ensure patients were kept safe from avoidable harm. The trust had safeguarding policies and procedures available to staff on the intranet including out of hours contact details for hospital staff. The trust safeguarding policies reflected relevant legislation and local requirements for safeguarding. Policies identified how to seek advice from the safeguarding team including advice on ‘did not attend/was not brought’ and described the system for following up children who missed one or more outpatient appointments. CAMH would be notified of an admission but the assessment would not be done prior to the child being medically fit.

There were named safeguarding nurses for children and a named safeguarding doctor for children (one of the paediatric consultants) and the director of nursing (DON) was the hospital lead for safeguarding adults and children. The safeguarding leads were supported by senior nurses with designated safeguarding responsibilities across children’s services. Children and young people under the age of 18 were under the remit of the children’s safeguarding team which was emphasised in staff training.

Nursing staff described how they identified children at risk of harm and how they made a safeguarding referral. We reviewed a sample of patient records and found safeguarding referrals had been made in accordance with hospital policy. Senior staff were involved in escalating concerns. For example, the safety of a patient when they felt returning home could be a safeguarding risk. The senior nurse had discussed the patient with the relevant social worker and a child protection plan had been agreed and an alert placed on the patient’s health record. Staff were aware of the alert and nursing staff said they drew the alert to the attention of medical staff prior to undertaking treatment.

The trust had an electronic information sharing system through which staff were able to share information with the safeguarding team. This enabled staff to inform the safeguarding team of any concerns they had about a child or young person in their care and receive advice and support.

In the safeguarding activity report January to March 2018, there had been ten cases where child protection concerns were raised and a child protection medical was undertaken. Three were investigated under section 47 of the Children’s Act (1989), which requires an investigation when there was ‘reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer significant harm’. Six children were assessed as having accidental injuries likely to have occurred through play or normal development and were followed up by social care and the 0-19 years teams. One child had no signs of neglect but there were issues with parenting.
and safety. In addition the children’s safeguarding team processed 342 information sharing forms from staff and external agencies.

The children’s emergency department, was covered in the emergency department report (and the paediatric assessment unit (PAU), assessed and admitted children and young people in education (up to the end of the school year when they were 16). There were exceptions due to the transition of young people into adult services. There was flexibility for children in this age group who may be vulnerable and their needs would be better met on paediatric wards.

Children and young people were admitted to wards for medical reasons and were not admitted primarily to await specialist inpatient mental health beds. Children and young people were not referred to the Children and Adolescent Mental Health Services (CAMHS) and provided by another NHS trust, until they were medically fit. The service was timely and flexible and ensured children and young people with mental health needs were cared for safely in the acute hospital environment. Waits for specialist inpatient mental health beds were kept to a minimum wherever possible. At the time of our inspection there was one patient requiring CAMHS.

Children and young people over 16 years could choose to be cared for on non-paediatric wards and were overseen by the matron for the area who informed the matron for paediatrics of their presence. Senior nurses were advised at daily meetings of any CAMHS admissions overnight. We saw in trust data this approach was being extended to all young people aged between 16 and 18 years admitted to non paediatric wards.

Female genital mutilation (FGM) was included in level 2 safeguarding training which all clinical staff attended. Staff were aware they had a mandatory reporting duty to report any cases of FGM in females under the age of 18 years of age, including those females who have given birth to a female infant. Staff knew their responsibility to report this to the Police within 24 hours ideally but certainly within 28 days after being made aware of FGM. FGM cases in children were reported to children’s social care using the interagency referral form and an appropriate alert placed on the safeguarding database.

Child Sex Exploitation (CSE) was included in levels 2 and 3 safeguarding training. CSE is a form of child abuse and reportable to children’s social services in line with safeguarding procedures. All children and young people admitted after self-harming were screened by the nursing staff for risk factors in relation to CSE. The hospital policy for safeguarding children included FGM and CSE.

Safeguarding supervision was a Department of Health requirement, as detailed in ‘Working Together to Safeguard Children’ (2010). However, not all nursing staff working in children’s services were able to access safeguarding supervision as insufficient staff had received the required training. This was being addressed by the children’s services and 18 supervisors had attended an accredited training programme and safeguarding supervision was planned to be implemented in September 2018. Staff in the NICU attended safeguarding supervision sessions and an action plan was in place to enable staff to access supervision. Additional training sessions were planned and the lead nurse had set a target of 60% training compliance by November 2018.

Debriefing arrangements were in place for staff following a safeguarding incident and supervision was provided using ad hoc arrangements. Medical staff had access to safeguarding supervision with the named safeguarding paediatric doctor.

Entry to the paediatric wards and neonatal unit was protected by keypads and buzzers to ensure the safety of children. We observed staff were vigilant when relatives wanted to gain entry and answered buzzers promptly. However, it was possible to enter the paediatric ward by tailgating through the door when the previous person had been buzzed onto the ward. We saw notices were in place requesting relatives not to tailgate and an additional surveillance camera had been fitted.
to mitigate the risk. A plan to create a manned reception area had been agreed by the trust and was recorded on the children’s service and Women’s and Children’s divisional risk registers.

**Safeguarding training completion rates**

The Intercollegiate Document (March 2014) states that: “Any clinician who is responsible for planning or assessing the needs of children who may be vulnerable or at risk of harm, require level 3 safeguarding training”. This included clinicians whether a doctor, nurse or allied health professional. Therefore, level 3 safeguarding training is the expected level for people caring for and assessing the needs of CYP.

The trust set a target of 80% for the completion of safeguarding training. At the time of the inspection nursing and medical staff were meeting the target of 80% for level 1, 2 and 3 safeguarding training. However, medical staff were not meeting safeguarding adults training at level 1 and 2. We saw in the workforce board report for July 2018, actions to be taken to ensure staff compliance with mandatory training requirements.

Safeguarding training included issues that occurred in the young person’s age group. Training was scenario based and focused on modern slavery; child sexual exploitation (CSE), Mental Health (MH) issues, female genital mutilation (FGM), domestic abuse and honour based violence were included in addition to physical, sexual and emotional abuse and neglect.

The safeguarding children team and doctors from the emergency department (ED) had been involved in a ‘weapons awareness’ programme for young offenders subject to orders which was ongoing. This included a presentation on the physical injuries from gunshot and knife wounds, how quickly a person can haemorrhage, what the experience was for the nurse/doctor in the ED and treating the injuries and what happened when the ED was on lockdown. Feedback from the young people at their 1:1 sessions was positive.

Staff told us they were able to obtain advice from the safeguarding children team or lead doctor or nurse. Information about safeguard children was available throughout the children’s services and involved information designed for children and young people. Staff told us they provided a chaperone for young people if they chose to see a clinician without their parent’s being present.

The trust set a target of 80% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for registered nursing staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - level 1 and 2</td>
<td>174</td>
<td>175</td>
<td>99.4%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 3 core</td>
<td>148</td>
<td>155</td>
<td>95.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 and 2</td>
<td>148</td>
<td>175</td>
<td>84.6%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In services for children and young people the 80% target was met for all three safeguarding training modules for which registered nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from May 2017 to April 2018 at trust level for medical staff in services for children and young people is shown below:
<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children - level 3 core</td>
<td>32</td>
<td>34</td>
<td>94.1%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 1 and 2</td>
<td>58</td>
<td>71</td>
<td>81.7%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 and 2</td>
<td>45</td>
<td>71</td>
<td>63.4%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

In services for children and young people the 80% target was met for two of the three safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean and used control measures to prevent the spread of infection. Nursing staff in children’s services were meeting the trust infection control training at level 1 and 2. However, medical staff were not meeting the trust standard of 80% (as previously mentioned under the Mandatory Training section of this report).

At the time of the inspection all areas in children’s services were seen to be visibly clean and clutter free. There were no reported cases of MRSA or Clostridium difficile in the period May 2017 to April 2018.

In the May 2018 executive board report children’s services had recently investigated a possible cluster of patients with MRSA on the neonatal intensive care unit (NICU). There had been two babies who were found to be MRSA positive, followed by two other babies in the unit. Appropriate infection control precautions were implemented and further screening in NICU did not reveal any other babies with colonisation due to MRSA. Typing studies (of the babies) showed the two babies were colonised with the same strain of MRSA. The other two babies had “distinct” patterns and were different from the two babies and also from each other. No staff members were found to have problems with skin lesions, etc. The trust reported there were three different types of MRSA detected which excluded cross infection and was unlikely to be related to healthcare workers or the environment. Dispensers of hand sanitising gel or foam were available at entrances to each department and within clinical areas. We observed staff adhering to good hygiene practices. In the period April 2017 to March 2018, results of hand hygiene audits in children’s services scored above 95% which showed full compliance against the trust standard. Results were displayed on the patient safety boards and posters promoting hand hygiene were visible to staff.

We observed staff complied with trust’s policies for infection prevention and control. This included wearing the correct personal protective equipment (PPE), such as gloves and aprons. We observed that staff adhered to the trust uniform policy and were ‘arms bare below the elbow’.

Staff told us they were satisfied with the levels of cleanliness in children’s services and if they identified a concern they contacted the housekeeping department who responded in a timely manner. Cleaning schedules were clearly displayed in all ward and department areas. Staff told us the NICU was classed as a ‘very high risk’ area and was subject to weekly cleaning audits as a minimum standard. Weekly cleaning audits from May to July 2018 scored above 98% for ten of the 12 weeks and between 96% and 97% for the remaining two weeks. Paediatrics was classed as ‘high risk’ and was subject to monthly cleaning audits as a minimum and the frequency was increased should any issues arise. Monthly cleaning audits from May to July 2018 scored above
95% for Rabbit, Hedgehog and Squirrel wards apart from one month where Hedgehog ward scored 94.5%.

We saw toys on paediatric wards and in children’s outpatients were cleaned in line with trust policy and were clearly documented. Waste was appropriately segregated in clinical areas with separate colour coded arrangements for general waste, clinical waste and sharps, (needles). Bins were clearly marked and were pedal operated and within safe fill limits.

At the time of the inspection all staff told us they had completed the required infection control training at level 1 and 2. In the period May 2017 to April 2018 all nursing staff in children’s services were meeting the trust standard of 80% for infection control training level 1 and 2. However, medical staff in children’s services were not compliant with Level 1 and 2 infection control training and had scored 62% against the trust standard of 80%. We saw in the board report for July 2018 compliance for medical staff mandatory training had increased to 74% and identified the actions to be taken to improve compliance to meet the trust standard of 80%

CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored worse than other trusts for 17 out of 62 questions. All but one of these were questions asked of parents of children aged from zero to seven years or from zero to 15 years of age. The trust had a credible action plan to facilitate improvement in response to this survey and changes to practice were evident throughout the inspection.

Conversely of the 21 questions asked of children and young people (aged eight to 11 years, eight to 15 years or 12 to 15 years) only one had a score worse than other trusts.

The trust did not score better than other trusts for any questions.

The trust scored 8.31 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Environment and equipment

The service had suitable premises and equipment and looked after them well. Equipment was checked at regular intervals to ensure it was safe for use.

In the 2016 CQC Children and Young People’s Survey, parents and carers of children under 16 years of age were asked to say whether the ward where their child stayed had appropriate equipment or adaptations for their child. The trust scored 7.8 (out of 10) which was consistent with other trusts.

The fabric of the hospital building was dated and not purpose built for the care of children and young people (CYP). However, the trust had continually updated paediatric and neonatal services and longer term hospital site development and provision included the refurbishment of facilities across children’s services and a potential rebuild (children’s services) was part of the trusts longer term plans for the hospital. Development plans had been identified but timescales were linked to the proposed hospital merger with a local NHS trust. Changes had already taken place and improvements made in the facilities for parents and the re-provision of intensive care facilities in the NICU. Two paediatric oncology bedrooms were being upgraded to provide a more relaxed, calming and home from home environment for children who were often required to spend several weeks in hospital undergoing treatment.

All equipment on paediatric wards and NICU had been electrically tested; we saw stickers on equipment which confirmed this had been completed in a timely way. Staff we spoke with told us
equipment repairs were undertaken promptly and equipment failures immediately addressed. This meant that risks to children from unsuitable equipment were reduced.

At our previous inspection in 2016 we saw on the women and children’s divisional risk register there was no rolling programme of replacement of equipment. During our inspection we were advised that the trust does not have in place a rolling equipment replacement programme but all equipment that breaks or is needed urgently is purchased in a timely manner and does not impact on patient care. There were no clinical incidents reported arising from outdated or unavailable equipment. The division together with the estates team and medical electronics services used the asset register process to ensure there was an effective equipment log for each department which was assessed against manufacturer recommendations for life span, safety and maintenance.

The trust had instigated a process through the executive directors in 2018 to review capital bids for each division to ensure prioritisation was appropriate and impact across the trust was considered. We saw paediatric and neonatal equipment bids that had been agreed from 2013/14 to 2018/19.

In 2017 the NICU had reduced the cot numbers in the intensive care unit to improve spacing between the cots to improve the experience of parents as there had been insufficient space to enable parents to spend time at their child’s cot-side. The rooming-in room had been refurbished and additional space was created for mothers to express their breast milk.

We reviewed the information on how the safety of patients being cared for on ward 25 (Rabbit ward) which cared for young people up to the age of 16 years was assured. Comprehensive risk assessments and associated risk management plans were in place for CAMHS patients and children at risk of self-harm behaviour. Risk assessments contained an environmental risk assessment and plans of care included the appropriate level of observation and supervision. All staff were trained in mental health awareness and conflict resolution training and attended annual updates. The service carried out annual ligature audits and bed spaces were safety checked daily. Resuscitation trolleys were checked daily, were tamper evident and all checks were clearly documented in line with trust policy.

