Luton and Dunstable University Hospital NHS Foundation Trust

Quality Report

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Unannounced visits on 27 January and 4 February 2016
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Outstanding
Are services at this trust well-led?	Outstanding

Summary of findings

Letter from the Chief Inspector of Hospitals

Luton and Dunstable hospital is part of Luton and Dunstable University Hospital NHS Foundation Trust and it is a medium size acute hospital comprising all acute services. There were approximately 679 beds at this trust including 544 general and acute, 76 maternity and 22 critical care and high dependency beds.

We carried out this inspection as part of our comprehensive inspection programme, which took place during 19 to 21 January 2016. We undertook two unannounced inspections to this hospital on 27 January and 4 February 2016.

We inspected eight core services, and rated three as good overall being surgery, maternity and gynaecology, and end of life care. Three core services were rated as outstanding being urgent and emergency care, children, young people and families and outpatients and diagnostics. Two services, medicine and critical care, were rated as requiring improvement.

We rated the Luton and Dunstable Hospital as good for two of the five key questions for effective and caring. We rated two key questions, responsiveness and well led, as being outstanding. For well led the trust had three outstanding ratings, four good ratings and one core service that required improvement, against our aggregation rules this would be rated as good, however, during our quality review in order to reflect the positive findings this was overruled and well led was rated as outstanding. We rated one key question, safety, as requiring improvement. Overall, we rated the hospital as good.

Overall, we rated the hospital as good.

Our key findings were as follows:

- Staff interactions with patients were positive and showed compassion and empathy.
- Feedback from patients was generally very positive.
- Staff morale was generally good and dedication and staff commitment to providing positive outcomes for all patients was high.
- Staff reported incidents appropriately, and learning from incidents was shared effectively.
- Staff we spoke with knew what duty of candour meant for them in practice and was evidenced by the way incidents had been managed.
- Most environments we observed were visibly clean and most staff followed infection control procedures. Equipment had been generally well maintained.
- Safeguarding systems were in place to ensure vulnerable adults and children were protected from abuse and staff followed these procedures.
- Appropriate systems for the storage and handling of medicines were generally in place.
- Nurse staffing levels were variable during the days of the inspection, although in all areas, patients' needs were being met.
- Medical staffing was generally appropriate and there was good emergency cover.
- Working towards providing a seven day service was evident in most areas.
- Patients generally had access to services seven days a week, and were cared for by a multidisciplinary team working in a co-ordinated way.
- Patients' needs were generally assessed and their care and treatment was delivered following local and national guidance for best practice.
- Outcomes for patients were often better than average.
- Pain assessment and management was effective in most areas.
- Most patients' nutritional needs were assessed effectively and met.
- Staff generally had appropriate training to ensure they had the necessary skills and competence to look after patients. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- Services were generally responsive to the needs of patients who used the services.
- The emergency department consistently met the four hour target for referral, discharge or admission of patients in the emergency department which was recognised at a national level.
- The number of bed moves of more than one was low within the hospital compared to the national average.
- The trust's average length of stay was lower than the England average for elective admissions.

Summary of findings

- There was support for vulnerable people, such as people living with dementia and mental health problems.
- We saw there were systems in place to monitor medical outliers effectively throughout the trust.
- We found surgical services were responsive to people's needs and outcomes for patients were good.
- The service regularly carried out operations on a Saturday to meet local need.
- Surgical care and treatment for patients having a fractured neck of femur was comparable to the national average.
- Cancellations of operations were similar to the national average
- The maternity service held stage two baby friendly accreditation
- We found there was a real commitment to work as a multidisciplinary team delivering a patient centred and high quality service in the children's and young people's service. Neonates, children and young people were at the centre of the service and the highest quality care was a priority for staff.
- The emergency department had an established and experienced leadership team who were visible and approachable to staff at all levels and had a clear and committed focus to drive improvements in patient safety and the quality of care and treatment throughout the department.
- Visionary leadership from the board to all areas of ED resulted in the ownership of the emergency pathway throughout the hospital. The leadership team in ED over the past five years had transformed the service from one of the worst performing ED's in the country, to one of best performing nationally. This significant improvement in performance, despite a continuing rise in year on year attendances, had been recognised at a national level by senior NHS and government leaders.
- The specialist palliative care team had a clear vision in place to deliver good quality services and care to patients. There was a long term strategy in place with clear objectives.
- Waiting times for diagnostic procedures was lower than England average.
- The trust consistently met the referral to treatment standards over time.
- There were effective systems for identifying and managing the risks at the team, directorate and organisation levels. The management of risks within services was generally robust and risks had been addressed in a timely manner.
- Generally, there were effective procedures in place for managing complaints.
- There was a strong culture of local team working across most areas we visited.
- Leaders in all services were visible in and the majority of staff felt valued and supported.

We saw several areas of outstanding practice including:

- The emergency department had a robust process for managing the access and flow in the department which was a multi-disciplinary approach to patient care and had helped to achieve the four hour target consistently since 2012 which was recognised at a national level.
- The dementia nurse specialist for the hospital was licensed to deliver the virtual dementia tour to hospital trust staff. The virtual tour gave staff an experience and insight to what it is like living with dementia and this was very popular and gave staff an understanding of people's individual needs.
- We saw strong, committed leadership from senior management within the surgical division. The senior staff were responsive, supportive, accessible and available to support staff on a day to day basis and during challenging situations.
- Implementation of Super Saturday for elective surgery lists helped to reduce waiting lists. Two separate general surgeons were on call to meet patient needs.
- The hospital had an Endometriosis Regional Centre, which was accredited for advanced endometriosis surgery within the region.
- Paediatric services had developed new models of care for the child in the right place, with the right staff, across tertiary, secondary and primary care boundaries.
- There was an exemplary holistic approach to assessing, planning and delivering care and treatment to patients in the children, young people and families' service.
- There were a range of examples of how, as an integrated service, children's services were able to meet the complex needs of children and young

Summary of findings

people. The level of information given to parents was often in depth and at times complex. Staff managed to communicate with the parents in a way they could understand.

- The neonatal unit had been at the forefront of introducing new treatments and procedures including nitrous oxide therapy, high frequency ventilation and cooling therapy which had resulted in a significant reduction in its mortality and morbidity. The use of innovative ways of working with almost 24 hours a day, seven days a week consultant cover due to the introduction of new consultants and meeting European Working Time Directives had led to the team being able to treat more complex babies.
- There was a range of examples of working collaboratively and the children's and young people's service used innovative and efficient ways to deliver more joined-up care to people who used services. We observed the service prided itself on meeting the transitional needs of young people living with chronic conditions or disabilities through engagement with adult and community services to improve transition from children and young people's services to adult services.
- The outpatients' division had very clear leadership, governance and culture which were used to drive and improve the delivery of quality person-centred care. Divisional leads were frequently involved with patient care and problem solving to ensure smooth patient pathway through departments.
- Involvement of clinical staff in the development and design of the orthopaedic hub and breast screening unit have enabled clinical needs to be met and promoted a positive patient experience.
- Joint ward rounds with pharmacy staff and ward based clinicians promoted shared learning promoting an improved patient experience and possibly improved outcome.

However, there were also areas of poor practice where the trust needs to make improvements.

- The trust took immediate actions during the inspection to address areas of concern regarding the staffing levels, medicines' management and bed space concerns in the high dependency unit.
- The trust took immediate action during the inspection regarding ensuring all executive team members complied with the fit and proper person requirement.

In addition the trust should:

- Ensure that all staff complete mandatory training in line with trust targets, including conflict resolution training.
- Ensure that all relevant staff have the necessary level of safeguarding training.
- Ensure all staff have had an annual appraisal.
- Ensure that information for people who use this service can obtain information in a variety of languages and signage reflects the diversity of the local community.
- Ensure that all services take part in relevant national audits to allow them to be benchmarked amongst their peers and to drive improvements in a timely way.
- Ensure the high dependency unit contributes to the Intensive Care National Audit and Research Centre (ICNARC) database, to allow benchmarking against similar services.
- Ensure the time to initial clinical assessment performance information is monitored to give an effective oversight of performance.
- Ensure that all handover documents are completed within the emergency assessment unit.
- Ensure there are consistent processes to enable patients to self-administer their medicines.
- Ensure that there is a standardised consultant led board rounds implemented within the medicine service.
- Ensure that patients receive the recommended input from therapists.
- Ensure environmental repairs are completed in ward areas and kitchen areas.
- Ensure that defined cleaning schedules and standards are in place for all equipment.
- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Ensure patients have their venous thromboembolism (VTE) re-assessment 24 hours after admission
- Continue to ensure lessons learnt and actions taken from never events, incidents and complaints are shared across all staff groups.
- Review the security systems at maternity ward entrances to further improve the safety of women and their babies on the unit.
- Improve the timing of reporting incidents to the National Reporting and Learning System (NRLS).