During our inspection we tracked two children using the surgical pathway to the operating theatre. The paediatric theatre recovery area had two bays allocated for children and young people. The bays were curtained off to ensure children were not exposed to adults being cared for after surgery, but were not child friendly. The area was appropriately equipped with paediatric resuscitation equipment and checked daily.

There were dedicated children’s outpatient facilities at the hospital. The department was child friendly and members of the multidisciplinary team such as paediatricians, dieticians and physiotherapists reviewed and treated children. Children’s areas were well equipped and supplied with age appropriate toys and books. Older children could access Wi Fi.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support where necessary. The service had assessed and was managing proactively the risk of patients with mental health conditions on an acute paediatric ward.

Appropriate systems were in place to assess risk and recognise and respond to deteriorating children and young people. Patients were assessed in terms of their health, care and individual needs on admission to the paediatric assessment unit (PAU) and the paediatric wards and the NICU. Each child or young person had a risk assessment in relation to manual handling, nutrition, pain, pressure ulcer risk and mental health concerns. These were completed in full in all the 12 care records we reviewed during the inspection.
During the inspection we identified there had been a decrease since the last inspection in the number and complexity of children and young people admitted with mental health needs and at risk of self-harm behaviours. There were 136 children and young people admitted to the paediatric wards in 2016 compared to 48 admitted to the wards from April 2017 to March 2018. A CAMHS crisis team (provided by a local NHS trust) was now based in the emergency department and undertook initial risk assessments and where appropriate discharged children and young people to home with a support plan. Of the 279 children and young people referred to the CAMHS crisis team in the last 12 months, 53 were discharged with a support plan.

Staff told us they were more confident caring for patients with mental health issues following their risk management, conflict resolution and mental health awareness training. The number of CAMH patients was reviewed daily at safety huddles which were documented to support the management of increased numbers and patient dependency. For example, increased staffing levels would be put in place when they were required. This meant that the changes to the management of children and young people with mental health needs and at risk of self-harm behaviours were being managed proactively and inappropriate hospital admissions were prevented.

On the wards we saw the service used pre-operative checklists for all children undergoing surgery which incorporated the recommendations from the World Health Organisation (WHO) and the National Institute of Health and Care Excellence (NICE). In records we saw the checklist was used in preparation for surgery at ward level.

WHO surgical safety checklists were used in the paediatric day theatre and we saw audits were undertaken. Staff were aware of the checks to be undertaken to ensure consent had been obtained for each child and the correct procedure had been undertaken. When children were moved to the recovery area staff followed discharge criteria to ensure children were safe to return to the ward. Parents could be with their child once they were awake. A paediatric trained nurse escorted the child to the ward with their parent(s) and a porter. The safety checklists we reviewed had been completed correctly.

Paediatric wards and the NICU used age appropriate specific observation charts. This included a paediatric early warning (PEW) score that helped staff to recognise when a patient’s condition was deteriorating and when to seek further help and support from medical staff. Staff we spoke with were familiar with PEW scores and how to use them. During our inspection we found observations had been completed accurately and legibly with evidence that the care of children and young people were appropriately escalated to either the nurse in charge or the doctor whoever was indicated.

A seriously ill child who required transfer to another hospital would be cared for by suitably qualified staff until transport could be arranged. This was provided by the children’s special transfer service (CATS) that operated through a network of local hospitals. This included critically ill children, young people and neonates. There was a service level agreement with another acute trust which ensured arrangements to care for children were in place.

The physiotherapist for NICU told us routine physiotherapy would not be continued for babies awaiting transfer. However, following a review of trust policy and appropriate training using a baby simulator, the physiotherapist could continue the provision of physiotherapy to critically ill babies which had helped to maintain their clinical condition. In the last 12 months three babies awaiting transfer to another NHS trust had benefitted from this approach and was demonstrated in case reviews. An audit to review the outcomes was planned.
The NICU ran “live” skills simulation training sessions. Information was taken from incidents and incorporated members of the multidisciplinary team and midwifery colleagues. Feedback was shared at governance meetings and had been presented at international neonatal conferences.

The trust had a programme of daily briefings about the deteriorating child which used a question and answer sheet at the safety briefings to prompt staff in the care of the ‘deteriorating paediatric patient’. The advanced nurse practitioner (ANP) in paediatrics held standard presentations for staff in relation to recognising the sick child, the completion of PEWS and escalation processes.

The trust had an action plan for the management of sepsis which included the National Institute of Health and Care Excellence (NICE) guidance 2016 to ensure continuity across divisions. The action plan was overseen by the sepsis board and escalation reports were provided to the clinical risk management committee and the subcommittee of the board responsible for quality. There were sepsis link nurses and champions in all clinical areas (in children’s services). The link nurses supported the matrons and lead nurses in reviewing current working practices and identifying themes and areas for improvement.

Monthly meetings were held within the division to review sepsis cases and establish if screening and treatment targets were being met. We saw in the minutes of the sepsis working group June 2018, a unified paediatric sepsis screening tool would be implemented for paediatrics. The tool would incorporate the same sepsis guidelines as two different screening tools were being used in the paediatric emergency department and PAU.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.03 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was worse than other trusts.

The trust scored 9.5 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

### CQC Children and Young People’s Survey 2016 questions, safe domain, Luton and Dunstable University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q6. How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults*</td>
<td>8.31</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.03</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q36. Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.50</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.

### Nurse staffing

The service had sufficient nursing staff with the right qualifications, skills, training and experience. Suitable measures were in place through the appropriate use of bank and agency staff known to the service which kept people safe from avoidable harm and abuse and provided the right care and treatment. Staffing levels were safe in children’s services at the time of the inspection and we saw evidence of this in all the areas we visited.
The matron and lead nurse for paediatric and neonatal services told us recruitment and retention remained a focus for nursing and midwifery across all nursing grades and plans for 2019 had been developed. The trust continued to attend local schools, university job fairs, job centre career days and academy events to promote the diversity the trust could offer.

The British Association of Perinatal Medicine (BAPM) published national recommendations of standards for hospitals providing neonatal care. The standards make recommendations for minimal staffing levels with specific guidance for patient to staff ratios. The NICU was staffed to 76% BAPM compliant and recognised it could not fully replicate the BAPM recommendations clinically. To provide a safe and effective service the NICU had implemented a model that allowed for effective skill mixing and had built in contingencies that allowed for surges in activity.

The service had continued to recruit to ensure compliance with RCN guidance which was challenging due to the national shortage of children’s trained nurses and the trusts close location to London where staff could access London weighting (an allowance paid to healthcare staff working in London with the higher cost of living). The trust had commenced a European nurse pathway which provided an in-hospital Occupational English Test (OET). The nurses were currently employed as band 4 pre-registration nurses. Ten staff were undertaking the programme and a further six had joined the programme in July 2018. This meant the trust had an innovative plan to resolve its recruiting challenges.

The trust had several strategies led by the chief nurse to ensure the delivery of safe patient care. Staffing was used flexibly across wards and clinical areas and was dependent on the acuity of patients and staff skill mix. Multi-professional operational meetings were held throughout the day where patient requirements were reviewed and planned for. Actions were taken in line with the trusts safe staffing policy (2016) which identified the escalation processes and outlined the risk assessments and communication required in paediatrics and the NICU.

The trust had introduced an electronic staff rota system that took into account patient numbers and their acuity and patient dependency to ensure the right staff were in the right place at the right time. This supported the escalation policy for children’s services where there were band 7 bleep holders on duty seven days a week and hospital at night arrangements supported the flexing of staff across the service.

In the NICU the escalation policy (currently under review) provided a pathway for contingencies to facilitate safe staffing. Staff risk assessments took place daily and vacancies were backfilled with bank cover. A senior nurse rota (in NICU) had been implemented which was helping to manage capacity issues more effectively. In the last six months the unit had closed six times to the East of England Network Neonatal Operational Delivery Network (EoE ODN) due to staffing issues but not to parents and babies requiring admission to the unit.

The high dependency unit (HDU) was a ‘virtual’ unit of six beds and was flexed according to the needs of children and young people. Staff on the paediatric ward had undertaken HDU competency training programmes to support the unit as required. Nurses from Squirrel, Rabbit and Hedgehog wards and PAU were flexible and told us they had completed the appropriate competency training to enable them to care safely for children across the service. For example, moving staff from clinical and non-clinical areas and deferring training to support front line activity. Staffing activity was incorporated into daily safety huddles that were held in clinical areas across the trust.

We observed nursing handovers on paediatric wards and in NICU which were detailed and effective and appropriate information was shared and discussed. Parents were encouraged by staff to participate in handovers by the bedside.
The trust reported their registered nursing staff numbers as below as of March 2017 and March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton and Dunstable University Hospital</td>
<td>164.4</td>
<td>201.3</td>
<td>81.7%</td>
<td>170.1</td>
<td>194.6</td>
<td>87.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 9.6% for registered nursing staff in services for children and young people. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

In the reporting period March 2017 to April 2018, data from the trust identified nursing vacancies across children’s services was 9.6% which was below the trust target of 10%. At the time of the inspection we saw on the clinical performance and governance score cards (quality dashboards) for paediatrics and NICU for June 2018, the vacancy rate in paediatrics was 6.95 and NICU was 6.8%. Nurses, health care support workers and nursery nurses told us matrons and ward sisters continually worked to address staffing shortfalls and recognised levels of increased activity in children’s services. Staff said the winter period had been the busiest they had ever experienced.

The service had used the Royal College of Nursing (RCN) guidance on staffing levels when undertaking a staffing needs analysis in 2015/16 and staffing levels were increased. RCN guidance states there should be a ratio of one nurse to three patients for children under the age of two years, a ratio of one to four patients over the age of two years and, during the day and night shifts, an experienced band 6 should be on duty over the full 24 hour period and the service was compliant with the RCN guidance All nurses on the paediatric wards were registered nurses (child branch). All shifts had a member of staff trained to the required level in life support. This was in accordance with the RCN ‘Defining Staffing Levels for Children and Young People’s services (2013)’ which states, “At least one nurses per shift in each clinical area will be trained in Advance Paediatric Life Support (APLS) / European Paediatric Life Support (EPLS), depending on the service we need. We reviewed a sample of eight whole shifts and all shifts had (at least) one member of staff trained in EPLS and /or APLS.

We saw on the patient safety board in paediatrics, 12 whole time equivalent staff (WTE) had been appointed from the registered nurse training cohort (child branch) and would take up post in November. The paediatric wards had actively recruited above ward establishments to cover current vacancies and maternity leave planned from September 2018.

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 8.8% for registered nursing staff in services for children and young people. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 4.3% for registered nursing staff in services for children and young people. This was higher than the trust target of 3.25%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and agency staff usage

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 17.4% for qualified nursing staff in services for children and young people. This was made up of 13.9% bank staff and 3.5% agency staff.

Over the same period 7.3% of shifts were left unfilled by bank or agency staff to cover staff vacancies, sickness or absence.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

In the NICU the escalation policy (currently under review) provided a pathway for contingencies to facilitate safe staffing. Staff risk assessments took place daily and vacancies were backfilled with bank cover. Agency staff were not used in the NICU.

Medical staffing

The service had enough medical staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Medical staffing levels and skill mix were planned in advance and were in accordance with relevant guidelines to ensure children and young people received safe care and treatment. There was a 24 hour, seven days a week consultant led paediatric service in place for children and young people. The Royal College of Paediatrics and Child Health 14-hour consultant review standard was being met. There was a designated lead consultant for paediatric and neonatal services.

During 2017/18 financial year there was a monthly average of 63.6 medical staff in post for services for children and young people. This was split fairly evenly between the services with an average of 32.4 WTE on the paediatric wards and 31.2 WTE working across the special care baby unit (SCBU) and the NICU.

There was a separate dedicated clinical director/ lead consultant for paediatrics and NICU. Paediatric consultant medical cover provided on site cover from Monday to Friday 8.30am to 10pm and from 8.30 am to 9.30pm at weekends and on bank holidays. Otherwise they were on call off site, and able to attend if required within 30 minutes. There was 24 hour cover by two junior doctors, one on the level 1 rota and one on the level 2 rotas. These are registrars or speciality trainees and were contactable by bleep.

The NICU complied with the BAPM (2010) standards for a neonatal intensive care unit that cares for very young babies with separate dedicated rotas at all three levels of cover. There was an average of 22 hours a day of consultant neonatologist presence on all days between the hours of 8.30am to 9.30pm. Overnight cover was provided by a hospital based team and supported by a non-resident on call consultant who was able to attend the unit within 30 minutes in the case of an emerge

Paediatric mental health services were provided by a local mental health trust and there was 24 hour access to on site liaison psychiatry team. There was also 24 hour access to a child and adolescent psychiatrist for advice and support.

Handovers took place twice a day and were led by a paediatrician or neonatologist. We observed a handover and found it to be appropriate, relevant and pertinent information was discussed with appropriate guidance for junior medical staff. Parents on the neonatal unit were encouraged to be present on ward rounds and told us they were included in the care of their child.

The service provided ‘consultant connect’ which allows immediate direct access for primary care
practitioners to a paediatric consultant for advice and guidance. This had proved to be a very popular service and was working well.

The trust reported their staffing numbers below as of March 2017 and March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Luton and Dunstable University Hospital</td>
<td>62.4</td>
<td>72.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a staffing surplus of 0.1% above establishment for medical staff in services for children and young people. The trust's target vacancy rate was 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 15.7% for medical staff in services for children and young people. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 3.1% for medical staff in services for children and young people. This was similar to the trust target of 3.25%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

The trust were unable to provide the numbers of shifts worked by medical locum and agency staff over the most recent year as requested in the Routine Provider Information Request (RPIR). Instead they supplied the sums of money spent on temporary medical staffing in each area, and these have been used to calculate temporary staffing rates for medical staff in each core service area.