Summary of findings

- Establish parameters for the gynaecology performance dashboard to enable the service to identify areas of compliance that needed addressing.
- Establish appropriate support is available to parents in the maternity unit following the death of their baby.
- Ensure effective collection and oversight of the end of life care service with regards to rapid discharge performance and preferred place of death for patients'.
- Provide adequate waiting area facilities for patient on beds or trolleys within diagnostic areas.
- Provide appropriate facilities to ensure privacy and dignity is maintained for patients who wear gowns for clinical investigations.
- Review plaster technician facilities to ensure appropriate storage and treatment areas are available across the trust.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Luton and Dunstable University Hospital NHS Foundation 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. It has one main hospital, the Luton and Dunstable Hospital which is a medium size acute hospital comprising all acute services. There were approximately 679 beds at this trust including 544 general and acute, 76 maternity and 22 critical care and high dependency beds. The trust has 4,006 staff (3,561 Whole Time Equivalent or WTE), including 508 WTE medical and dental and 1,150 WTE nursing and midwifery staff. The trust has an annual turnover of £259 million, and in 2014/15 it had a surplus of £65,000.

The trust's main commissioner is Luton Clinical Commissioning Group.

Between January 2015 and December 2015 there were 131,030 emergency department attendances at this trust 79,495 inpatient admissions. Of the inpatient admissions, 8,171 were elective and 32,304 were day case and 39,020 were emergency admissions. There were 387,596 outpatient attendances of which 134,637 were first attendances and 252,959 were follow up attendances.

In the latest CQC Intelligent Monitoring report (May 2015), the trust had two risks and one elevated risk. The priority banding for inspection for this trust was 6, and their percentage risk score was 2.1%.

The risks identified were as follows:

- Safeguarding concerns
- GMC – enhanced monitoring

The elevated risk was:

- Composite of hip related PROMS indicators.

The health of people in Luton is varied compare to the England average. Deprivation is higher than average and about 22.4% (10,780) of children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in Central Bedfordshire is generally better than the England average. Deprivation is lower than average and the life expectancy for both men and women is higher than the England average.

In Luton 45% of people were of black, Asian and ethnic minorities (BAME) which was higher than the England average. Central Bedfordshire local authority had a much lower BAME ethnicity with 94% of the population being of white ethnicity.

Last inspected under the old methodology (with published report) in October 2013. Found to be compliant against six out of eight standards inspected. Found not compliant in outcomes 13 (staffing) and 21 (records).

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Wilde, BSc, BM, BCh, MRCP, FRCR

Head of Hospital Inspections: Helen Richardson, Head of Hospitals Inspection, Care Quality Commission

The team included 11 CQC inspectors and a variety of specialists including: medical consultants, senior managers, child and adult safeguarding lead, an obstetrician, a surgeon, a midwife, end of life care specialists, a paediatrician and paediatric nurse and experts by experience who had experience of using services.

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held about Luton and Dunstable University Hospital NHS Foundation Trust and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, Monitor, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges, the Health Overview and scrutiny committee and the local Healthwatch.

We held a listening event in the week of the inspection where people shared their views and experiences of services provided by Luton and Dunstable University Hospital NHS Foundation Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection between 19 and 21 January 2016 and two unannounced inspections on the 27 January and 4 February 2016.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, healthcare assistants, student nurses and midwives, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from all the departments and clinic areas. We also reviewed the trust's performance data and looked at individual care records.

We talked with patients and staff from all the ward areas and outpatients services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Luton and Dunstable University Hospital NHS Foundation Trust.

What people who use the trust's services say

In July 2015, the Friends and Family Test recommended rate for this trust was lower than the England average.

The trust scored in the top 20% of trusts for 22 out of 34 indicators in the Cancer Patient Experience survey and scored in the middle 60% for the remaining indicators.

The trust scored better than the England average for each indicator in the patient led assessments of the care environment (PLACE) audits for the past three years.

The trust came out as about the same as other trusts in the CQC Inpatient Survey.

Facts and data about this 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.

It has one main hospital, the Luton and Dunstable Hospital (RC971) which is a medium size acute hospital comprising all acute services.

Other locations registered:

Summary of findings

- Chaul End Community Centre Health Suite (RC9X3): for clinic appointments
- Kingsway Medical Centre (RC9X2): for clinic appointments
- Luton and Dunstable University Hospital Orthopaedic Centre (RC9X5): clinics and day case services

There were approximately 679 beds at this trust including 544 general and acute, 76 maternity and 22 critical care and high dependency beds The trust has 4,006 staff (3,561 Whole Time Equivalent or WTE), including 508 WTE medical and dental and 1,150 WTE nursing and midwifery staff. The trust has an annual turnover of £259 million, and in 2014/15 it had a surplus of £65,000.

Between January 2015 and December 2015 there were 131,030 emergency department attendances at this trust 79,495 inpatient admissions. Of the inpatient admissions, 8,171 were elective and 32,304 were day case and 39,020 were emergency admissions. There were 387,596 outpatient attendances of which 134,637 were first attendances and 252,959 were follow up attendances.

The trust has a well-established executive team with the newest appointment being in 2012. Chair has been in post since 2014.

The Parliamentary Review in 2014/15 highlighted the trust as providing excellence in emergency medicine.

Our Intelligence Monitoring report of May 2015 showed these areas of risk:

- Safeguarding concerns – risk
- Enhanced GMC monitoring - risk
- Composite of hip related PROMS indicators – elevated risk.

At time of the inspection, there were no ongoing mortality outlier alerts.

Safe:

- There was one never event between August 2014 and July 2015 which occurred in the core service of maternity and gynaecology.
- The trust reported one never event the week prior to inspection in the outpatients and diagnostic service.
- There were fewer incidents reported per 100 admissions compared to the England average.
- Prevalence rates of pressure ulcers and falls have remained similar over time.
- Catheter acquired urinary tract infections (C.UTIs) prevalence were similar over time but it was noted there were no C.UTIs reported in the Safety Thermometer in three months in a row (January 2015 to March 2015).
- From April 2014 to March 2015, there were three MRSA bacteraemia cases. From April 2015 to March 2016, there was one MRSA bacteraemia case.
- Cases of Clostridium Difficile per 10,000 bed days were generally below the England average.
- Number of consultants was comparable to the national average.

Effective:

- The Hospital Standardised Mortality Ratio in May 2015 comparable to national average.

Caring:

- The trust scored in the top 20% of trusts for 22 out of 34 indicators in the Cancer Patient Experience survey and scored in the middle 60% for the remaining indicators.
- The trust scored better than the England average for each indicator in the PLACE audits for the past three years.
- 2014 Inpatient survey: the trust scored about the same as other trusts for indicators relating to caring in the in-patient survey.
- In the Friends and Family Test for inpatients, from August 2014 to July 2015, the trust consistently scored lower than the England average for percentage of patients who would recommend the trust to friends and family.

Responsive:

- A higher proportion of patients had their discharge delayed due to completion of assessment and due to disputes compared to the England average.
- The trust has had a higher bed occupancy rate than the England average for six out of eight quarters (from Q2 2013/14 to Q1 2015/16).
- Number of complaints have risen by 5- 6% each year.

Well led:

- The trust's sickness absence rate was consistently lower than the England average.

Summary of findings

- In 2015, the trust scored worse than expected in the General Medical Council national training scheme survey for induction and feedback.
- In the NHS staff survey in 2014, the trust had four negative findings and four positive findings out of 31 indicators. The remaining indicators were within expectations.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall, we rated safety of the services in the trust as requiring improvement. Six out of eight core services were rated as good for safety, with medicine and critical care requiring improvement. The trust generally had a systematic approach to the reporting and analysis of incidents. There were plans in place to manage risks identified to prevent future incidents and opportunities to prevent or minimise harm were reviewed. The trust met the requirements of the duty of candour regulation and there was evidence of good ownership of senior leaders within clinical teams. Infection control practices were mostly followed in line with trust policy. In medicine, we found that not all staff adhered to infection control prevention. The environment and equipment was generally appropriate and well maintained in most areas. Most staff had had mandatory training, but compliance of conflict resolution training was poor across most services. Staff were able to explain their role in safeguarding children and vulnerable adults from abuse and took a proactive approach to the early identification of safeguarding concerns. Not all staff had had the required level of safeguarding children's training. Medicines were generally stored safely and securely to prevent theft, damage and misuse in all services. The trust was planning to develop a policy for those patients wishing to self-medicate. There were inconsistencies in medicines' management and administration in some areas. Not all venous thromboembolism (VTE) assessments were completed in accordance with trust policy. The trust was aware of this concern and was taking actions to improve completion of these assessments and carrying out regular audits. Whilst the service was improving the number of patients that received appropriate antibiotics within one hour for the management of suspected sepsis, not all patients were having appropriate treatment within the specified time.	**Requires improvement** 

Summary of findings

Nurse staffing levels generally meet patients' needs. Systems were in place to assess and respond to staff shortages.

Medical staffing across the trust was appropriate for the services delivered and in line with relevant guidance. There was not consistency in daily consultant led ward rounds, which the trust was planning to address.

We found that the trust's system for ensuring all temporary staff had received a comprehensive induction was generally effective and there were systems in place to ensure staff were appropriately inducted.

Do not attempt cardiopulmonary resuscitation forms were completed in accordance with trust procedures.

Patient records contained sufficient detail to ensure all aspects of their care were clearly and comprehensively recorded.

Major incidents arrangements were suitable to ensure patients, staff and the public were adequately protected and that patients were cared for appropriately in the event that a major incident occurred.

Duty of Candour

- There were processes in place to support the requirements of the duty of candour and there was in the main good knowledge amongst staff.
- Staff were able to describe how complaints and concerns were being managed which assured us they were implementing the principles of the duty of candour and kept patients informed about how their concerns and complaints were being managed and outcomes were shared.
- The trust had a being open policy in place which outlined expectations and we found that there was consistent understanding of this policy by all staff.

Safeguarding

- Overall, staff told us they felt confident reporting safeguarding concerns and were given support with this. Policies and procedures for safeguarding were in place and were being updated to reflect changes in national guidance.
- The trust had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff.
- Staff received training and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.

- Staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- Staff had access to the trust's safeguarding team and they told us they were helpful and responsive.
- Staff were able to tell us how they would report concerns through the trust's procedures and they knew who they should contact.
- We were told of the trust's good engagement with both the adult and children's local safeguarding children boards.
- Trust compliance with safeguarding children training was variable. As of January 2016, compliance with level one was 97%, level two 89% and level three 46%. We saw that there was an improvement plan in place to address compliance with level three training.
- As of 30 November 2015, trust compliance with safeguarding adults training for nursing and midwifery staff was 89.4% and for medical staff 69.6%.
- We saw evidence of the use of an electronic child protection alert system in the emergency department (ED) which was linked to community and primary care.
- At the time of our inspection, the trust did not have processes in place for formal safeguarding supervision. We saw evidence of an improvement plan which identified a structured supervision programme would commence in April 2016.

Incidents

- The trust reported 6,662 incidents during the period July 2014 to June 2015 with:
    - 2 deaths
    - 31 severe harm incidents
    - 100 moderate harm incidents
    - low harm incidents and
    - 6,256 classified as no harm incidents
- The trust reported 7.3 incidents per 100 admissions which was below the England average (of 8.4 incidents per 100 admissions).
- The trust reported 41 serious incidents between August 2014 and July 2015. Of these, one was further classified as a never event (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented).The never event was a classified as wrong route administration of medication. The incident occurred in July 2015 in obstetrics.

- We found that this had been appropriately investigated, that learning identified had been shared and actions had been taken to prevent a recurrence.
- In January 2016, the trust reported a never event related to ophthalmology. At the time of our inspection this was under investigation. Appropriate measures were in place to minimise the risk of reoccurrence whilst the incident was being investigated.
- Throughout the inspection we found that most staff knew how to report incidents using the trust wide electronic system. However feedback to staff was not always provided on incidents reported.
- In surgery, mortality and morbidity meetings took place on a monthly basis and reviewed any deaths that had occurred in the division. Root cause analysis following incidents were discussed, and any lessons to be learnt were shared and distributed to the staff team.
- We saw that the trust had a policy in place for serious incident investigation and reporting although we noted that this did not reflect the NHS England Serious Incident Framework (2015) but the trust informed us that the policy was approved on the 10 February 2016.
- The trust had also established visible patient safety rules to embed learning from serious incidents.

Staffing

- Medical staffing across the trust was appropriate for the services delivered and in line with relevant guidance.
- The trust had 40% consultant cover compared to the England average of 39% and a slightly higher percentage of junior doctors (16% compared to the average of 15%).
- Consultant reviews were inconsistent. The mortality review report for December 2015 recommended a standardisation of consultant ward rounds within the medicine service. On most wards consultants visited their patients every two or three days.
- Nursing numbers were assessed using the national Safer Nursing Care Tool and National Institute of Health and Care Excellence (NICE) 2014 guideline which identifies organisational and managerial factors that are required to support safe staffing for nursing and makes recommendations for monitoring and taking action if there are not enough nursing staff available to meet the nursing needs of patients on the ward. The wards used this tool to ensure they identified the minimum staffing levels required for each ward.

Summary of findings

- The trust performed biannual staffing reviews for all wards which included benchmarking with four neighbouring trusts and professional judgement to identify allocation of nursing numbers.
- As of October 2015, nursing staff vacancies were at 15% in the women and children's division, 16% in surgery, 19% in medicine, 1% in diagnostics, therapeutics and outpatients and 14% in the corporate division.
- Temporary staff were employed to cover vacancies and we saw evidence of processes in place to ensure temporary staff had received an induction. We saw completed induction checklists in place for bank and agency staff within the wards and clinical areas. This ensured staff were orientated to the ward and aware of where equipment was stored and how to access information.
- In September 2015, the trust reported its use of agency staff at 6.2%. 9.4% of shifts were covered by bank staff which is above the England average of 6.1%.
- On the high dependency unit (HDU), nursing staff levels during the initial inspection did not meet the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. We raised this with the trust during our inspection who took immediate actions to mitigate any risks posed to patients.
- The trust applied the principles recommended in the 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007) to calculate midwifery staffing. This is a system for ensuring sufficient staff availability to provide safe care. Based on the expected national birth rate, national recommendations are for one whole time equivalent (WTE) midwife to 28 births (1:28). Data from the hospital in May 2015 informed us that the ratio of all midwifery staff to births was 1:26 including bank staff, compared to 1:27 nationally. During the inspection, we were informed that the midwife to birth ratio was 1:29.
- We saw the General Medical Council (GMC) survey report from Health Education England. The report identifies where Luton and Dunstable hospital stood relative to other trusts participating in the survey. Overall, the survey showed that the trust was performing better than other trust in key indicators such as; handover, induction, clinical supervision and local teaching.
- The hospital had a revalidation officer who ensured that all clinical staff requiring revalidation was completed.
- The trust had systems and procedures in place to support the process for all doctors who required revalidation. The aim of revalidation is to ensure that all doctors are up to date and remain 'fit to practice'.

Summary of findings

Environment and Equipment

- Wards and clinics we visited were generally well maintained and met the needs of patients using them.
- We found the environment on the HDU to be cluttered and non-compliant with national building guidance for critical care units. This was a risk to patient safety and clinical care. We raised this with the trust at the time of our initial inspection who took immediate action. On re-inspection one week later we found the service had taken comprehensive actions to mitigate the risks.
- We examined the resuscitation trolleys located throughout the departments and found evidence that they were secure and sealed and regular checks had been completed.
- All equipment had received portable appliance testing to ensure it was safe for use.
- Equipment we checked was fit for purpose.
- All areas we visited appeared visibly clean.
- In maternity we could not see documented evidence that the post-partum haemorrhage trolley weekly checks were being completed. We found that the recordings for September 2015, October 2015 and November 2015 were missing. We raised this with the ward manager at the time of inspection who advised immediate action would be taken.
- The trust risk register included a risk relating to the absence of a rolling medical equipment replacement programme. Whilst no plans were in place to mitigate the risk, we saw evidence that it had been monitored and reviewed. During our inspection staff told us this had not impacted on patient care.
- In the 2014 CQC Children and Young People's Survey, the trust scored about the same as other trusts for the three questions relating to the environment and equipment. This included questions on if the ward had appropriate adaptations and safety on the ward.
- The hospital received a Macmillan Quality Environment Award in February 2015 which assessed how well the hospital buildings such as the chemotherapy units provided support and care for people affected by cancer.
- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, was checked daily, and documented as complete and ready for use. The trolleys were secured with tags which were removed daily to check the trolley and contents were in date.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.

- The outpatient and diagnostic environments varied across the trust. Some areas had been recently refurbished and modernised; however there were pockets of services which were cramped and in need of attention. The clinical leads told us that a refurbishment programme was underway, with plans to move or amalgamate services to produce a patient friendly environment and improve functionality. The plans included working with an architect to redesign the x-ray department, amalgamating laboratory space and the removal of offices from clinical areas. Building works had commenced across the organisation, with changes planned to take up to 18 months.
- The orthopaedic hub opened in November 2015 and was situated a short distance from the main site. The new build was planned to address the large number of patients attending the department and was instrumental in the redesign of the main hospital site. The facilities at the new site were designed in discussion with the orthopaedic clinical director. The facilities included an increased number of clinic rooms, x-ray and plastering facilities and physiotherapy rooms. The redesign of clinic rooms was to provide a streamlined appointment system with reduced patient waiting times. This was to be achieved by the consultant moving rooms rather than patients, which allowed for additional clinic appointments where the consultant would have previously been waiting for patients to enter and leave the rooms.