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 10.9% of total spending on medical staff in services for children and young people. This was made up of 9.6% on bank medical staff and 1.3% on agency medical staff.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

As of December 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average. The proportion of junior (foundation year 1-2) staff was lower than the England average.
Staffing skill mix for the 66 whole time equivalent staff working in children’s services at Luton and Dunstable University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>3%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patient’s care and treatment and individual records were managed in a way that kept patients safe. Records were stored securely in all the areas we visited in children’s services.

All babies, children and young people had individual medical records which were electronic and paper based. Records were clear, accurate and legible. We reviewed the records of 12 babies, children and young people across children’s services. During our inspection we saw records were comprehensive, fully completed and included diagnosis and management plans, consent forms, PEWS forms and evidence of multidisciplinary input and evidence of discussion with parents and families. The trust used an electronic document management system which had replaced traditional hospital paper records.

Monthly documentation audits were undertaken as part of the Harm Free Care data through a one day snapshot audit review of nursing records. This provided information from quality indicators and patient experience scores which were presented to the trusts quality committee. The director of nursing used the information to meet with nursing teams to review performance and identify trends and remedial actions. The trust had continued to deliver Harm Free Care above the national expected threshold of 95% which demonstrated records were being completed appropriately and in line with trust policy.

On the NICU, we case tracked three sets of records in which personal details for the baby and parents had been completed and recorded correctly. There was chronological recording of all contacts and events including physical and social histories and evidence of multi-agency working. There was a clear record of communication with parents and of conversations regarding the planning of care and decision-making processes. We reviewed seven sets of paper records on the paediatric unit and observed that patients’ details were recorded; there was evidence of discussion with parents and assessments that had been completed, including pain and nutritional assessments. There were details of GP visits and interactions with health visitors, physiotherapists and children’s community nursing services.
We saw documentation compliance data in the PAU for the period May to July 2018. Medical documentation plans, GP letters and nursing documentation had scored 100% and other areas for example, PEWS, had continued to improve. We saw a memo from the PAU lead nurse praising staff for their efforts to improve patient documentation and outlining the areas that still required improvement.

During our inspection we saw that records were managed safely. Records were stored in designated trolleys and in offices behind public areas which were secured at night.

**Medicines**

Staff prescribed, gave, and recorded medicines well. Patient's received the right medication and the right dose at the right time. However, we found inconsistencies in the escalation of clinical room and fridge temperatures when this exceeded acceptance guidance levels.

Medicines (including controlled drugs) were stored securely and there were appropriate medicine disposal facilities. A controlled drug (CD) register was used to record the details of CDs received and administered as well as CDs that had been disposed of. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally and causing harm.

Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly. Trust systems provided assurance that blood glucose testing kits were calibrated before use. Paediatric wards had access to pre-packed insulin administration bags which contained all the necessary equipment required by staff to administer insulin to a child safely.

Staff could access medicine supplies throughout the day and out of hours. The paediatric pharmacist had been on long term leave and another clinical pharmacist was providing support. They attended ward rounds, conducted medicines reconciliation and supported wards with medicines related activities. All prescribing on the paediatric wards was via the electronic prescribing and medicines administration system (EPMA).

We reviewed a sample of EPMA records (10) and saw they were completed fully with no administrations not recorded. However, we saw the EPMA system did not alert staff if medicines were administered at incorrect intervals. For example, we saw an antibiotic was prescribed three times a day over 18 hours, every six hours. However, we saw that the medicine was administered with dosage intervals of two hours and six hours. The EPMA system did not alert or prevent medicines being given too close together.

We saw insulin and fluid charts were kept on paper charts, however there were inconsistency about how these were cross referenced to the EPMA system. We found some children’s electronic charts prompted staff to look at the paper charts but others did not. Staff told us they would be informed at handover about children who required insulin and fluids and would check the charts during medication rounds. We advised the matron for the paediatric wards at the time of the inspection who took the appropriate action.

We found medicines on paediatric wards were stored in the clinic room and medicines fridges were not always kept within their recommended temperatures to remain effective. When fridge temperatures went out of range staff did not always take remedial action. At the time of the inspection the paediatric pharmacy technician was informed and took the appropriate action.

From July 2017 to July 2018 there were 169 drug incidents reported across the NICU,
paediatrics, PAU and children’s outpatient services. This was an increase on drug incidents reported at our last inspection in 2016 where 135 drug incidents had been reported. However, this reporting period was one month longer than the 2014/15 reporting period. Drug incidents in 2017/18 were graded as; 161 incidents graded as ‘no harm’, seven incidents graded as ‘low harm’ and one incident graded as ‘moderate harm’. The moderate incident related to a missed dose of medication on the paediatric ward. All drug incidents had been investigated in line with the trusts medication policy and actions to prevent further incidents recorded on the incident reporting system and shared with staff at team meetings and daily safety huddles.

We saw in paediatric and NICU newsletters pharmacy interventions were written to aid staff learning in the safe administration and management of medicines. For example, ensuring patient’s on home leave have their administration record updated on the electronic prescribing system otherwise it would appear the patient had missed doses of their medication. We saw error notices for staff where the information on the side of the packet for a brand of medication for injection was ‘extremely’ misleading and could cause calculation errors when working out the volume of medication to be used.

In the Medication Safety Review Group minutes April 2018, an analysis of administration errors had been undertaken as this was the most prevalent medication related error group on the trusts electronic incident reporting system in 2017. In total 192 administrative errors were reported with the top three being wrong drug (36), wrong frequency (29) and wrong dose (26). A quality improvement project on reducing selection errors on the electronic prescribing medical administration system was being undertaken and the extent of the problem was being collated from a baseline audit which would incorporate the last pharmacy intervention audit. It was agreed the data would be shared with senior sisters and possible solutions would be discussed to help change current practice.

**Incidents**

Staff recognised incidents and reported them appropriately. Managers investigated incidents and provided feedback to staff. Lessons were learnt as a result of incidents and actions monitored. When things went wrong, staff apologised and gave patients honest information and suitable support.

During our inspection we observed that staff understood their responsibilities to report incidents and children and parents were informed when things went wrong. Incidents were reported and investigated and were subject to high quality review by the matron and lead nurse in the children and young person’s service. Evidence of decisions and discussions at team meetings were consistent and learning outcomes were recorded in the minutes of team meetings, staff handover sheets and staff newsletters in paediatric and neonatal services.

The trust used an electronic reporting tool to record incidents. Staff we spoke with were confident in the use of the system and told us they always reported incidents. Staff told us they were given feedback about incidents at daily handovers, safety huddles and team meetings. Clinical performance and governance scorecards (quality dashboards) provided the Women’s and Children’s division with safety data to enable the identification of themes and trends and take appropriate actions. Actions were monitored locally and overseen at monthly clinical governance meetings in paediatrics and NICU and we saw evidence of this in minutes of June and July 2018 meetings.

In the period April 2017 to June 2018 there were 78 child related incidents in the paediatric service. Of the 78 incidents, 54 were graded as ‘no harm’ 19 as ‘low harm’ and five as ‘moderate
harm. Printed handover sheets contained information prompts following children’s incidents. Where incidents had occurred, actions were identified to limit the risk of a further occurrence.

Newsletters in children’s services highlighted safety incidents that had occurred in the previous month. A range of examples was used which included what went wrong and what actions had been taken to prevent it happening again. For example, in the paediatric staff newsletter for July 2018, a fluid chart for a diabetic child was not completed so statements were being acquired and an action plan from the ward managers shared with staff. An incident related to the safety of needles not administering the full amount of insulin to patients had been addressed by the needles not being used for diabetic patients until information was obtained from manufacturers.

Staff in children’s services attended multi-disciplinary patient safety huddles which provided an opportunity for staff to review the incidents from the previous day and safety issues for the day ahead. A weekly grand round for paediatrics and NICU reviewed themes and risks and encouraged development of safety improvements.

The children’s service incorporated learning from mortality and morbidity issues in clinical governance meetings. Monthly meetings discussed neonatal and paediatric deaths, adverse events and reviewed the care provided. Minutes indicated a full discussion of cases took place and learning points identified. The trusts teaching programme ensured there was shared learning from mortality and morbidity issues. The Women’s and Children’s division promoted learning through journal clubs and teaching reports where cases had been summarised.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify parents (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medical and nursing staff understood their responsibilities regarding the duty of candour regulation and were aware of the trigger for the application of duty of candour for moderate harm and above. All staff received training in duty of candour at induction which included the principles and when and how to apply them. It focussed on the ‘Saying Sorry’ messages outlined in the NHSR leaflet which provided reassurance to staff that saying sorry is not an admission of liability.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported no incidents classified as never events in services for children and young people. However shortly before the start of this period, the trust reported a never event of type “Overdose of insulin due to abbreviations or incorrect device” in this core service. This concerned the accidental administration of an overdose of insulin to a child with type 1 diabetes. The child received Dextrogel to correct the hypoglycaemia.

*(Source: Strategic Executive Information System (STEIS))*

The child received the appropriate medication to correct the insulin overdose and appeared to have not incurred long term harm from the incident. The incident underwent a root cause analysis investigation in line with the trusts incident reporting policy which included lessons learnt and action plans. The parents of the child had been advised of the incident and had been provided with support in line with duty of candour regulations. The case was reviewed at the paediatric and
neonatal clinical governance meetings, the Women’s and Children’s divisional meetings and trust board meetings to ensure wider organisational learning.

We saw in the paediatric newsletter for December 2017 that 99% of eligible staff in the paediatric service had undertaken insulin competency training to ensure they knew how to administer insulin to children safely. Managers were reminded about staff returning from maternity leave requiring training.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in services for children and young people which met the reporting criteria set by NHS England from June 2017 to May 2018.

(Source: Strategic Executive Information System (STEIS))

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from May 2017 to May 2018 in services for children and young people.

(Source: NHS Digital)
Is the service effective?

**Evidence-based care and treatment**

There was a holistic approach to assessing, planning and delivering care and treatment to children and young people in the children’s service. The service used safe and innovative approaches based on evidence based techniques to support the delivery of high-quality care.

Babies, children and young people’s care was consistently planned and delivered in line with evidenced based guidance. Staff followed National Institute for Health and Care Excellence (NICE) and other professional guidelines regarding the treatment of babies, children and young people. For example, the British Association of Perinatal Medicine (BAPM), the Royal College of Paediatrics and Child Health (RCPCH), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE-UK), Baby Friendly (Unicef) the BLISS baby charter initiatives and national audits were used to monitor the effectiveness of standards of care.

NICE guidelines relating to neonatal care were reviewed and incorporated into locally specific guidelines. For example, guideline CG98, Jaundice in newborn babies under 28 days, guideline CG149 Neonatal infection (early onset): antibiotics for prevention and treatment. Guideline NG72, Developmental follow-up of children and young people born preterm, was being reviewed and action plans developed to ensure children’s services were compliant with the guidance.

Neonatal clinical guideline meetings reviewed and agreed clinical guidelines before ratification by the trust guidelines committee. Clinical guidelines were reviewed monthly at clinical governance meetings and by the Children’s Board who co-ordinated issues relating to children across the trust. For example, minutes of the March 2018 meeting recorded chicken pox guidelines in paediatrics had been ratified and would be uploaded onto the trust intranet.

Children’s services were involved in national and local audit programmes for example, paediatric epilepsy, diabetes and asthma audits. Local audits included documentation, pain, PEWS, neonatal deaths, medication audits, and paediatric ‘did not attend’ DNA children’s outpatient audit. Audit results were presented at Women’s and Children’s divisional audit meetings and clinical governance meetings in children’s services.

In 2017 paediatric and neonatal services had received an award for being the best training unit in the East of England deanery at the PAFTAS – the paediatric awards for training achievements. The service was applauded in the East of England Quality Surveillance Programme (EOEQSP) (2017) peer review report following their visit to NICU in January 2018.

The service participated in the National Neonatal Audit Programme (NNAP) published in 2017 and reporting on data from 2016. The NICU was taking part in the ‘first hour of care project’ an East of England Neonatal Network Operational Delivery Network (EoE NODN) approach to the first hour of care for babies to ensure all babies received the same care and management.

The NICU used Bayley Scales of Infant Development (Bayley-111) tool, an internationally recognised tool to assess children from one month old and used at intervals until the child reached two years of age.

The NICU was Unicef baby friendly level 2 accredited. Baby friendly initiative awards are based on evidenced-based interlinking standards for maternity, health visiting, neonatal and children’s centred services. Standards are designed to provide parents with the best possible care to build close and loving relationships with their baby that support optimal health and development. Standards are implemented in stages over a number of years and are externally assessed by Unicef UK. Level 2 accreditation is based on all staff in NICU being educated according to their
role to care for mothers and families effectively. For example, all health care staff were trained to support mothers to express breast milk for their babies and staff had undertaken practical skills reviews as part of their mandatory training.

The trust had an action plan for the management of sepsis which included the National Institute of Health and Care Excellence (NICE) guidance 2016 to ensure continuity across divisions. The action plan was overseen by the sepsis board and escalation reports were provided to the clinical risk management committee and the subcommittee of the board responsible for quality. There were sepsis link nurses and champions in all clinical areas (in children’s services). The link nurses supported the matrons and lead nurses in reviewing current working practices and identifying themes and areas for improvement. Monthly meetings were held within the division to review

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

At the time of the inspection children and young people’s nutrition and hydration needs were being met. Menus on paediatric wards identified a variety of nutritious meals that took into account the choices made by young people. Play specialists and health care support workers involved children in choosing their meals. Parents told us they were happy with the variety, choice and quality of food.

We reviewed ten sets of records that showed dietary and fluid intake was monitored, recorded and where required, reviewed. Neonatal feeding plans and feed charts were reviewed and were up to date and clearly documented. This ensured babies, children and young people were receiving age appropriate nutrition and hydration. Staff were aware of how to access dietetic services and how to order specialist menu choices such as vegetarian and gluten free meals.