Medicines

- The trust was in the process of implementing an electronic prescribing and medication administration record system which was in use on most wards and which facilitated the safe administration of medicines. We saw that the pharmacy team used the system to record advice to guide safe prescribing such as completing antibiotic prescriptions with the reason and the recommended course length. However, we saw examples where further information would have helped nursing staff to administer medicines safely. On one ward we saw that several doses of an eye drop had been missed because there was no reminder for staff that it was stored in the fridge. Once staff were made aware, the patient received their treatment and no harm was caused.
- We found medicines were stored safely in wards and departments. We found that the temperatures of the rooms and refrigerators used to store medicines was monitored and recorded in line with trust policy so that medicines were stored in a way which maintained their quality.

- 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. The drugs, in terms of their booking into stock, administration to a patient, and any destruction, were recorded clearly in the controlled drug register. Stocks were accurate against the records in all those we checked on the units.
- The pharmacy team used a range of methods to share medicines safety information including newsletters, screen savers and workshops.
- We saw evidence of a clinical forward audit plan for pharmacy (2015/16) which included plans for dissemination of learning to staff.
- In HDU, we found medicines management including prescription of high risk medication to be of concern. This included the management of sedation for confused patients. We raised this with the trust during our inspection who took immediate action to ensure patient safety was not compromised.
- In medicine, we found inconsistencies in the recording of medicine administration on some wards. The trust had carried out audits regarding controlled drugs and safe and secure storage of medicines in November and December 2015 on these wards and we saw that improvement action plans were in place to address identified risks.
- We found no process to enable patients to self-administer their medicines, which the service stated was to be addressed. Both the ward staff and pharmacy informed us the policy was in the process of being written to address the issue.
- Not all venous thromboembolism (VTE) assessments were completed in accordance with trust policy. The service was aware of this concern and was taking actions to improve completion of these assessments and carrying out regular audits.
- During the surgical ward rounds, medication charts were not always reviewed by the medical team as they were electronic and we were told that junior doctors reviewed these after the ward rounds under the direction of their consultant. We raised this with the trust, who informed us that each surgeon had an agreed amount of ward time in their job plans and senior clinicians reviewed the prescription charts whilst on their ward rounds. All patients had a responsible medical officer who was a consultant and who has overall responsibility for reviewing all aspects of patient treatment and care, which included medication.

Cleanliness, Infection Control and Hygiene

- From April 2014 to March 2015, there were three MRSA bacteraemia cases. From April 2015 to March 2016, there was one MRSA bacteraemia case. The threshold for MRSA is set at zero for all trusts.
- There were 14 cases of C.Difficile and 16 cases of MSSA.
- Data from the Patient Safety Thermometer showed that there were 15 falls with harm, 44 pressure ulcers, and 15 catheter associated new urinary tract infections between December 2014 and December 2015.
- As at 30 November 2015 the trust met their target of having 80% of all nursing staff completing the mandatory training for infection control. However only 70% of medical staff had completed the training
- We observed that staff followed infection prevention and control guidelines and good hand hygiene was practiced.
- We saw examples of where results from infection prevention and control audits had been responded to appropriately to ensure patient safety.
- In most areas we saw that the environment was clean, cleanliness was well maintained and staff took action when there were concerns about cleanliness.
- We saw evidence of the use of the sepsis six care bundle in the ED. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- The processes for decontamination and sterilisation of instruments complied with Department of Health (DH) guidance.

Mandatory Training

- Staff received training in mandatory topics such as infection control, information governance, manual handling, risk management, safeguarding adults (level one) and, safeguarding children (level one).
- There was a robust induction programme for all new staff, and staff who had attended this programme felt it met their needs.
- As at December 2015, nursing staff met or exceeded the trust's 80% target in all mandatory training modules, except conflict resolution with only 59% of nursing staff having completed this training.
- As at December 2015, medical staff did not meet the 80% training compliance target in most of the mandatory training modules with overall compliance of 70%. The highest

compliance for medical staff was seen in the fire training module (with 80%) and the lowest compliance was in conflict resolution with 58% of medical staff having completed the training.

Records

- The hospital had an electronic patient record system where previous records were stored on the computer and current records were hard paper copy.
- Patient care records were completed in accordance with trust policy and records contained sufficient detail to ensure a full chronology of care had been recorded.
- The nursing assessment documents were well completed overall. We saw completed entries for bedrail management, malnutrition screening, falls risk, stool assessment, patient manual handling assessment, wound and communication charts. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.
- Patient's records were generally stored securely. This meant there was not a risk of people's records and personal details being seen or removed by unauthorised people in the department.
- The trust had introduced a new end of life care plan called 'Principles of Care for a Patient who is Dying' in 2014. An audit of 40 sets of notes allowed a benchmark to be set and ensure that staff had all the information they required to deliver the care required to meet each patient's needs .We reviewed the medical and nursing notes for 12 patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.
- We reviewed 28 do not attempt cardio-pulmonary resuscitation (DNACPR) records and found these were consistently well completed in accordance with trust policy.
- The outpatient department used a combination of paper medical records and an electronic system. Paper records were maintained for each clinic attendance and then scanned into the patients' electronic record. The diagnostic imaging, pathology and microbiology, diagnostic results were recorded electronically. This meant that patients were always able to be seen when attending the department as the medical records were always available.
- Wi-Fi was widely used across the trust, and minimal problems were identified by staff apart from the urology one stop clinic who told us that they sometimes had issues with signal. However this did not affect patient care.

Major Incident Awareness and Training

Summary of findings

- There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken by ward staff in the event of a utilities failure or major incident. Plans were available at ward level and via the trust intranet. These plans were familiar to most staff.
- Overall, compliance with major incident and emergency, preparedness, resilience and response awareness training for ED staff was 82% above the trust target of 80%.
- The service had procedures in the event of a "black alert." A black alert occurs when a combination of the following factors occur:
    - There are no available beds and predicted beds significantly fall short of those required.
    - Accident and emergency waiting time over two hours
    - More than 55 patients in the emergency department
    - Cancellation of elective cases due to capacity.
- The trust had contingency plans for maternity services that had been ratified in January 2014. Staff we spoke with throughout the service were aware of these plans.

Are services at this trust effective?

Good

Overall, we rated the effectiveness of the services in the trust as good.

Six out of eight core services were rated as good for effectiveness, with children and young people being rated as outstanding and medicine being rated as requiring improvement.

We saw evidence based care and treatment within the trust was generally effective and based on national guidance.

Outcomes for patients were variable as compared to similar services and where outcomes where below expectations, the service was taking a series of actions to address this.

The Hospital Standardised Mortality ratio (HSMR) was rising above the expected rate; the service was taking a series of actions to understand and address this issue. Outcomes for patients were variable as compared to similar services and where outcomes where below expectations, the service was taking a series of actions to address this.

There was participation in relevant local and national audits such as national diabetes and the heart failure audit but outcomes were mixed and whilst plans were in place to improve performance, progress was variable.

Summary of findings

The trust's Sentinel Stroke National Audit programme (SSNAP) performance data regarding care and treatment for patients with a stroke indicated that there were issues with the stroke pathway and the service was taking a series of actions to improve performance indicators.

In the children's and young people's service, patients received treatment and care according to national guidelines and the service used an audit programme to check whether their practice was up to date and based on sound evidence. The service was obtaining good-quality outcomes as evidenced by a range of national audits such as the Royal College of Paediatric Child Health (RCPCH) National Neonatal Audit Programme (NNAP) and the National Paediatric Diabetes Audit (NPDA).

The Neonatal unit had been at the forefront of introducing new treatments and procedures including nitrous oxide therapy, high frequency ventilation and cooling therapy which had resulted in a significant reduction in its mortality and morbidity. Staff were very proud about their cooling service which they had developed and continued to deliver.

Plans were in place to provide a seven day service in most areas, but not all patients were being reviewed by consultants on a daily basis in all medical wards.

There were effective systems in place to ensure that staff were registered to work with their professional body.

In the main, we saw good multidisciplinary working with seven day working embedded in some areas.

Clinical staff were able to access the information they required. Where agency staff were used, they were able to access information about patients they were supporting.

Nursing and medical staff generally had good knowledge of their responsibilities under the Mental Capacity Act (MCA) and were clear about the procedures to follow when reaching decisions in persons' best interest.

Evidence based care and treatment

- Patient's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence based guidance.
- The trust had a pathway for patients with sepsis to enable early recognition of the sick patient and prompt treatment and clinical stabilisation. We saw this was linked to national guidance.