In paediatrics, tube-fed children usually had a chronic illness requiring long term feeding. The clinical nurse specialists (CNS) for gastroenterology and nutrition had 159 children on home enteral feeding in their caseload. In the annual report for 2018, children in Luton and Bedfordshire were more likely to have a gastrostomy tube than national figures suggest and only 5% would return to oral feeding each year. Many of these children sought advice from the CNS either indirectly or through a school nurse or directly with their parents/carers as outpatients via open access arrangements or as inpatients.

In the NICU a milk kitchen was available for preparing babies milk and was secured and only accessible to staff in the unit. Parents were unable to borrow or hire breast feeding pumps from the unit but were signposted to local hirers. Donation of breast milk was discussed when appropriate; the unit could receive breast milk for mothers and if mothers wished to donate their breast milk they were given the information to arrange this directly with the local milk bank. There was a breast feeding support nurse in the unit and good information leaflets about breast feeding and breast feeding support which was available in a number of languages. The number of babies receiving mother’s milk at the time of discharge was 71% which was above the national average of 59%.

Neonatal and paediatric dietetic support was provided by two specialist paediatric dieticians who had completed the British Association neonatal module. Dietetic cover was shared between the dieticians to give resilience to the service. The dieticians attended one ward round a week on the special care baby unit and a weekly multi-disciplinary nutrition round with the neonatologist with an
interest in nutrition during which any baby on the unit who had growth and nutrition concerns was reviewed.

**Pain relief**

Patients’ pain was mainly managed well through assessment and management of age appropriate pain tools. However, there were inconsistencies in recording of pain scores in paediatrics.

Pain was assessed and managed on an individual basis and was regularly monitored by nursing staff. We observed nursing staff monitoring the pain levels of children and young people using age appropriate tools and observation sheets, recording the information and taking appropriate action to control patients’ pain.

Pain levels were routinely assessed during the completion of patient observations and were recorded on the PEWS charts. We observed nursing staff asking children and young people if they were in pain and the intensity of pain by using pictures and diagrams to aid understanding. We reviewed five medication records on the electronic prescribing system which showed the appropriate prescribing of pain relief. Medical staff prescribed anticipatory pain relief for children and young people following procedures.

In the latest CQC children’s survey 2016 in children aged 0-15 years were asked did staff do everything they could to help the child’s pain? The trust scored 8.4% (out of 10) for the question which was about the same as other trusts. The survey asked parents and carers if they though staff did all they could to ease their child’s pain. The trust scored 7.9% (out of 10) for the question which was about the same as other trusts.

In the pain service annual trust audit (August 2017) pain scores were recorded with every observation in 92% of cases. However, paediatric wards performed pain assessment in 67% of their patients with every observation and 33% were undertaken intermittently. In the pain survey action plan (May 2018) we saw paediatric acute pain guidelines and associated documentation, had been updated and training in pain assessment and management was ongoing.

Children’s services adhered to the Faculty of Pain Medicines’ Core Standards by undertaking monthly pain audits. On the paediatric clinical performance and governance scorecard (quality dashboards) 2018, paediatric wards were rated green (above 80%) in April but had scored 39% in May and 54.2% in June 2018. However, in July the total audit score for Rabbit ward was 91.75%. For the question “Had the pain score been assessed and documented on the observation chart?” and the ward had scored100%. This was an improvement on the May 2018 audit where the same question had scored 50% for ‘always’ completed and 50% for ‘intermittently’ completed. On Hedgehog ward the total score for July 2018 was 94.01% and the same question scored 75% for ‘always completed’ and 25% for ‘intermittently’ completed. This meant there was an improvement since the 2017 pain service audit, but there were still inconsistencies in recording of pain scores in paediatrics.

**Patient outcomes**

Staff were actively engaged in activities to monitor and improve quality and outcomes in children’s services and opportunities to participate in benchmarking were actively pursued at all levels of the service and performance was recognised by credible external bodies. Outcomes for babies, children and young people who used services were variable and action plans were in place to address any shortcomings.

Outcomes regarding patient’s care and treatment were collected and monitored in line with national requirements. The service participated in national audits to examine the clinical outcomes.
in children and young people’s services including MBRACE-UK 2016 and published in 2018, the National Paediatric Diabetes Audit 2015/16, Epilepsy 12, the National Neonatal Audit 2017 and the British Association of Perinatal Medicine (BAPM).

The MBRACE report for 2016 (published in 2018) showed extended perinatal mortality rates were up to 10% lower in the NICU than the group average in the East of England Neonatal Operational Delivery Network (EoE NODN). Mortality figures for 2017 had been calculated locally and were not standardised or adjusted. However, trust data for the last 12 years had been used as a comparator. The 2017 national data was due to be published in 2019.

The Bliss Baby Charter was designed to standardise high quality family centred care across the UK. It is a practical framework for NICU to self-assess the quality of family centred care they deliver against seven core principles. It enables NICUs to audit their practices and develop meaningful plans to achieve changes that benefit babies and their families. NICU had undertaken an initial baseline audit in 2014 which was repeated in November 2017.

The audit had been submitted to Bliss who will review the evidence and arrange to inspect the service and evidence collection was ongoing.

Appropriate positioning in the neonatal period is essential for good neurodevelopment outcomes in preterm infants and its importance has been well documented. The aim of neonatal positioning is to provide appropriate flexion, support and postural stability and promote self-calming. Positioning training in the NICU was undertaken by neonatal physiotherapists and six-monthly audits were ongoing to monitor standards of developmental care positioning within the clinical setting to ensure they continue to be achieved and maintained.

In the January 2018 NICU audit, 14 babies were audited in both the supine/side lying position and prone position. All babies scored either ‘very good’ or ‘good’ and all babies were seen to be using appropriate equipment. The audits reported an overall improvement in positioning of babies and positioning equipment used. Areas to continue to improve were the promotion of appropriate support in the prone position and adjusting the sizes of boundaries (aides) appropriately.

We saw in the peer review visit report from January 2018 as part of NHS England Quality Surveillance Programme (2017/18) the service had been identified as being a ‘cohesive team with good collaboration from all specialities to deliver optimal neonatal services’. There were no immediate risks or serious concerns identified during the peer review visit. The NICU had undertaken a self-assessment and had rated themselves at 87.5%. The peer review had rated the service as being 81.3%. Areas for improvement were documented in the peer review action plan. For example, the reduced number of QIS trained nurses impacting on activity. We saw a three year succession plan was in place to increase compliance from 76% to 90% BAPM compliance for QIS nurses.

Paediatric diabetes audit 2015/16

The trust takes part in the National Paediatric Diabetes Audit (NPDA) which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and managed by the Royal College of Paediatrics and Child Health (RCPCH). In addition to auditing the quality of care the NPDA has Developed Patient and Parent Experience Measures (PREMS). The NPDA survey provides feedback to the diabetes team about the children and young person’s experience of using the service. The outcomes for the service were either similar to or better than the national outcomes.

In the 2015/16 Paediatric diabetes audit, the proportion of patients receiving all key care processes annually at Luton and Dunstable University Hospital was 17.6% which was less than (worse) than the national aggregate of 35.5%. The hospital’s score for the previous year was not
identifiable due to the low number of eligible patients.

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The mean average HbA1c value (adjusted by case-mix) for this hospital was 67.7 mmol/mol which was within the expected range. The national aggregate was 68.3 mmol/mol. The hospital also performed within the expected range for this metric in the previous year’s audit.

The median HbA1c value recorded amongst the 2015/16 sample for this hospital was 65.3 mmol/mol, which was a clinically significant improvement from the previous year’s median of 68.3 mmol/mol.

(Source: National Paediatric Diabetes Audit 2015/16)

The action plan for the 2015/16 diabetes audit identified four areas for improvement and was being monitored by the diabetes nurse specialist;

- Increase the screening rates of microalbuminuria through reminder text messages.
- Increase compliance of patients receiving all seven key care processes through improved checking procedures at each clinic visit.
- Reduce percentage of patients with HbA1c of > 80mmol/mol through diabetic specialist nurse led clinics with two-four weekly reviews and structured education when appropriate.
- Reduce percentage of patients with HbA1c of <58mmol/mol by setting individual targets at each clinic.

Emergency readmission rates within two days of discharge

The tables below show the percentage of patients (by age group) who were readmitted following an elective admission. The tables show the three specialties with the highest volume of readmissions and only those specialities where six or more readmissions recorded are shown in the table.

The data show that from February 2017 to January 2018 the percentage of patients aged 1-17 years old that were readmitted following an elective admission in paediatrics was similar to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Luton and Dunstable University Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>0.7%</td>
<td>970</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.
The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data show that from February 2017 to January 2018 a higher percentage of patients aged under one were readmitted following an emergency admission in paediatrics compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Luton and Dunstable University Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.9%</td>
<td>3,559</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

A higher proportion of the trust’s patients aged 1-17 years who were admitted as an emergency in paediatrics were readmitted compared to the England average.

A lower proportion of the trust’s patients in this age group who were admitted as an emergency in general surgery were readmitted compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Luton and Dunstable University Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics</td>
<td>4.4%</td>
<td>5,694</td>
</tr>
<tr>
<td>General surgery</td>
<td>2.0%</td>
<td>399</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

(Source: Hospital Episode Statistics, provided by CQC Outliers team) Paediatric readmission rates were reviewed and monitored against the trust standard to offer parents 24 to 48 hour open access following attendance at the paediatric assessment unit (PAU) or discharge from the unit. Parents were advised to ring PAU to discuss concerns prior to re-attending if necessary.

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From March 2017 to February 2018, similar proportions of the trust’s patients aged from one to 17 years of age had at least one readmission for asthma and epilepsy in comparison to the England rates. Over the same period a higher proportion of the trust’s patients in this age group had at least one readmission for diabetes in comparison to the England rate. It should be noted that the numbers involved were small.
Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under one year and from one to 17 years).

(March 2017 to February 2018)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Luton and Dunstable University Hospital NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>15.6%</td>
<td>147</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>19.6%</td>
<td>46</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>8</td>
</tr>
<tr>
<td>1 to 17</td>
<td>25.0%</td>
<td>48</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’. Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

The trust takes part in the National Neonatal Audit Programme (NNAP) which monitors aspects of care that has been provided to babies on neonatal units in England, Scotland and Wales. In the 2017 NNAP the trust performed much better than the national average in three measures relevant to children and young people and was in the top 25% of hospitals for the forth measure of babies with gestation of birth >30 weeks who had received documented follow-up at two years gestationally corrected age.

In the 2017 National Neonatal Audit, Luton and Dunstable University Hospital’s performance in the four measures relevant to services for children and young people was as follows:

**Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc**

Out of 80 eligible cases identified for inclusion, 70.7% of babies less than 32 weeks gestation had a temperature taken within an hour of admission that was between 36.5ºC and 37.5ºC. This was better than expected when compared to the national aggregate of 61.0%.

The hospital did not meet the audit’s recommended standard of 90% for this measure.

**Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission**

Out of 529 eligible cases identified for inclusion, 97.9% had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. This made the hospital a positive outlier when compared to the national aggregate of 90.5%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.
Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity

Out of the 91 eligible cases identified for inclusion, 97.7% of babies of very low birthweight or less than 32 weeks gestation received appropriate screening for retinopathy of prematurity. This was within the expected range compared to the national aggregate of 94.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age

Out of the 45 eligible cases identified for inclusion, 88.9% of babies with a gestation at birth of less than 30 weeks received a documented follow-up at two years gestationally corrected age. This placed the hospital in the top 25% of hospitals in England for this measure. The national aggregate was 61.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health

Competent staff

Staff were proactively supported and encouraged to acquire new skills and use their transferrable skills and share best practice. Children’s services recognised that the continuing development of its staff was integral to ensuring high-quality care. All staff in children’s services told us they had an annual appraisal as part of their personal development review. Staff said they had completed an appraisal within the previous year and had found it a helpful and constructive process.

The service had processes in place to identify training needs and compliance, which ensured staff were confident and competent to undertake their roles. The current nursing workforce in the neonatal unit was compliant with the BAPM standard which states that at least 70% of the registered workforce holds an accredited post-registration qualification in specialised neonatal care; Qualified in Speciality course (QiS). At the time of the inspection 76% of staff had attended a QiS course.

Practice development nurses supported staff in children’s services by providing individual and group training and competency based clinical assessments. Rolling programmes of study days helped facilitate staff release. For example, sickle cell and thalassaemia, stabilisation and transfer of the critically ill child, epilepsy rescue medication and basic life support workshops, drug calculations and intravenous medication training for newly qualified nurses. Staff completed equipment training competencies and attended simulation training in the NICU.

Following a ‘never event’ in May 2017, an action plan and insulin competencies check list (with standards attached for assessors) was developed and introduced by the paediatric diabetes team and practice development staff. At the time of the inspection 99% of eligible staff had undertaken insulin competencies training. Diabetes consultants and clinical nurse specialists (diabetes), ensured equipment (insulin syringe) was shown (not just mentioned) at teaching sessions for paediatrics, adult, medical and nursing) including induction, intravenous study days, updates and clinical refresher courses. Adult and paediatric diabetes teams had worked together to promote e-learning modules and a review of the ‘Virtual College’ e-learning modules (where factual inaccuracies had been identified) had been addressed.

Specialist nurses had qualifications appropriate to their role. We spoke with specialist nurses in diabetes, epilepsy, oncology, haematology, nutrition and gastroenterology and research who told
us they were well supported in their roles by lead clinicians and the matron in paediatrics and had completed training competency programmes and post graduate courses in their specific area of expertise.