Summary of findings

- Local policy and procedure guidelines for all specialties were available on the trust intranet and were easily accessible by all members of staff with a current access password.
- The emergency department (ED) contributed to national audits to benchmark performance to continuously develop the service. When the trust recognised that the department's submission for the RCEM audits for 2013/14 and 2014/15 had not been reflected in the national reports, due to an administrative error, benchmarking of performance based on the outcomes of the RCEM audits was carried out to understand the national position and to compare performance. Action plans to improve performance based on these audits had been put in place to drive improvements. The department had completed the data submission to the 2015/16 RCEM audits and were awaiting the outcome of this national audit.
- The trust participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme. The trust performed better than the England average in eight out of the nine measures. The trust had improved in every indicator from 2014 to 2015.
- On the stroke ward, patients' needs were assessed and care and treatment was delivered in line with the National Institute for Health and Care Excellence (NICE) quality standard CG58 Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). For example, there was 24 hour access to a 'hyper acute' stroke facility.
- An effective replacement for the Liverpool Care Pathway, end of life care planning documentation was in place.
- We saw evidence of a formal action plan in maternity which included outcomes from the Kirkup report (2013).
- An audit in October 2015 showed that pharmacy staff carried out a medicines' reconciliation for 45 to 50% of patients at some point during their admission. Medicines reconciliation includes taking a detailed medicine history and checking that any prescribed medicines are correct. This falls short of best practice (NICE guidance NG5) which is for a full medicines reconciliation to be carried out for all adult and complex paediatric patients at admission. The trust did not have the resources to meet the NICE standard but had identified those categories of patient who were most at risk of inaccurate and incomplete prescriptions. The pharmacy team had developed an electronic dashboard to ensure that they prioritised these patients, and their audit showed that 90 to 100% of priority patients had a medicines' reconciliation during their stay.

- Specialist pharmacists provided input to multi-disciplinary teams including the NICU pharmacist who was involved in the provision of parenteral nutrition to premature babies and the HIV pharmacist who reviewed patients on complex medication regimens.
- The Neonatal unit (NNU) was taking part in the 'first hour of care project" which was an East of England approach to the first hour care for babies and would ensure all babies received the same care and management.
- Staff were very proud about their cooling service which they had developed and continued to deliver. NICU had a protocol to follow which allowed them to cool a baby to 34.5 degrees and scan the baby at one week to check if there was any brain damage.
- The NNU used an Early Onset Sepsis Care Bundle which was implemented within the NNU in December 2015. This included the risk factors and clinical signs of sepsis and if the neo-natal baby scored one red flag or two amber flags a sepsis screen would be performed.

Patient outcomes

- For the time period April 2014 to March 2015 the Summary Hospital Mortality Indicator (SHMI) value for this trust was 103.2, which was 'as expected' compared to other trusts. The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
- For the time period August 2014 to July 2015 the Hospital Standard Mortality Ratio (HSMR) in this trust was 110.8. This was significantly high compared to other trusts. The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than expected.
- The trust had undertaken significant work with the aim of reviewing and improving mortality including a systematic review of all deaths. The trust told us of a mortality summit held in September 2015 of which the final report had been published and was being used to inform a further external review. It was acknowledged that data management and coding particularly in relation to end of life had been a considerable factor in mortality rates.

Summary of findings

- The trust had noted the recent increase in HSMR but with a stable SHMI. The mortality board met regularly to review mortality and initiated an in depth programme of work to analyse the current trend in mortality. This had been reported to the board. The trust told us that there were clear indications that their clinical coding was a contributory factor to the elevated HSMR, particularly regarding low palliative care coding. Therefore, the mortality board had recommended that the trust improved the documentation of both diagnosis/ palliative care to ensure the most accurate coding of these cases.
- The mortality review update report for December 2015 outlined how the trust was going to review the risk. This included a review by an external expert to quality assure the work done by the trust. This was due to completed in February 2016.
- There were no mortality outliers for this trust in the May 2015 CQC Intelligent Monitoring Report.
- The medicine service took part in the Sentinel Stroke National Audit programme (SSNAP). Luton and Dunstable Hospital had consistently shown an overall score of E from July 2014 to June 2015. This was the lowest score possible. The trust had identified the risk to the patients and had set up an action forum to review the outcomes of the SSNAP audit. We saw the action plan with identified targets for March 2016, which included ring fencing beds to improve flow, prevent admissions to non-stroke beds, enhancing speech and language therapy provision (provided by another trust) and improved therapy input for patients in non-stroke beds. Actions were being monitored by the stroke forum and supported by the clinical commissioning group (CCG).
- The records showed that the stroke data for July 2015 was invalidated. Due to this the trust and the CCG established a stroke forum in October 2015 to improve the overall performance. We saw the action plan for 2015/16 which identified the SSNAP domains. The performance identified was red, amber and green (RAG) rated. Examples for red included the percentage of patients admitted directly to a stroke unit within four hours of clock time. The quarter one (April to May) target showed a shortfall of 4% and a shortfall of 3% for quarter two (June to August). Actions for improvement included increasing the capacity of stroke beds. We saw the trust had implemented this action by increasing the stroke bed capacity by eight beds.
- A new standard operating procedure had been introduced for wards 16 and 17. This meant that all stroke patients were admitted directly to ward 17 until a stroke diagnosis was

excluded whereby patients stepped down to ward 16. Further actions included the validation of the data and the appointment of two new consultants. Senior staff said that all actions would be reviewed at the stroke forum.

- The trust took part in the 2013/14 Heart Failure Audit (published October 2015). The trust scored similar to other trusts for the majority of indicators such as patients being seen by a cardiologist and patients that were referred for or had an angiogram. The trust scored 100% for patients receiving an echocardiogram. An echocardiogram is a scan used to look at the heart and nearby blood vessels. The trust also scored high at 90% for patients receiving a discharge plan. However, the input from a consultant cardiologist was at 48% and the follow up from a heart failure nurse was at 49%. Also only 9% of patients were admitted to a cardiac unit or ward compared to an England average of 55%. The trust had improved all scores in the 2013/14 audit compared to the 2012/13 audit. The monthly cardiology business reviewed the performance and audits within the service. We saw the actions and the person responsible. These had been reviewed monthly within the minutes seen.
- The trust took part in the National Diabetes Inpatient Audit in 2013, and performed worse than the England average in 13 out of 21 indicators. We saw the completed action plan which addressed identified concerns. Areas identified included; diabetic menu choices available on all meals and qualified and non-qualified nursing study sessions on diabetes. This equates to over 60% of all indicators being worse than the England average. The trust did not participate in the 2014 audit due to a delay in upgrading the diabetes computer system. This was recognised on the risk register and we saw that the diabetes computer system was due to be operational in April 2016.
- Based on the 2013/2014 audit, the trust told us key areas for improvement were identified for the service that formed an overarching improvement plan. This plan focussed on key investments such as:
    - An increase in the Clinical Nurse Specialist team to improve ward presence and specialist advice.
    - Implementation of electronic drug prescribing to improve prescribing and reduce error
    - Further investment in training and development for all clinical groups.
- The Royal College of Physicians' Inpatient Falls Audit report was released in September 2015. The report found that across England and Wales, the mean rate of falls per 1000 bed days

was 6.63, the hospital rate was better at 5.49. Rates of falls resulting in moderate or severe harm across England and Wales was 0.19, the hospital rate was better at 0.14. Assistive technology to minimise falls was being used following a risk assessment process.

- Historically mortality following fracture neck of femur was higher in the trust in 2013 at 13% and 2014 at 8% compared to the national average of 7%. The trust implemented a specific action plan to reduce the mortality. Staff were aware of the actions taken which included a named orthogeriatrician for each patient, a dedicated fracture neck of femur ward and a new integrated care pathway. The recent data for 2015 showed an improvement at 6%.
- The Hip Fracture Audit in 2015 showed the trust performed better than the England average for eight out of nine applicable measures. They performed worse for patients admitted to an orthopaedic ward within 4 hours (27.8% compared to the England average of 46.1%). The trust improved in every indicator in 2015 compared to 2014.
- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme, and the National Joint Registry (NJR). Overall, the trust was matching results seen nationally in PROMS measures for hips, knees, varicose veins and groin hernia which measure patient's outcomes of health following surgery.
- The trust was aligned with the improvement seen nationally in PROMS and had a lower proportion of patients worsening than the national average. The results indicated that the trust had improved the scores compared with the national average. This is a measure of general health rather than specifically related to outcome following surgery.
- Data from the Bowel Cancer Audit 2015 showed that several results for the trust were not available due to data not being submitted. The risk-adjusted 18-month stoma rate in rectal cancer patients undergoing major resection was 58% which was worse than the England average of 50% although not an outlier. The trust told us that the service had made significant progress in data collection for the 2015 data (to be reported in 2016) through:
    - Implementing a revised outcome proforma that included additional data requirements relating to pre and post-surgery performance data;
    - Improvements in the data collection and uploading onto the trust's electronic systems and data revalidation processes;

- Consultants had been trained and were now responsible for the uploading of the clinical information for their respective patients.

- In relation to the stoma rate, the trust said the rate of 58% was well within the 95% limits (as per the Bowel Cancer Audit 2015 requirements) and was not therefore identified as an outlier in this area.
- The trust performed similarly to the England average for indicators in the 2014 national Lung Cancer Audit, for example cases discussed at multi-disciplinary team meetings and percentage of patients in receipt of a CT scan before bronchoscopy.
- Data from the National Emergency Laparotomy Audit 2015 showed that the trust had a mixed performance. The audit rates performance on a red-amber-green scale where green is best. Three green results related to “final case ascertainment”, “consultant surgeon available in theatre” and “arrival in theatre in timescale appropriate to urgency”. The trust scored red against four ratings; “consultant review less than 12 hours of emergency admission”, “ risk documented pre-operatively”, “preoperative review by consultant surgeon and anaesthetist” and “ assessment by medical crisis in older people (MCOP) specialist for patients over 70 years of age”. The remaining four measures scored amber.
- Patient reported outcome measures (PROMS) for groin hernia, hip replacement and knee replacement were similar to the England average. However, outcomes for two of the three indicators for varicose veins were worse than the England average.
- The trust achieved two of the seven organisational key performance indicators in the national care of the dying audit (NCDA) 2013/14 performing below the England average for eight out of ten of the clinical key performance indicators. The worst performing indicator related to the number of assessments undertaken in the patients last 24 hours of life which scored 37 compared to an England average of 82.
- We saw that the trust was working on an improvement plan to reduce the rate of avoidable cardiac arrests by 20% by April 2016. A number of measures to improve care had been identified including appropriate completion of do not attempt resuscitation (DNAR) forms.
- The NNU had a summary report for January 2015 to September 2015 which demonstrated the service was performing much better than the national average for temperature recording (100%) with a national average of 91%, all babies under 1.501

kg undergoing retinopathy (98%) national average 90%, babies less than 33 weeks receiving mother's milk on discharge (70%) national average 59% and documented consultation with parents by a senior member of the neonatal team (96%) national average 86%.

- Whilst the NNAP standard for screening for retinopathy was 100% the NNU showed one infant being screened outside the national standard. Medical staff told us this was due to the condition of the infant and screening could not take place due to the baby being too ill. Retinopathy is a non- inflammatory disease of the retina which may be found in premature babies.
- The NNU had been involved in the original trial (The TOBY trial) of cooling babies to treat asphyxia and was now one of three centres in the East Anglia to provide this therapy. Cooling therapy is used when a baby is deprived of oxygen at birth and improves their clinical outcomes and chances of growing up without disabilities such as cerebral palsy.

Competent Staff

- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs. We saw completed training workbooks which had been reviewed, dated and signed by senior staff. This meant that staff had support across the service in completing their local induction from experienced staff.
- There were robust processes in place for medical revalidation and the trust was prepared for the implementation of nurse revalidation. The revalidation officer ensured that all clinical staff requiring revalidation had been completed. This meant that staff had the necessary skills to manage the care and welfare of patients.
- Generally, all areas had achieved target for medical staff revalidation.
- Overall, the trust appraisal rate for April to December 2015 was 80% below the trust target of 90%.
- Staff told us they had regular annual appraisals, but did not receive formal supervision. They said they received appropriate ad hoc support from their colleagues and felt that handovers, ward rounds and board rounds provided then with learning opportunities.
- Senior staff on the wards visited said there was a good leadership programme available for all Band 7 nurses. Staff currently undertaking the programme said that it was very good and they felt proud to be given the opportunity to develop within the trust.

- The education department confirmed that they worked alongside the human resources team to ensure that all agency nurses had the appropriate training prior to being employed by the trust. This was confirmed in the records reviewed on the wards.
- The Nursing and Midwifery council (NMC) Midwives Rules and Standards (2012) require a ratio of one Supervisors of Midwives (SoM) for 15 midwives. We saw that the SoM ratio in December 2015 was 1:21, which was above the recommendation of 1:15. The service told us that the HOM was aware of the current structure of Supervision of Midwifery at the Trust, and had agreed a local arrangement for enabling the SoM extra time allocation for work related to Supervision, which is funded through the temporary staffing (bank) arrangements.
- The trust worked in partnership with a local Sixth Form College to select six young people who aspired to study medicine. Each of the mentees were matched with a consultant.
- There was children's assessment knowledge and examination skills (CAKES) course which was accredited by the Royal College of Nursing (RCN) and RCPCH and took place three times a year. This was a multi-professional educational course which ensured competency/confidence of staff in all settings to recognise sick children needing urgent hospital treatment and appropriately assess/manage children safely outside-of-hospital settings and at home. This had been developed by the paediatric assessment unit staff.

Multidisciplinary working

- The staff we spoke with reported good multi-disciplinary (MDT) working both internally and externally. Staff reported that medical and nursing/midwifery staff worked well together and that the MDT handovers took place regularly within services.
- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors and physiotherapists.
- We were told that external arrangements also worked well and that there were good communications and links with community nurses and midwives, GPs as well as social services, information was regularly received from social services regarding individuals specifying any support they may be receiving or may need.
- Generally ward teams had access to the full range of allied health professionals and team members described them as good, collaborative working practices.

- Specialist pharmacists provided input to multi-disciplinary teams including the NICU pharmacist who was involved in the provision of parenteral nutrition to premature babies and the HIV pharmacist who reviewed patients on complex medication regimens.
- Over the last 18 months the trust had been working with the Child and Adolescent Mental Health Service (CAMHS) to streamline and improve the process for children and young people who were admitted to hospital and required a review by specialist mental health teams. This had resulted in the redesign the process of how children were referred, reviewed and supported in a safe and timely manner.
- We were told that the integrated discharge team worked well to facilitate early discharge for patients needing input from Social Care. The integrated manager was a joint post provided by both the trust and the local authority and had been successful at strengthening relationships within the wider health and social care system.
- Paediatric consultants were working with adult services to develop transition clinics. Children were invited to attend adult clinics at their 15th birthday so they were given time before being handed over to full time adult care.
- The children and young people's service had a transition checklist which was adapted from the Adolescent Health Transition Project 2014 and was used to ascertain a child's knowledge of their condition, medication, implication of their condition and whether they knew who their specialist doctor and nurse were.
- Transition clinics were already available for diabetes, inflammatory bowel disease, epilepsy cystic fibrosis, primary ciliary dyskinesia, severe asthma, other respiratory diseases, complex gastro-intestinal diseases, HIV, oncology, endocrinology and those children requiring nutrition support such as enteral feeding.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The safeguarding lead and the dementia nurse specialist provided Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) training to staff. They ensured that staff had an understanding of MCA and DoLS. They were able to support staff in the interpretation of the legislation.
- We saw consent to care and treatment was obtained in line with legislation and guidance.
- We found children's rights were protected and consent to care and treatment was obtained in line with the Children's' Acts

1989 and 2004. Staff we spoke with demonstrated a clear understanding of Gillick competencies. These helped clinicians to identify children aged less than 16 years of age who had the legal capacity to consent to medical examination and treatment.

- We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- Mental capacity was assessed for patients who may have lacked capacity. Knowledge of staff was good about the assessment and recording of mental capacity assessments (MCA).
- A database of all DoLS applications was maintained by the adult safeguarding team and the relevant medical and nursing teams who were updated with the on-going outcomes of the process.
- The adult safeguarding team reviewed all the DoLS authorisations on a daily basis.
- There were no consent forms available in other languages.
- Trust compliance with training on mental capacity and DoLS was at 63% against an internal target of 80%.

Are services at this trust caring?

Good

Overall, we have judged the services at the trust as good for caring.

All eight core services were rated as good for caring.

In all areas, patients were treated with dignity and respect and were provided with appropriate emotional support.

Staff were caring and compassionate to patients' needs in all services.

Patients and most relatives said they were kept informed and felt involved in the treatment received.

Compassionate care

- Staff cared for patients in a compassionate manner ensuring dignity and respect. Both patients and their relatives were very satisfied with the care provided.
- Staff generally respected people's individual preferences, habits, culture, faith and background. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- Confidentiality was generally respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.