Band 3 nursery nurses in NICU had completed the special care baby unit (SCBU) module and undertaken competency based training to enable them to support family friendly Unicef and Bliss initiatives. Part of their development was to have link roles within the service for infection control, Friends and Family feedback and breast feeding support.

Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses and midwives must follow every three years to maintain their registration. At the time of the inspection we were told all nurses who needed to revalidate had done so successfully. Clinical supervision was provided to newly-qualified nurses as part of their preceptorship programme and to the recently recruited European nurses in the trust.

A children’s assessment, knowledge and examination skills (CAKES) course ran two to three times a year and was accredited by the RCN and RCPCH. This was a multi-professional educational course which ensured competency and confidence of staff in all settings to recognise sick children needing urgent hospital treatment and appropriately assess and manage children safely outside-of-hospital settings and at home. The course had been developed by PDU staff.

The NICU had an advanced neonatal nurse practitioner (ANNP) who covered the post-natal unit, the delivery suite and the NICU. The ANNP worked at senior house officer level and was part of the medical rota. The ANNP supported the delivery of the sugar, temperature, airway, blood pressure, lab work and emotional support (STABLE) programme at the local university which focuses on the delivery of the post-resuscitation/pre-transport stabilisation care of sick newborns.

In 2017 the paediatric and neonatal departments had received the award for the best training unit in the East of England deanery at the PAFTAS, the Paediatric Awards for Training Achievements. The service was 'applauded' in the NHS England Quality Surveillance Programme 2017/18, peer review report published in June 2018, for its educational achievements.

The trust was a teaching hospital and therefore trainee doctors were supported locally and at the university by tutors. The trust provided trainee doctors with a named clinical supervisor as outlined in ‘The Gold Guide-6th edition’, Foundation Programme Reference Guide and standards for trainees outlined in the General Medical Council (GMC) publication ‘The Trainee Doctor’. Junior doctors in the children’s service told us senior medical staff and consultants provided ongoing supervision, teaching and support, signposted relevant training sessions and provided immediate feedback on their performance. Doctors told us “They always find time for us” and “This has been my best placement to date and I would love to come back to paediatrics”.

The General Medical Council (GMC) annual review of trainees in the Paediatric Trainer Speciality 2017/18 Health Education East of England, reported the trust as being in the top four of participating trusts for overall satisfaction of trainees for paediatrics (86%) and neonates (89%). The trust scored well for providing a supportive environment in paediatrics (81.43%) and neonates (87%) which supported the feedback from trainees throughout the inspection.

There was a strong ethos of professional development and support across the children’s service and we saw examples of where staff had been enabled to develop across career pathways to undertake new roles. For example, from health care support worker to registered nurse (child branch).

**Appraisal rates**

From June 2017 to May 2018, 88.2% of staff in services for children and young people at the
trust received an appraisal compared to a trust target of 90%.

The breakdown by staff group is shown in the table below. Please note that the trust was unable to provide separate appraisal completion data for registered nursing staff. In the trust’s appraisals data these staff are included in the staff group “nursing and ward based staff”.

As well as registered nursing staff, this group also includes healthcare assistants, health care support workers, modern matrons and nurse managers, dental surgery assistants and play specialists.

Staff we spoke with during the inspection told us they had undertaken an appraisal in the last 12 months. In the neonatal service appraisal rates for all staff groups had increased from 79% in April 2018 to 89% in June 2018 and the service was just below the trust target of 90%. In paediatrics the appraisal rate for all staff was 89% in June 2018 and was just below the trust target of 90%.

<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>27</td>
<td>29</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing/ward based staff</td>
<td>166</td>
<td>189</td>
<td>87.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>221</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Children’s services were committed to working collaboratively and had found innovative ways to deliver more joined up care. There was a holistic approach to planning young people’s transition to adult services which was done at the earliest possible stage.

Multidisciplinary teams involved paediatricians, neonatologists, nurses, physiotherapists, speech and language therapists (SALT), dieticians and play specialists. There was a cohesive and thorough approach to assessing the needs of children and young people which involved setting individual goals and providing child centred care. Nurses worked alongside therapists and specialist nursing services, for example, diabetes, oncology nutrition and gastroenterology.

Clinicians told us the paediatric team continued to work closely with the Medical division to further improve pathways for children in the children’s emergency department to further enhance the care of diabetes in pregnancy in line with new guidelines. The service also worked collaboratively with the surgical division to support the resilience and development of children’s surgery. A programme of joint training events between surgical and paediatric services had provided positive feedback across the teams which was helping to ensure better communication, service planning and delivery. The paediatric team had welcomed increased support through appointment of additional surgeons and anaesthetists who were supporting paediatric services.

Staff described good collaborative working practices and nurses and medical staff told us there were good working relationships within multidisciplinary teams This was evident throughout our inspection. We observed three multidisciplinary safety huddles in paediatric and neonatal services which were well attended and enabled staff to be informed of safety issues relating to their service.

Effective transition arrangements for patients with diabetes, endocrinology, gastroenterology, epilepsy and chronic respiratory conditions were provided by the CNS and consultant paediatrician on the hospital site. Young people were transitioned into the trust hosted adult
clinics using appropriate care pathways.

On NICU the multidisciplinary team saw babies born under 32 weeks or with a low birth weight. The team completed hand on and video assessments to facilitate development.

**CQC Children and Young People’s Survey 2016 – Q36**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.11 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was worse than other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Seven-day services**

Children’s services offered a 24-hour, seven day a week service. This included the ward presence of a consultant paediatrician and consultant neonatologist on paediatric wards and in NICU and access to the PAU.

Play specialists supported children and young people seven days a week.

Children’s outpatient services held monthly blood transfusion clinics at weekends.

There was access to radiological imaging 24 hours a day and access to physiotherapists outside of working hours via an on-call arrangement.

Pharmacy provided a full weekday service with a dispensary service available at weekends and outside of working hours via an on-call arrangement.

**Health promotion**

**Staff were consistent in supporting babies, children and young people to live healthier lives.**

Staff in the service spoke about interventions to maximise health promotion opportunities. We saw smoking cessation advice was available and patients had access to a smoking cessation nurse.

Information was available on the integrated sexual health and contraceptive health and HIV clinic which had open access available to anyone of 13 years and over from any area.

Children’s outpatient services had a wide variety of health promotion information for children and young people. There were notice boards promoting healthy eating, diabetes including promotional events and guidance on vaccination programmes for children and young people. For example, measles and flu.

Staff could signpost patients to GPs and there were displays across the hospital advising patients on the importance of health lifestyles, diet, exercise and ways to reduce health risks.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.**

Staff we spoke with had an effective understanding of gaining consent from children and young people and the guidance around this with regard to capacity to consent, including Gillick and Fraser competence. Gillick and Fraser competency is used to help decide whether a child or young person was mature enough to make their own decisions and helps to balance the rights and wishes of the hospital’s responsibility to keep children and young people safe from harm. Gillick competence is concerned with determining a child or young person’s capacity to consent. Fraser
guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

The trust’s consent to treatment policy (2018) described how young people under the age of 16 years might be considered Gillick competent to consent to treatment. This meant that children who have sufficient understanding to enable them to understand fully what was involved in a proposed intervention would have the capacity to consent to the intervention.

We saw all grades of staff seeking appropriate consent from patients and relatives (where required) before undertaking an intervention. Nursing staff gained verbal consent before undertaking interventions such as clinical observations or giving medication. Where children or young people were unsure about a procedure, play specialist supported them to make an informed decision.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) levels 1 and 2 training was completed by 74.1% of staff in services for children and young people compared to the trust target of 80%.

This included 84.6% of registered nursing staff and 63.4% of medical staff. Therefore the 80% target was not met for medical staff in services for children and young people. This was being addressed within the division and we saw the actions recorded in the board minutes for April 2018.

Deprivation of Liberty Safeguards training is covered under the trust’s Safeguarding Adults Level 1 and 2 and Safeguarding Adults Level 3 training modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed worse than other trusts for three of the six questions relating to effectiveness in the CQC Children and Young People’s Survey 2016, and about the same as other trusts for the remaining three questions.

Following the findings of the CQC Children and Young People’s Survey in 2016, the trust had undertaken an inpatient survey in 2016. An overall satisfaction rate was reported from children and young people aged eight to 15 years of 86% and 80% from parents and carers.

Feedback was combined with the national survey and Friends and Family Test (FFT) results and an action plan developed. The plan was monitored at paediatric divisional meetings. For example, actions relating to effectiveness of the service included, extending the opening times of the play room and creation of a “What are we doing” board displayed outside the playroom. Children and parents reported they were more aware of the play service and play staff were more visible in ward areas.

**CQC Children’s Survey questions, effective domain, Luton and Dunstable University Hospital NHS Foundation Trust**
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21. Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>7.86</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q9. Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>6.57</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.43</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.11</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q33. During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>5.78</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q54. Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 children</td>
<td>4.43</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.
**8-11 children = asked of children aged from eight to 11 years of age

(Source: CQC Children and Young People's Survey 2016, RCPC)

### Is the service caring?

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness. Parents and carers told us they were very happy with the care and support they received and feedback was overwhelmingly positive throughout the inspection.

Staff were friendly, professional and compassionate and helpful to patients and their parents and families in all the interactions we observed. Parents and carers told us they were very happy with the care and support they received throughout children’s services. A parent said, “staff were always very kind to their child and spent as much time as was needed to explain what was going to happen to them”. Another parent said, “My child has recently been diagnosed with a long term clinical condition and has lots of questions for the nurses and doctors. No matter how many questions my child asks staff always find the time to answer and write down any further questions they might have”.

In NICU parents told us how caring and compassionate and insightful staff were. Parents had often been on the unit for several weeks and had built close and trusting relationships with members of the care team. We spoke to three sets of parents in the special care baby unit (SCBU) which supported parents to be actively involved with the care of their child. The unit promoted family friendly care and had received Unicef level 2 accreditation.

Parents were unreserved in their praise for the care they received on SCBU and in children’s services. One parent told us they would score the service ten out of ten. The parent said, “I have been able to be part of my child’s life from the moment they were born and can never thank the staff enough for helping us to become a family and to help us believe that we can manage the challenges around our child’s care even when we take them home”.

Parents told their children had been transferred from other hospitals and although they had been very anxious, staff had been overwhelmingly kind and supportive at a very challenging and difficult time. Staff told us how they worked closely with the children’s transport service to repatriate babies and children closer to home who required care in specialist units often many
miles away.

The Friends and Family Test (FFT) is a method used to gauge people's perceptions of the care received and how likely patients would be to recommend the service to family and friends. For inpatient paediatric services, patient's rated the service as 'highly likely' they would recommend the service to friends and family. The service scored, 95% in April, 97% in May and 96.6% in June 2018. In the children’s outpatient service scores were similar and the service scored, 99% in April 98% in May and 94.3% in June 2018. In NICU parents rated the service as ‘highly likely' they would recommend the service to friends and family. The service scored 100% in April, 95% in May and 100% in June 2018. Response rates were above 60% which was above the national average which indicates the sample was representative of people’s views.

Neonatal services had undertaken their own inpatient survey which scored similarly to the FFT in the same time period. Parents reported in the inpatient survey that they were very satisfied with the care of their babies. For example, ‘All staff in NICU have been fantastic. We are very happy with how our baby has been cared for and for us to’, and, ‘Incredible staff, expert care. There is attention to detail here that you do not see in many hospital units and there were extremely high standards’, and, “I am 110% happy with NICU. All my three children have spent time with your team and your care is invaluable’.

In children’s outpatient services we saw comments about the care of children and young people. For example, ‘Just wonderful staff, clean environment and lots to entertain children. Thank you for wonderful caring staff’ and ‘Care about patients and shared parents concerns’ and, ‘Put things in a way that was easier for a young person to understand’.

Staff acted upon concerns and suggestions raised in FFT questionnaires which were reported on safety briefing boards and at team meetings. Children were asked to feedback about their Roald Dahl nurse specialist (haematology) and said, ‘Our Roald Dahl nurses is very welcoming and makes us feel at ease about anything that is happening. I like it when she does my cannula because it doesn’t hurt and she makes me feel happy’ and ‘She is very caring towards the children and she makes our hospital experience less stressful’.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for four of the 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016. All four were questions asked of parents of children in the 0-7 and 0-15 age groups. The trust score about the same as other trusts for the remaining six questions.

Following the findings of the CQC Children and Young People’s Survey in 2016, the trust had undertaken an inpatient survey in 2016. Areas of improvement in relation to the care of children and young people were identified which were combined with national survey data and FFT results. An action plan was created and monitored by the paediatric divisional meeting. For example, information from family centred care sessions, complaint themes and communication issues were being shared weekly at nurse teaching sessions, nursing update days and one to one sessions with lead nurses.
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.55</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.53</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.41</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q42. Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>8.16</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q43. Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-15 adults</td>
<td>8.20</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q44. Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>8-15 children</td>
<td>7.27</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q58. Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children</td>
<td>5.39</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q64. If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children</td>
<td>7.84</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q74. Do you feel that the people looking after you were friendly?</td>
<td>8-15 children</td>
<td>8.92</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q75. Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 children</td>
<td>8.65</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Staff provide emotional support to patients to minimise their distress. Staff were able to build relationships very quickly with children and young people, parents and their families. We saw evidence of this in all areas we visited. For example, on the paediatric ward staff were able to support a child and parent by ensuring they understood what was going to happen to them (in relation to a clinical procedure) and the procedure was explained in a way the child could understand.

In the NICU parents with a baby in an incubator were encouraged to care for them using a ‘Skin to skin’/kangaroo care approach which helped parents to bond with their new baby. Staff were trained to enable parents to move their child out of the incubator and supported them throughout the process to enable ‘Skin to skin’ to be experienced. Parents with babies on NICU were provided with information about Bliss, an organisation to support parents of children born prematurely.