- We observed children and young people being communicated with by nursing and medical staff in a compassionate way. Curtains were drawn around patients to ensure privacy and dignity and voices were lowered to avoid private and confidential information being overheard.
- The trust's Friends and Family Test performance was worse than the England Average between December 2014 and November 2015. In November 2015 the trust performance was 94.6% compared to a national average of 95.4%.
- The trust took part in the 2014 Cancer Patient Experience Survey (CPES). CPES, run by Quality Health, provides insights into the care and treatment experienced by cancer patients in 153 NHS hospital trusts across England. Luton & Dunstable Hospital was in the top 10 most significantly improved trusts for 2014. The CPES showed consistent improvements across many areas, especially verbal communication, written information and having confidence in ward nurses. There were some areas where progress was still needed. These included care planning with 44% of patients not fully informed about side effect that could affect them in the future and 78% were not offered a written assessment and care plan. Patients (60%) said that doctors and nurses asked what name they preferred to be called by.
- The trust's performance across all of the four 2015 Patient Led Assessments of the Care Environment (PLACE) indicators was better than the England average (food, privacy/dignity/ wellbeing and facilities).
- PLACE performance at the trust was better for cleanliness and food in 2014 and 2015 when compared to 2013. Trust performance declined from 95% to 90% between 2013 and 2015 for privacy, dignity and wellbeing and from 95% to 94% between 2013 and 2015 for facilities.
- The Healthwatch inpatient report for 2015 showed that 84% of patients (496) scored their overall inpatient experience as good or excellent. 92% of patients rated the nurses as good or excellent and consultants were scored as good or excellent by 85%.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant.

- Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns with regards to the way they had been spoken to. All were very complimentary about the way in which they had been treated.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- The trust performed about the same as other trusts for the five questions relating to understanding and involvement of patients and those close to them in the 2014 CQC Inpatient Survey.
- Parents were involved with their child's care and decisions taken. We saw evidence in the clinical notes that patients were involved in making decisions about care and treatment. Children were involved in their care whilst going through the care planning process with their parents.
- Most patients told us they felt involved in the decision making process regarding their care. Feedback from relatives reported consistent communication from the medical staff and they knew about the care and discharge arrangements.
- We saw the paediatric wards had 'my daily plan' at each bedside which was used as a communication plan and gave parents the opportunity to write their concerns or thoughts so staff could discuss with them when necessary. Parents told us this worked well and was responsive to their children's daily needs.
- Parents told us staff went the extra mile to ensure they were kept up to date on their child's care and treatment.

Emotional support

- There was a trust wide spiritual care and chaplaincy team available to patients' and their families. Patients said the hospital chaplaincy had a visual presence around the hospital and they were happy to meet them.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke services, cancer services and for heart failure patients.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.
- Staff we spoke with both in maternity and gynaecology told us they referred patients on to services that provided counselling to assist women in coming to terms with their condition and circumstances when necessary.

Summary of findings

- There was not a bereavement midwife in post to support parents in cases of stillbirth or neonatal death although there were four additional members of staff who had been trained in the provision of bereavement support. The trust informed us of their intention to recruit a bereavement midwife.
- Staff carried out daily quality checks at handovers to ensure care plans were up to date and patients' needs had been assessed including emotional and mental health needs.
- The trust performed about the same as other trusts for the two questions relating to emotional support in the 2014 CQC Inpatient Survey.
- Parents told us that they considered their children's privacy and dignity had been maintained throughout their stay in the service. Staff had good awareness of patients with complex needs and those patients who may require additional support should they display anxious or challenging behaviours.

Are services at this trust responsive?

Outstanding

Overall, we rated the trust as outstanding for responsiveness**.**

Six out of eight core services were rated as good for responsiveness, with the urgent and emergency care and outpatients and diagnostic services being rated as outstanding.

The emergency department consistently met the four hour target to admit, refer or discharge and were generally performing significantly better than the England average. Between December 2014 and November 2015, the trust exceeded the target of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month.

Referral to Treatment (RTT) standard performance for incomplete pathways was also consistently better than the England average over time.

The trust consistently met national cancer targets regarding referral to treatment times between December 2014 and November 2015. This included patients being seen within two weeks of referral from GP, the 31 day diagnosis to treatment time and 62 day GP referral to commencement of treatment target.

Between December 2014 and November 2015, the trust consistently performed better than the England average with diagnostic testing being completed within six weeks of referral.

Good initiatives were in place to improve care for those living with dementia.

Summary of findings

Whilst the bed occupancy was high and the trust was working to improve the safety and timely discharge of patients.

Effective systems were in place to manage medical and surgical outlying patients.

Working towards providing a seven day service was evident in most areas.

We found that outpatient and diagnostic services were responsive to the needs of patients who used the services.

Waiting times in all clinics were well within acceptable timescales.

Outpatient DNA (did not attend) rates were comparable to the average for trusts in England.

Patients were able to be seen quickly for urgent appointments if required.

Staff showed an awareness for diversity and appropriate translation services were in place.

Service planning and delivery to meet the needs of local people

- The trust was working with key stakeholders to ensure that health and social services met the changing needs of the local area.
- The service monitored the use of its operating theatres to ensure that they were responsive to the needs of patients. To meet the needs of local people, theatres were opened once a month on a Saturday for elective cases.
- Work with Luton GPs had resulted in giving children living with a long term condition a patient passport which provided open access and highlighted the specific needs for that child's long term condition. This supported the reduction in avoidable hospital attendance for minor illness.
- Staff showed a good awareness and knowledge of equality and diversity and we saw evidence that this formed a part of service planning with external providers and local authorities. Services were planned and delivered in a co-ordinated way that met the needs of the local population.
- We saw effective planning and service delivery designed to support people with complex needs.
- The emergency department had recently developed networks with external providers to deliver increased mental health provisions for the local population. We saw evidence that some of these services provided help and support for people with

eating disorders and substance abuse. There were plans to monitor how this had impacted on the reduction of avoidable admissions and the department had a CQUIN in place related to this with defined targets in place for each quarter.

- The Clinical Navigation Team (CNT) worked within the ED and was staffed by community nurses working with the hospital physiotherapy and occupational therapy teams to identify patients presenting to ED who might need community support. We saw evidence that the department had worked with external providers to plan and deliver this service since April 2015. Performance over this period had been monitored and improvements made which resulted in a reduction of avoidable admissions through co-ordinated care.
- The service received patients that had sustained major trauma and were transported by air ambulance. Staff told us that the landing area for the helicopter was in a school field which was 2.5 miles away and that the new design would create a helipad which would mean that patients would arrive for treatment sooner.
- The outpatient and diagnostic teams offered bespoke appointments for patients. All departments described flexibility in services to meet the patients' needs. This was particularly evident in the breast clinic, where all investigations were planned for one appointment, including scanning, biopsies and discussions with clinicians. This meant that patients would only need to attend the hospital once to gain a diagnosis and discuss a treatment plan. We were told that results from biopsies were available within one week of the biopsy undertaken and patients would receive their diagnosis and confirmation of a treatment plan within that first week.
- Where possible, joint clinics were held for patients. This included joint elderly care and diabetic clinics, paediatric to adult diabetic clinics, and oncology and urology clinics. The joining of clinics ensured that patients had a reduced attendance at the hospital but also ensured that the patients and staff were aware of treatment programmes and pending investigations.
- The orthopaedic hub had been designed in conjunction with the clinical team. The design included increased numbers of clinic rooms and reduced desk space. Two clinic rooms enabled doctors to see patients in quicker succession increasing productivity as they did not have to wait for patients to enter or leave the clinic rooms. The clinical lead suggested minimal desk space was required as all patients' notes were held electronically, and therefore no desk space was required for writing.

- The trust offered the regional Bariatric service for patients aged 18-70 years. The catchment area covered Cambridgeshire, Norfolk, Suffolk, Essex, Hertfordshire, Buckinghamshire and Bedfordshire. The service consisted of two tiers of service. The first (classed as tier 3) offered medical care and assessment, and the second (tier four) offered surgical procedures.
- The pharmacy department provided a dispensing and supply service and clinical pharmacy service to most wards between 8am and 5pm Monday to Friday and 10am and 3pm at weekends and bank holidays. On-call pharmacists were available at other times. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- There were plans for the new neonatal unit to provide increased capacity to support the care and return of all babies and mothers who required specialist neonatal care. The unit would also support transitional care so that mothers and babies could receive dedicated care together and improve accommodation to support parents with premature babies.
- Work with Luton GPs had resulted in giving children living with a long term condition a patient passport which provided open access and highlighted the specific need for that child's long term condition. This also supported the reduction in avoidable hospital attendance for minor illness.