A parent told us how they had been supported by a play specialist when their child (who had a learning disability) was undergoing a surgical procedure. The parent and child had been supported throughout the pre and post-operative care pathway by the play specialist. This had
enabled the child to become familiar with the play specialist and the care environment which had helped to minimise anxiety and stress. The forthcoming procedure was explained (as appropriate) by the play specialist who had used a variety of approaches such as pictures and toys to help demonstrate what was going to happen to them.

Children and young people who were experiencing mental or emotional distress had access to a child psychologist through the CAMHS service. Staff told us they had received specialist training on how to care for children and young people with mental health conditions which had been developed with support from CAMHS.

There was a range of specialist bereavement services available when needed such as the oncology nurse to support families of children with cancer. Parents and children and young people could access support through service level agreements with Keech Hospice. Following a child’s death families could use the Meadow Suite at Keech Hospice even if they had not previously used the hospice’s facilities.

**CQC Children and Young People’s Survey 2016**

The trust performed worse than other trusts for two of the five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

The trust performed about the same as other trusts for the remaining three questions.

Following the findings of the CGC Children and Young People’s Survey 2016, the trust had undertaken an inpatient survey in 2016. Areas of improvement in relation to the emotional support of children and young people were identified which were combined with the national survey data and FFT results. An action plan was created and monitored by the paediatric divisional meeting. For example, measures to improve the privacy and dignity needs of children and young people by providing additional treatment areas and ensuring privacy for parents when confidential discussions were taking place about the care of their child.

**CQC Children and Young People’s Survey 2016 questions, emotional support, Luton and Dunstable University Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.37</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q29. If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>7.92</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>8.47</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q65. Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children</td>
<td>8.53</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q67. If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 children</td>
<td>8.37</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Understanding and involvement of patients and those close to them

Staff involved parents and those close to them in decisions about their treatment. Parents were encouraged to be actively involved in their children’s care.

Family friendly care in the NICU encouraged parents to be central to their babies’ care and development. Neonatal nurses were supported by nursery nurses, unit based physiotherapists, the clinical lead for family centred care, the breast feeding lead and discharge planning lead that had identified time to undertake their roles. Families were encouraged to be with their baby for medical and nursing handovers and the visiting policy (2018) ensured parents had 24 accesses to their child. Parents told us they had been asked to identify other family members or close friends to provide additional support as the unit recognised that support networks for parents and babies varied.

We spoke with parents in children’s services who told us they were encouraged to be actively involved with their child’s care including the planning of their child’s care plan. On wards where English was not the parent’s first language a translator was arranged when they met with the paediatrician in charge of their child’s care. This meant they could understand what was happening and ask questions about their child’s care.

Parents were involved with their child’s care and decisions taken. We saw evidence in clinical notes where young people were involved in making decisions about their care and treatment and in the care planning process with their parents. Parents told us staff went the ‘extra mile’ to ensure they were kept up to date on their child’s care and treatment. Three parents told us how staff would contact them at home if necessary to keep them up to date. Parents told us they were encouraged to attend ward rounds and we saw this throughout our inspection.

Children and young people were involved as much as possible in their oncology treatment plan and were encouraged and supported by the oncology nurses and play specialists (as appropriate). In the NICU inpatient survey for the period January to February 2018, 76% of parents reported they ‘strongly agreed’ with the question, ‘Always felt updated with their babies’ condition and plan of care’ and 19% reported they ‘agreed’ with the question and 5% reported a neutral rating.

Transitional care was provided by maternity services but NICU was working jointly with maternity services to ensure a stronger process was in place to enable mother and baby to be kept together.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for six of the 21 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. The trust scored about the same as other trusts for the remaining 15 questions.

Following the findings of the CQC Children and Young People’s Survey 2016, the trust had undertaken an inpatient survey in 2016. Areas of improvement in relation to understanding and involvement of patients and those close to them were identified and combined with the national survey data and FFT results. An action plan was created which was monitored by the paediatric divisional meetings. For example, a review of all inpatient information leaflets and communication with patients and families were incorporated into safety huddles.

In NICU, the service had implemented the VALUE standards in relation to communicating a baby’s plan of care. For example, V-aloe comments made by the family, A-knowledge family emotions, L-listen, U-understand each individual as a person, E-list questions.
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q11. Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.54</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q12. Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.15</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q13. Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.76</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>7.85</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Were you given enough information to be involved in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.35</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>7.94</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.49</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q31. Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.23</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.20</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.51</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. When you left hospital, did you know what was going to happen next with your child's care?</td>
<td>0-15 adults</td>
<td>7.56</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q41. Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>7.83</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q59. Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 children</td>
<td>8.76</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q60. When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 children</td>
<td>8.02</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q61. Did you feel able to ask staff questions?</td>
<td>8-15 children</td>
<td>9.28</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q62. Did the hospital staff answer your questions?</td>
<td>8-15 children</td>
<td>9.36</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Age Group</td>
<td>Percentage</td>
<td>Comparison</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Q63. Were you involved in decisions about your care and treatment?</td>
<td>8-15 children</td>
<td>5.46</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q66. If you wanted, were you able to talk to a doctor or nurse without</td>
<td>12-15 children</td>
<td>8.19</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your parent or carer being there?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q69. Before the operations or procedures, did hospital staff explain</td>
<td>8-15 children</td>
<td>9.44</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>to you what would be done?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q70. Afterwards, did staff explain to you how the operations or</td>
<td>8-15 children</td>
<td>8.44</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>procedures had gone?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q72. When you left hospital, did you know what was going to happen</td>
<td>8-15 children</td>
<td>7.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>next with your care?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Children’s services worked with commissioners and other providers to support young people transitioning to adult services.

The hospital provided a wide range of children and young people’s services which included inpatients, day care services, outpatients a paediatric assessment unit (PAU) and a separate children’s emergency department with a waiting area. The children’s outpatient department was a separate outpatient facility managed by children’s services. There were separate wards which were not purpose built but had been developed to meet the needs of infants, children and young people. A ‘virtual’ paediatric high dependency unit (HDU) had four beds. Care was provided for emergency admissions, medical day case admissions, surgical day cases and in-patient surgical cases. There was a level 1 POSCU (children’s oncology service) on the paediatric wards.

The neonatal intensive care unit (NICU) was a specialist regional intensive care unit service which provided care for newborn babies requiring treatment. It is one of three centres providing specialist neonatal; medical and intensive care within the East of England Neonatal Operational Delivery Network (EoE ODN). There are 17 hospitals across the region and two other tertiary centres within the network. Care was provided via 37 cots of which 11 were intensive care, eight were high dependency and 18 were special care with facilities for families and parents to stay with their baby in hospital.

Care for children and young people were supported by a school, a seven day a week play specialist service and a wide range of specialist support staff, including dieticians, physiotherapists, speech and language therapists (SALT) and community nursing staff.

There were dedicated paediatric theatre lists for: ophthalmology on Monday mornings; orthopaedics all day on Thursdays and ear nose and throat (ENT). For other specialties, children’s lists were grouped together and usually run in the morning and were dependent on demand. Each of these lists had a paediatric consultant anaesthetist and a consultant surgeon who was experienced in paediatric surgery.

The trust had a transition working group and had adopted the ‘Ready, Steady, Go…Hello’ as a framework for transition which aimed to support young people to be able to independently access health care systems with appropriate support from family and friends. There were well-established sub-speciality specific transition arrangements for children with long term conditions such as diabetes, endocrinology, gastroenterology, epilepsy, movement disorders, chronic respiratory conditions and haematology.

Developments were ongoing to facilitate the smooth access for young people with metabolic conditions and learning disabilities when they presented at the emergency department (ED). This would enable young people’s healthcare needs to be flagged at the earliest opportunity so appropriate interventions were initiated without delay. There was an agreed pathway for the care of young people between the ages of 16 and 18 years who presented to the ED who may need the care of multiple specialist teams including the intensive care unit (ICU).

The paediatric service cared for a significant group of children and young people with learning disabilities which ranged from mild to severe. Patients with a learning disability were mainly looked after by paediatricians with an interest in neurology or neurodisability or a paediatrician with a relevant speciality interest such as metabolic, respiratory or endocrine disorders. We were told the usual age of transition was 16 years or at the end of year 11 at school. However, for young people
with learning disabilities there needed to be a more flexible and holistic approach to transition care and usually achieved by 18 years. A specialist nurse for adults had recently been appointed to work alongside the adult safeguarding team to ensure the needs of this vulnerable group of patients were met.

Parents told us facilities for family members staying at the hospital were good. On paediatric wards there were pull out beds and reclining chairs so parents could stay overnight. A parents’ room had toilet and tea and coffee making facilities and snacks were available.

In NICU parents whose child had been admitted were able to stay on the unit. There were five rooms, three of which were double rooms and located in a bungalow in the hospital grounds, a short walk from the unit. Two rooms were located immediately outside the main entrance to NICU and were prioritised for parents not local to the hospital. A further room was available for parents planning the discharge of their baby.

### CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for one of the 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. The trust scored about the same as other trusts for the remaining 16 questions.

### CQC Children and Young People’s Survey 2016 questions, responsive domain, Luton and Dunstable University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.80</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q5. Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.60</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.88</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>4.65</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>6.32</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q55. Was the ward suitable for someone of your age?</td>
<td>12-15 children</td>
<td>7.82</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>6.72</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q24. Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.16</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q37. Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.15</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.29</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.01</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q56. Were there enough things for you to do in the hospital?

<table>
<thead>
<tr>
<th>Children</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15</td>
<td>5.95</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Q57. Did you like the hospital food?

<table>
<thead>
<tr>
<th>Children</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15</td>
<td>6.25</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Q71. Did a member of staff tell you who to talk to if you were worried about anything when you got home?

<table>
<thead>
<tr>
<th>Children</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15</td>
<td>8.01</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Q73. Did a member of staff give you advice on how to look after yourself after you went home?

<table>
<thead>
<tr>
<th>Adults</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>3.05</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Q2. Did the hospital give you a choice of admission dates?

<table>
<thead>
<tr>
<th>Adults</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>3.05</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Q3. Did the hospital change your child’s admission date at all?

<table>
<thead>
<tr>
<th>Adults</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>8.63</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source specialist: CQC Children and Young People’s Survey 2016, RCPCH)

**Meeting people’s individual needs**

The service took account of patients’ individual needs. Children’s services accepted children and young people up to the age of 18 years. Young people over 16 having completed their GCSE year, would be identified for adult departments primarily, but where there were complex needs they would remained under the care of the children’s ward. The paediatric wards and children’s outpatient department had dedicated play areas with age specific games and toys. There was an indoor play areas which children were able to access and use. The play areas were well equipped and catered for all ages of children. Sensory equipment was available for children with complex and special needs. There was a dedicated lounge area for teenagers equipped with age appropriate games and electronic equipment.

Children’s services were committed to ensuring children could continue with a normal home routine during their hospital stay. School educational services on paediatric wards were funded and run by the local borough council educational service. The school room was open during term time (normal hours) except on Thursdays to support school age children. The hospital education service liaised with children’s schools to ensure educational needs of children within the care of the trust were being met. The service facilitated the required examinations for children who were medically well enough to sit their exams. The educational provision was not assessed by Ofsted as the trust was not a registered site.

Initial contact was made with the child or young person and their parents/carer to assess current needs including their short/long term educational needs. This included daily liaison with the medical and multi-disciplinary team and information gathered from patient’s schools. An appropriate plan for individualised educational support was formulated and was dependent on the child’s age, ability, special needs and social circumstances. Provision was made to allow the child or young person to keep up to date with current school work and provide 1:1 teaching across all key stages. The service offered advice to young people aged 16 years and over on educational opportunities and career advice.

Clinical nurse specialist’s (CNS) in the gastroenterology and nutrition service provide clinically effective, safe, high quality nursing care to children and families with gastrointestinal disease or requiring artificial nutritional support. Children were seen in nurse led clinics and attended three one hour appointments to enable nurses to assess, teach, support and counsel parents of children referred for a gastrostomy (feeding tube) insertion. Other children, for example, with inflammatory bowel disease, were seen to undertake transition work from the age of 13 years.
The CNS supported teams in managing unusual or complex nutritional support in children and young people on PAU, the ward, or in clinic. These interventions were classed as ‘rescue work’ and 51 rescue episodes and four admission avoidance episodes were documented in 2017. This meant children and young people could avoid a potential admission to hospital and difficulties with their nutritional support were immediately addressed.

An epilepsy clinical nurse specialist (CNS) had been commissioned by the Luton clinical commissioning group (CCG). Other CCGs in across the geographical area were not currently providing this service.

The service had appointed a paediatric clinical nurse specialist (CNS) for haematology as a result of their successful application for Roald Dahl nurses who support children living with a variety of serious, rare and undiagnosed conditions. The CNS was providing much needed support for children and families managing complex blood disorders such as thalassaemia.

A monthly neonatal dietetic clinic supported NICU babies post discharge. This was a shared arrangement with the dietician and neonatologist with an interest in nutrition.

The neonatal physiotherapy service covered NICU outpatient follow ups for three months old babies whose developmental needs had been corrected and babies on the Bayley (developmental) scale who required more frequent developmental checks at nine months and two years. The paediatric physiotherapists had a gym which was adjacent to the paediatric wards which meant children and young people had easier access to a gym when they needed exercise. The gym was well equipped with ‘state of the art’ exercise equipment and children told us it had ‘brilliant’ facilities.

The epilepsy CNS provided a community based service which was funded by the local healthcare commissioners to support the care of complex care children and young people who experienced prolonged seizures in the community. The CNS held ‘virtual’ face-to-face clinics for children who were often transitioning into adult epilepsy services. The aim of the service was to provide a more holistic care approach to the management of emergency seizures by identifying the individual seizure triggers for each child or young person. The care plan would ‘flow’ between community and hospital services and be stored in emergency ‘pink folders’ which are recognised nationally and enable children at risk of seizures to travel abroad.

The CNS worked in partnership with GPs, the continuing care team and the special needs service as well as holding clinics in children’s outpatients. A programme of parent group support sessions were held regularly as understanding of epilepsy in ethnic minority groups was less understood. A band 4 associate practitioner supported the CNS in the delivery of rescue medication training, care planning reviews and updates.

Parents of babies, children or young people requiring palliative care or end of life care were supported by staff to identify how they wanted the care of their child or young person to be managed. Children’s services worked closely with a local children’s hospice and care pathways were in place to facilitate timely admission and transfers between services. Staff in paediatrics and NIC supported bereaved parents in creating memory boxes and could provide photographs, hand and foot prints and a lock of hair if requested by parents.

Play specialists were familiar with children who had complex needs who attended the ward regularly. Each child had a hospital passport developed in partnership with the child and their parents to support their care in hospital. For example, they were familiar with each child’s likes and dislikes which were documented and how each child communicated when they were happy or in pain.
Children with a Luton GP had shared open access to their GP and paediatric assessment unit (PAU) through an open access passport. The passport gave parents open access to specific problems related to their child’s individual health needs and gave specific guidance to either contact the GP or PAU. Staff in PAU were able to undertake telephone triage (urgent assessment) and rated the child’s condition as green, amber or red which helped staff to decide on the appropriate action to be taken. For example, direct referral to the children’s rapid response service, the GP or to attend PAU.

**Access and flow**

Patients were able to access the service when they needed it. Waiting times for referral to treatment arrangements to admit, treat and discharge patients were in line with practice.

Neonatal activity and cot location was coordinated through the Emergency Bed Service (EBS) under the operations of the Acute Neonatal Transfer Team (ANTS). The acceptance of referrals was dependent on capacity, acuity and staffing levels which were discussed between the consultant covering the NICU and the nurse in charge of the unit. The service was currently updating the admission and escalation policy and discussions concerning patient flow and capacity were included in the daily safety huddles and staff briefings.

There was collaboration between the NICU and maternity services concerning the acceptance of mothers whose babies had yet to be born, as only 30% of mothers who were transferred into the hospital in potential pre-term labour, go on to deliver their babies. The unit provided support and care for infants who were likely to be born requiring intensive care and were less than 27 weeks gestation or less than 28 week gestation and born as a result of a multiple birth. There were agreed surgical pathways in place to facilitate timely transfer of babies to specialist centres for intervention.

The community team consisting of a neonatal community consultant and community nurses worked jointly with the EoE ODN to facilitate a more timely and safe discharge of babies from NICU. The team had cared for 137 babies in 2017. Three babies were discharged whilst receiving nasogastric tube feeds and 13 babies had received home oxygen. All babies discharged from NICU had a copy of their discharge summary and growth chart sent to the health visitors to be printed off and placed in the child’s red book on their first check-up.

The paediatric unit was funded for four high dependency (HDU) beds via a virtual HDU setting as there were no dedicated high dependency beds. Children requiring HDU care ranged from neonates to a young person who may be over the age of 16 years but may have underlying complex medical conditions for which they might not have been transitioned as yet to adult services. In the period August 2017 to July 2018 there were 2266 total bed days for 725 patients. This showed there had been an increase for the same period in 2016/17 where there were a total of 1920 bed days for a total of 733 patients.

The average length of stay had increased from 48 hours to 72 hours. Although patient numbers were similar there had been an increase in overall bed days as there had been an increase in long-stay patients with complex care conditions on the ward. Increased bed days reflected the acuity of patients being managed locally with advice and support from the Children’s Acute Transport Team (CATS) and the acute paediatric consultants on the ward. Expected surges in HDU activity were supported by nurses who had undertaken the high dependency module in high dependency care or paediatric high dependency care. A contingency plan was in place for the winter months to accommodate increased high dependency activity.

Children and young people were admitted to wards for medical reasons and were not admitted
primarily to await specialist inpatient mental health beds. Children and young people were not referred to the Children and Adolescent Mental Health Services (CAMHS) which was provided by another NHS trust, until they were medically fit. Children’s services had access to CAMHS assessments and support on a daily basis between the hours of 9am and 9 pm Monday to Friday and at weekends and bank holidays between the hours of 10am and 2pm. There was access to an onsite on call adult psychiatric liaison team able to assess children and young people requiring an immediate review. The CAMHS service also provided access to an on call CAMHS consultant for telephone advice out of hours.

There were 279 children and young people seen by CAMHS from April 2017 to March 2018, in an acute mental health crisis. The crisis team in the emergency department (ED) assessed 153 children and young people and sent them home with an appropriate plan of care. There were 126 children and young people admitted to the hospital. Of these, 48 were admitted to the paediatric wards and required 1:1 specialist mental health nursing. Sixteen patients were transferred to a specialist mental health placement and had varied lengths of stay on the paediatric ward.

Children and young people not requiring 1:1 nursing were nursed appropriately on the ward and discharged home with support plans in place.

We were told CAMHS related admissions to children’s services had dropped significantly since the introduction of the CAMHS crisis team in the emergency department. Patients requiring admission following assessment were followed up on a regular basis by the CAMHS team in addition to daily medical review by the paediatric team. If required 1:1 nursing was arranged with ward staff and specialist mental health nurses for as long as necessary.

The PAU provided medical assessment for children and young people. Referrals were received from a variety of routes from GPs, paediatric emergency department, midwives, walk-in centre, community children’s nursing team, children’s clinics and open access. Of the 2,230 admissions to the ED from May to July 2018, 94% had a senior review within four hours and 62 stayed for more than six hours. The length of stay was dependent upon the complexity of the child’s condition. A monthly audit of documentation undertaken in the same period showed 96% of patients were seen by a nurse within 20 minutes and 77% were seen by a doctor within one hour. This was an ongoing audit and feedback was shared monthly with staff during one to one sessions and discussions at safety briefings.

Children and young people needing elective surgery were pre-assessed prior to surgery and operated upon in the main operating theatres either at the beginning or the end of a theatre list. There were no dedicated operating theatres or lists for children. There were two bays in the recovery area allocated for children’s surgery. Although the bays could be curtained off to maintain their privacy, they were not child friendly. For emergency surgery children and young people could be admitted under general surgery, ear nose and throat (ENT), ophthalmology, oral maxilla facial, gynaecology or orthopaedic and those requiring overnight/ high dependency (HDU) care were admitted to either Squirrel or Rabbit wards. The median length of stay was between one and 1.5 days.

There was a dedicated children’s outpatient department with a mixture of general paediatric and speciality clinics working alongside the trust’s own teams. In England, under the NHS Constitution, patients ‘have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible’. Referral to treatment time (RTT) for admitted pathways are the waiting times for patients whose treatment started during the month as an inpatient or day case. The waiting time starts from the point the hospital or service receives the referral. The service met the referral to treatment time of within 18 weeks 96% of the time in the
period April to June 2018. In the same period, children referred by their GP waited on average ten weeks for their first outpatient attendance.

In the period April 2017 to March 2018, there were 42,803 outpatient attendances in the under 16 age group and the ‘did not attend’ (DNA) rate was 11.8% (5,700). In the same period there were 47,977 attendances in the under 18 age group and the DNA rate was 12.0% (6,565). The DNA rates were below the trust target of 15%. The 16 to 18 year old data had been collected separately as serious case reviews had shown failure to attend appointments was a factor in neglect. Medical staff told us they would check the DNA’s at the end of clinic and would offer a repeat appointment and would speak to the safeguarding team if there were concerns.

We reviewed the children’s outpatients Friends and Family Test (FFT) results for the period January to June 2018. Comments received overwhelmingly praised the service and commented positively on clinic waiting times. Of the 291 comments reviewed, five comments related to lengthy waiting times. The service had reviewed feedback from patients and service users and made improvements. For example, flexing staff hours to cover late clinics, increased number of pre-assessment clinics and access to ‘on the day’ blood clinic appointments.

The Woodland unit (paediatric wards) was part of the Child Heath Paediatric Shared Care Unit (POSCU) and provided care to children and young people with cancer. The service was part of an integrated cancer network for children and young people which ensured appropriate elements of treatment and care were provided to children at their local hospital, at home and in children’s outpatient services. There was 24 hour open access to POSCU which was overseen by the oncology clinical nurse specialist (CNS). The service was supported by eight nurses on the paediatric wards trained to administer chemotherapy medication to children and young people.

**Neonatal Critical Care Bed Occupancy**

From May 2017 to April 2018, the trust had 19 open neonatal intensive care and high dependency cots in every month. Occupancy was highest from May to July 2017 (94.7% in each month) and in January and March 2018 (100% and 89.5% respectively). Otherwise 14 or fewer of these 19 cots (equivalent to 73.7%) were open in each of the remaining seven months.

The trust’s occupancy rate was higher than the England average in 10 out of the 12 months over this period.

![Graph showing Neonatal Critical Care Bed Occupancy](image)

Please note that data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. *(Source: NHS England)*

During the inspection the lead nurse in NICU told us occupancy issues were being discussed at national and network level due to the high occupancy levels of NICUs across the country. The NICU had a clear escalation policy for the unit and issues were recorded on trust and divisional risk registers. The unit was part of a pilot scheme to electronically track babies across the network.
and early findings were this was a useful tool to help improve the management of babies in a more structured and timely way.

During the period April to June 2018, total occupancy figures were 71.6% in April, 68.7% in May and 78.7% in June. This was an improving figure against the target occupancy figure of 80%.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared those with staff. There were processes in place for responding to complaints and information was available to make children, young people and relatives aware of how to complain. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available in the paediatric wards, NICU and children’s outpatient services.

Parents told us they knew how to make a complaint and if they had concerns about their child’s care would discuss it with the nurse in charge. Complaints were recorded on monthly paediatric and neonatal clinical performance and governance score cards (quality dashboards) and circulated with minutes of paediatric and neonatal governance meetings.

Governance minutes detailed the number of complaints received in a month, the number ongoing and detailed if there had been any delays in responding to the complainant and the learning that had taken place including changes to practice which were shared at meetings and safety huddles.

**Summary of complaints**

From April 2017 to March 2018 the trust received 18 complaints about services for children and young people. The trust took an average of 49.5 working days (mean) to investigate and close these complaints. This was not in line with their complaints policy, which states that complaints should be responded to within 35 working days. However, the service had improved the response time in the period April to June 2018 and was meeting the trust target of 90%.

The breakdown of complaints by subject is shown in the table below. Because one complaint can have multiple subjects, the total below exceeds the total number of complaints.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>22</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

During the inspection staff told us when a complaint was received staff were encouraged to be proactive and manage patient and parent’s concerns at the earliest opportunity. Local resolution meetings were implemented in April 2018 following an increase in complaints in 2017/18. The meetings had enabled staff to meet with patients/parents and families at the earliest opportunity to explore in detail issues around complaints.

Complaint themes were recorded in action plans in the paediatric service. For example, communication with families, focusing on support for children with complex needs and learning
disabilities. A robust process had been developed to ensure cases were reviewed and actions followed through and we saw this recorded in the minutes of paediatric and neonatal governance meetings from April to June 2018. In the period April to July 2018, four complaints had been received in paediatrics and no complaints were received in neonatal services.

**Number of compliments made to the trust**

From April 2017 to March 2018 the trust received no compliments about services for children and young people.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*
Is the service well-led?

Leadership

Leaders at all levels of children’s services demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Leaders led their service and supported the wider development of services for children across the whole hospital.

The women’s and children’s division was led by a divisional director, divisional general manager and a clinical director and divisional matron for paediatrics and a clinical director and lead nurse for neonatal services. The service had a non-executive lead that championed issues and ensured the profile of children’s service was part of the executive meetings. The leadership team was well established and had clearly defined roles and responsibilities which demonstrated good leadership across the service. Staff across all disciplines told us leadership was outstanding and staff we spoke with told how happy they were working for their managers.

Staff were very positive about the local leadership across each of the children’s services and told us they felt very well supported by their line manager. There were clear management structures within each service and managers were very approachable. Managers were visible and staff told us they felt connected to the wider team across children’s services. We heard and saw examples of proactive, supportive leadership within the children’s service. The managers, clinical leads, matrons, paediatricians, neonatologists and doctors were passionate about delivering an excellent service and it was clear the patient was at the heart of each service.

We saw in the NICU peer review report June 2018, (NHS England Quality Surveillance Programme 2017/18) the reviewers reported on ‘a strong and cohesive team, demonstrated by the significant attendance at the peer review meeting from all neonatal specialities who delivered the neonatal service; this collaboration between the specialities was further evidenced at the meeting by the contribution of all members of the team and was applauded by the reviewers’.

Clinical leads and senior managers across all children’s services had an inspired and shared purpose. We spoke with managers who clearly strived to deliver and motivate their staff to succeed and there were strategies in place to support them in this purpose.

The trust had a division of women and children which operated paediatric and neonatal services. However, as children were seen and treated in a variety of settings across the trust a children’s board was in place. Terms of reference had been reviewed in July 2018 which said; ‘the purpose (of the children’s board) is to act as a co-ordinating group for clinicians across divisions to consider issues relating to children, provide a more consistent approach, taking a more strategic view and promote better understanding, with the purpose of driving up standards for children’. The board was a clinically led group for leads of services caring for children to function as the major advisory group to the trust executive team, the trust board and where appropriate the locality group on children’s issues. The board acted as a key group in generating and influencing the trust’s strategic approach to children’s services.

The hospital had a well-established leadership programme which included for staff at supervisory level, the seven habits of highly effective people and the fundamentals of human resources which was used as a foundation for leadership. Band 6 and 7 nurses on the paediatric wards told us their leadership development needs had been discussed during the annual appraisal process and they had been encouraged to attend a specific band 6 or 7 leadership development programme. Senior managers in the service had been interviewed to ascertain their development needs in the management role they were undertaking. Tailor made development programmes had been
accessed which were a combination of mentorship, coaching and some specially commissioned study days from recognised learning organisations such as the Kings Fund.

In NICU the lead nurse had implemented a model of staff engagement that was enabling staff to develop clinical leadership by empowering the nursing team to participate in service provision. The model was based around 12 areas of service development. For example, family centred care, benchmarking, bereavement and palliative care and patient experience. Staff were part of a group for each service development which was led by a band 7 nurse. The model was underpinned by monthly 1:1 career development meetings, weekly catch ups and presentation of results and developments to the wider nursing team. We saw displays showing the early results of the service development groups. For example, under benchmarking, the service group had assessed the unit against a national nutritional pathway. The unit had achieved a score of 92% and information was displayed on dedicated service group notice boards.

**Vision and strategy**

Children's services had a strategy and supporting objectives and plans that were innovative while remaining achievable. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

Children’s service had a Strategic Plan Document 2014-19 for the development of paediatric and neonatal services which had direct links to the overarching trust strategy, organisational goals and objectives.

Paediatric and neonatal services had their own vision and strategies which supported by development plans. For example, the development of intensive and critical care for neonates to match the demand of an increasing catchment area, further development of rapid response paediatric services and provision of specialist paediatric services in community locations, and the planned expansion of the provision of paediatric surgery including ENT and orthopaedic specialties to meet the needs of children closer to their home.

Staff were very clear in their understanding of how the vision and values for children’s services supported the trust vision of better care for patients and putting patients first. The service was continuing to grow its profile as an excellent state of the art paediatric tertiary neonatal service through involvement in national research and innovation.

**Culture**

Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff groups and staff were proud to speak up and raise concerns at all levels of the children’s service.

Staff told us they felt valued and respected by managers within their own service and by senior managers in children's services. Staff described the culture of services for children, young people and their families as open, transparent, dynamic and forward thinking. Staff came together regularly to attend patient handovers, safety huddles and team meetings and informal supervision took place on a daily basis supported by formal supervision arrangements.

We found staff were very supportive of each other and there was a very strong culture of collaborative team work. The different parts of children’s services worked well together with strong leadership support from senior managers all focused on improving health outcomes for children and young people. Junior medical staff and newly appointed nursing staff told us they had returned to the service as they had been so well supported and felt it was an environment that promoted excellence.
Staff were encouraged to report incidents and highlight any concerns. Staff felt confident that if concerns were raised in relation to patient safety, action would be taken. We saw examples where actions had been taken and improvements made as a result. This was evidenced in the no blame approach regarding the ‘never event’ in May 2017. The health and well-being of staff was a high priority for the trust and the division and staff told us they received excellent support from line managers and occupational health services.

**Governance**

**Governance arrangements were proactively reviewed and reflected best practice. The service used a systematic approach to continually improve the quality of its services and safeguarding high standards by creating an environment in which excellence in clinical care would flourish.** Paediatric wards and NICU reviewed the quality of care through attendance at the daily safety huddles, weekly meetings and a review of the ward and unit quality data about their service. The governance framework ensured staff responsibilities were clear and quality and performance risks were understood and managed. Senior staff understood their roles in relation to governance and their level of accountability regarding providing a safe service to children and young people.

During our inspection we identified children’s services had a robust and effective governance structure and risk management framework to support the delivery of high quality care. Paediatric wards and NICU reviewed the quality of care through attendance at daily safety huddles, weekly meetings and reviews of wards and unit level quality data about their service. The governance framework ensured staff responsibilities were clear and quality and performance risks were understood and managed. Senior staff understood their roles in relation to governance and their level of accountability regarding providing a safe service to children and young people.

Staff told us how strong they thought the governance structure was. They believed communication was very good and felt, despite the number of services that made up children’s services they worked well together. There were systems to review National Institute for Health and Care Excellence (NICE) guidelines and other nationally recognised guidance. We saw evidence of internal quality audits across all services and in some instances across organisational boundaries to ensure safe and effective care for children and young people. There were robust quality assurance systems and performance measures across the service. Staff had a solid understanding of the outcomes they were measured against and told us these were reported and measured regularly in team meetings through action plans, and discussed during supervision and one-to-one meetings.

There were monthly departmental meetings for paediatrics and NICU, which reported to the women and children’s board meeting which reports to the trust board. There were monthly divisional clinical governance meetings which fed into divisional board meetings and included discussions and information on incident reports, clinical audit activity, compliments and complaints, mortality and morbidity, training and safety requirements, risks and patient safety.

Clinical performance and governance scorecards (dashboards) were reported at all levels of the service and were evidenced in minutes of departmental clinical governance meetings, Women and children’s board minutes and trust board minutes from January to June 2018. For example, management of nursing vacancies on the paediatric wards, NICU and children’s outpatient services. We saw where discussions had taken place and actions agreed to address current service shortfalls.

There were link roles and dedicated staff to lead on governance and quality assurance and dedicated time was allocated to enable staff to undertake their governance duties. Medical staff told us they attended regular half day clinical governance meetings every month which included progress on clinical audit programmes, risks attributed to paediatrics and NICU, education and infection control issues. Information from governance meetings was cascaded to staff via emails,
staff handovers and safety briefings. Information was recorded on safety boards in ward and department areas to ensure that staff that had missed a safety briefing, were able to receive feedback. There were patient safety and ward and unit newsletters which included safety messages, incidents and learning opportunities.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, coping with both the expected and unexpected. The women and children’s division and a divisional risk register which identified key risks and was regularly reviewed. During the inspection we did not identify any risks that were not recorded on the risk register.

The women and children’s division had a divisional risk register which identified key risks and was reviewed monthly at the women and children’s board meetings. The children’s service had its own risk register which identified each risk with a description of the mitigation and assurances in place and the nominated risk owner. Risks included, staffing shortfalls in paediatrics and NICU, security of the paediatric entrance and capacity issues in NICU. There was a systematic approach to the identification and management of risk across the children’s service. During our inspection we did not identify any risks that were not recorded on the risk registers.

The service investigated had investigated the ‘never event’ in May 2017 in line with national and trust requirements. We reviewed the root cause analysis report which demonstrated clear actions and changes to practice.

Patients received care and treatment according to national guidelines and the service had a comprehensive audit programme to ensure practices were current and based on sound evidence. The service was able to demonstrate good quality outcomes as evidence by NNAP, MMBRACE, National Diabetes Audit and the NHS England Quality Surveillance programme 2017/18.

There were monthly staff meetings to share learning from incidents and complaints and compliments. Where specific actions were required they were fed back at daily handovers and safety huddles. For example, at the NICU safety huddle staffing issues were shared with an update of shifts filled or still required from the previous day. Safety incidents in the last 24 hours were discussed including examples of good practice. Staff were aware of the duty of candour requirements which identified the importance of sharing information with parents and families when an incident had occurred which involved them.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust had a wide number of electronic information systems across the organisation that captured relevant clinical and demographic data about patients along their care pathway. There were clinical and non-clinical systems in place that captured areas such as incident reporting which directly contributed to the quality of patient care through the identification of themes and trends.

This helped in the development of safer working practices and leaders and senior managers had a holistic understanding of performance across children’s services. Information was used to measure service improvements and there were clear and robust service performance measures in place which were monitored at governance meetings. For example, quality, safety, patient experience and operational performance.
The trust produced a monthly clinical governance performance scorecard (dashboard) for paediatrics and NICU and trust targets were set in relation to the service indicators. Performance was rated using the traffic light, RAG (red, amber and green) rating system. This allowed managers to assess their performance at a glance and identify areas which required further improvement or investigation.

Staff had access to up-to-date comprehensive information on patients’ care and treatment. Staff were aware of how to use and store confidential information.

**Engagement**

**The service engaged with patients, staff and the public to plan and manage appropriate services for children, young people and their families.**

The service took the Friends and Family Test results seriously and there were comprehensive plans in all areas where parents, children and young people identified as needing improvement. For example, creating an out-of-hours waiting area for PAU, refurbishment of oncology cubicles, improving transition arrangements for young people, sharing good practice models of supporting and engaging with patients and parents and upgrading parents facilities in the NICU.

A neonatal patient experience group was implemented in 2017 and chaired by a patient representative. The group was working with the service to develop a family centred model of care of service delivery had identified a number of improvements to the unit including improved facilities for parents and a new and more inclusive visiting policy. The NICU held a parent engagement event in 2018. As part of the workshop three families shared their experiences in the hospital and life after their child was discharged from hospital. Feedback given to NICU staff enabled them to invest in headphones which enabled parents to stay by their baby’s bedside whilst the unit care round was in progress. The NICU has limited space and conversations were easily overheard. By using the headphones, confidential discussions with parents about their child’s treatment could not be overheard. We spoke to three parents who had used the headphones throughout their child’s stay in the NICU who said, “Brilliant idea and should be used in all hospitals” and “It was nice to know the conversations about my child’s care were private”.

The service had access to charitable funds that were used for improving facilities for parents, neonates and young people. We saw displays across all children’s services where staff had actively engaged in numerous fund raising and awareness raising events. For example, diabetes, oncology, neonatal and paediatric services. Events were celebrated through staff newsletters and staff were praised and thanked for their continued efforts in supporting children’s services.

The trust participated in the Pets as Therapy which is a national charity that enables children and young people in hospital to experience therapeutic animal visits to bring comfort and joy to children’s lives.

The service held a wide range of engagement events for patients and their families. For example, the endocrine service ran an open evening for parents to support further development of the service and provide parents with the information to manage emergency regimes for their child. A teenage support group session was also held for young people to meet older children experienced in managing their emergency medication regime. This enabled young people with a clinical condition to discuss their concerns with or without their parents being present with the aim of feeling less isolated and better able to manage their condition safely.

The paediatric diabetes service held update sessions for parents and children who used an insulin pump to manage their clinical condition. If children were able to manage their own pump they were
invited to attend and spare pumps were available to practice on. Parents of children too young to manage their own pumps had the opportunity for guided support in the management of their child’s insulin pump.

The epilepsy service provided out of hours workshops at evenings and weekends twice a year and invited families and carers of children prescribed rescue medication for prolonged seizures to attend. The aim of the workshops was to increase patient trust in local epilepsy services and improve carer confidence in administering rescue medication. Refresher training in administering rescue medication and basic life support skills were provided to parents and carers. Carers reported, ‘I gained insight into how other carers deal with seizures’ and ‘very enjoyable and beneficial’.

In the NHS staff survey (2017) the overall staff engagement was 3.87% (out of five) and there was no change in the rating from 2016 when the trust was compared to all acute trusts and was rated above (better than) average for overall staff engagement.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when things went wrong promoting training, research and innovation.

There was a culture of continuous learning, improvement and innovation across the children’s service. Staff told us their managers actively encouraged them to look at different ways to improve their service. For example, in the NICU the service had introduced a safeguarding tool.

In the NHS staff survey (2017), the trust scored 72% for the question, ‘Percentage of staff able to contribute towards improvements at work’. This was higher than the national average in 2017 of 70% for acute trusts.

The play specialist team provided a seven day service to children and young people and were constantly exploring innovative ways to improve the experience of children and young people attending the hospital.

The neonatal team were active in neonatal research and recruited to national neonatal research studies. For example, ‘real time continuous glucose monitoring in preterm babies’ REACT trial, and, ‘outcomes after selective early treatment for closure of patient ductus arteriosus in pre-term babies’ OSCAR trial.

The division was engaged in the flying start ‘5 to thrive’ approach of respond, cuddle, relax, play and talk which helps parents and practitioners gain appropriate awareness of the science of brain development whilst ensuring the focus remains practical rather than academic. The service was working in partnership with children’s centres, primary care, and Luton local authority to ensure cohesive ways of working across boundaries to improve parenting from pre-conception through to maternity and paediatrics. A baby app had been implemented in 2017 and staff told us how helpful it had been to parents and families.

The service had implemented the following improvements since the last inspection:

In children’s gastroenterology there were puppets specifically designed for children with altered body image called Gastronauts. The aim of the puppets was to bring physical comfort, understanding and psychological wellbeing to children. The puppets had been designed individually to represent a child’s own body as it was difficult to find age appropriate suitable toys for children with altered appearance. There were teaching puppets for the team to use who could choose the most appropriate design of puppet for the child they were caring for. For example, the
gender, design and types of stomas. Each puppet came with a certificate of ownership and a passport and the child could be part of an online community.

The paediatric service was continuing to develop its paediatric surgical services. Following the appointment of the paediatric orthopaedic surgeon there were plans to further expand the surgical paediatric surgical services through the appointment of a paediatric general surgeon. The service planned to develop links with specialist services to enable them to offer more complex treatment for children closer to home.

Children’s services had implemented a creative recruitment strategy to help fill posts that were hard to recruit to. For example, developing a “grow your own” concept to enhance current nursing establishments. Existing band 5 nurses in the trust that could pursue career development opportunities to enable them to take up posts in the neonatal unit.

A pathway had been developed between the oncology service and a local children’s hospice to enable children and young people who become medically unstable whilst resident at the hospice and require immediate transfer to the hospital for on-going care and treatment. The pathway had been developed as the trust would not always be aware of these children as they may not be resident in the Luton area. Therefore, there was a need for a ‘step up’ pathway into the hospital that was pre-arranged by stakeholders. A ‘step-down’ pathway from the hospital was also required to facilitate the safe, effective, planned and timely transfer of any child requiring end of life care or medically stable children known to the hospice. Where possible children were transferred during daytime hours to ensure safe handover of all care requirements between medical and nursing staff.