Meeting people's individual needs

- The needs of people living with a dementia were generally detailed in care plans and were person centred.
- The hospital provided dementia link nurses on most wards to help support effective care for people living with a dementia. The hospital used the "This is Me" documentation books that, when completed by patients and their families, gave person centred information to staff to facilitate more effective care.
- The trust had a named dementia lead. Staff confirmed they were able to readily access advice and support as required.
- The trust had completed the Department of Health (2015) Dementia Self-Assessment Framework for all inpatient settings. Out of 27 best practice criteria the trust judged itself to be compliant at level two for six components and at level three for 21 components. The self-assessment is based on a traffic light system where level two implies the organisation has made progress between 50-75% and level three between 75-100%.
- The trust had a Dementia Strategy in place which outlined strategic objectives including improving clinical outcomes as well as development of partnership working.

Summary of findings

- The trust had access to mental health advisers who could provide support, guidance and review patients as required.
- We saw examples where there was support for people with a learning disability and reasonable adjustments were made. For example, patients were given longer outpatient appointment times to take account of any anxiety.
- Staff were aware of the learning disabilities liaison nurse and the safeguarding nurse, who both provided advice and support for people in vulnerable circumstances. Staff were able to refer any issues or concerns to the learning disability lead.
- We saw some information leaflets were available in easy-to-read formats. An interpreting service was available and used.
- In maternity a standard delivery room had been converted with the support of a local charity into a bereavement room to ensure bereaved parents had personal time with their baby, the room had been appropriately decorated and was located so that bereaved families could have minimal contact with other new mothers if they preferred to ensure bereaved parents had personal time with their baby.
- Not all literature was available in different languages but interpreter and translation services were effective.
- For children living with a learning disability, the trust had an adult learning disability nurse who worked across the trust. We were told the majority of these children were well known to paediatric staff and would rarely use the expertise of the adult learning disability nurse. However, if there was a new child who was not known to the service they would use the adult learning disability nurse as a point of reference.
- There were links with the community learning disability nurses to ensure continuity of care. The discharge coordinator and other professionals such as dietitians, physiotherapy and speech and language therapists would also meet to discuss a child's care and treatment.
- Care plans for children living with a disability had input from their families and included play plans. Children had their own open access passports.
- The pharmacy team had developed an electronic dashboard to identify priority patients, so while they were not able to see every new patient they did ensure that they focussed their resources on those most at risk of incorrect or incomplete prescriptions.
- Visiting times could be flexible to allow for relatives of elderly patients to maintain family contact throughout long periods of admission.
- Some wards, patients had access to activity kits for meaningful stimulation.

- Some wards had quiet areas for discussion with patients and relatives. Wards had access to a chapel and multi faith room on site.
- We saw cultural information files available, with details of religions and their naming conventions, beliefs, rites and rituals and end of life beliefs. Staff said they had had training and support in this area.

Access and flow

- In medicine, the trust met the 92% Referral to Treatment (RTT) standard for incomplete pathways with over 96% of patients with incomplete pathways waiting less than 18 weeks every month between December 2014 to November 2015. This was also consistently better than the England average. Each specialty within medicine individually achieved above the 90% target for the 12 month period.
- In surgery, between December 2014 and November 2015, the percentage of patients waiting less than 18 weeks from referral to treatment time (RTT) was consistently 92%, which met the national average of 90%, in all specialities apart from trauma and orthopaedic which was at 82%. RTT monitors the length of time from referral through to elective treatment. These targets are no longer collated and were stopped by the NHS in June 2015.
- The trust participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme. In 2015, 75% of patients with a fractured neck of femur had surgery within 24 hours of admission, which was the same as the national average. The length of stay in hospital was 14 days, which was better than the national average.
- Between October 2014 and September 2015, 286 patients had their operations cancelled and seven were not rebooked within 28 days. This was in line with the England average.
- The average length of surgical patients' stay for both elective and non-elective patients was lower than the England average for July 2014 to June 2015. For all elective Luton and Dunstable was 2.2 days compared to 3.3 for the England national average and for non-elective surgery it was 3.7 days compared to the England average of 5.2.
- We saw the trust had developed an escalation plan to enable patients to be assessed, treated and managed in a safe environment during episodes of surge in activity. The trust had recognised the risks associated with the management of patients spread over a number of wards and had introduced a model to improve the management of medical and the

department of medical elderly (DME) outliers. Medical teams were allocated to the escalation wards which evened out the workload and improved patient tracking. Examples included; gastroenterology to ward 22a and acute admissions to the cardiac centre.

- The escalation plan supported patient safety during increased attendance to the hospital. The aim of the escalation plan is 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 and any identified concerns.
- The trust's average length of stay was lower than the England average for elective admissions. At speciality level the trust had a particularly higher length of stay for non-elective respiratory medicine admissions. We saw the length of stay between one day and four weeks for 2015. For example; 48 patients (10%) had a length of stay of one day whilst 44 patients (9%) had remained in the hospital for over four weeks. The records showed that the length of stay was mainly due to the availability of a package of care for patients.
- We saw there were systems in place to monitor medical outliers throughout the trust. Nursing staff on these wards told us outliers were reviewed on a daily basis by the ward doctors but had access to specialist consultants when required.
- Senior nursing staff we spoke with told us discharges did not always happen in a timely way. However, there were fewer problems with medicines to take home. To assist in the progress of timely discharges the integrated discharge team were involved in discharge meetings and, commenced continuing healthcare documents.
- Between December 2014 and November 2015, the trust exceeded the target of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month. The trust had been meeting this target annually since February 2012.
- Between December 2014 and November 2015, the percentage of patients waiting in the emergency department four to 12 hours after the decision for the patient's admission was made was consistently below the England average. Between June 2015 and November 2015, the percentage for this trust was less than 1% compared to the England average of 8%.
- The emergency department was a part of the East of England Trauma network (EETN) providing specialist care for patients

with serious traumatic injuries. Between December 2014 and November 2015, there had been no patients waiting in ED for over 12 hours, after a decision had been made to admit them to hospital for care.

- The department had pathways of admission to ambulatory care for patients with specific diagnosis' who could be treated as outpatients and reduce the need for admissions.
- In critical care there were issues with delayed discharges to the ward resulting in patients remaining on the Intensive Care Unit (ITU) or High Dependency Unit (HDU) that were safe to be discharged.
- The division had implemented "SMART" appointments. This was a computerised process where patients' previous attendances at hospital were reviewed and a probability of attendance ascertained. This meant that patients with a history of non-attendance were scheduled for the same appointment slots as others who were unlikely to attend. This process enabled patients to be seen if they did attend the department, but also meant clinic productivity was not affected for prolonged periods by non-attendance. This process was trialled within the breast screening service and was being monitored for effectiveness by the clinical leads.
- The division had piloted partial booking for clinic appointments. This system allowed patients to book appointments within a time scale and to a time slot that suited their individual needs. The trial had increased attendance at clinics. To assist with the development of this across clinics the division had introduced co-ordinators who were responsible for the development and monitoring of the system. The division's aim was for a "did not attend" rate of less than 8% by the end of 2016.
- The trust operated an open access referral service for GPs for echocardiograms. The referrals were printed on the electronic investigation request cards and picked up by the department. The referral waiting time was approximately four weeks; however we were told that each referral was assessed on priority basis. The team had two nurses dedicated to the procedure and provided a seven day service. Working hours were extended to increase productivity when demand was particularly high.
- Effective systems were in place to manage medical and surgical outlying patients. The trust had robust procedures in place for governing the use of escalation areas and provided additional staffing at all times to ensure patients' needs were met.
- Nursing staff told us there could be delays in the provision of take home medicines, but we saw that the pharmacy team had

put measures in place to minimise delay. These included the use of satellite dispensaries near to the wards, attending daily meetings to find out which patients were going to be discharged, and improving the provision of discharge medicines at weekends.

- The Paediatric Assessment Unit (PAU) provided medical assessment for children and young people. Referrals were received via a number of routes including from GPs, the urgent care centre, paediatric emergency department, midwives, walk-in centre, community children's nursing teams, children's clinics and open access.
- Of the 5,952 admissions to PAU in April 2015 to December 2015, 2,074 stayed in less than two hours and 499 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 November 2015 on PAU showed 82% of children and young people were seen by a nurse within 20 minutes, 76% were seen by a doctor within one hour and 82% seen by a senior registrar or consultant within four hours. This was an ongoing audit and feedback was shared monthly with staff during one to one sessions, discussion at safety briefings and information on operating practices for medical staff.
- The diagnostic service had a dedicated paediatric list on a weekly basis. The appointments were longer and managed jointly by the paediatric team and diagnostic staff. Patients were able to be brought to the department with their parents and staff from the wards to ensure that they knew staff present. Diagnostic areas were appropriately decorated with children's characters to assist with them feeling comfortable.

Learning from complaints and concerns

- Patients generally knew how to raise concerns or make a complaint. The wards encouraged patients, those close to them or their representatives to provide feedback about their care.
- Complaints procedures and ways to give feedback were in place.
- People were supported to use the system and to use their preferred communication method. This included enabling people to use an advocate where they needed to. People were informed about the right to complain further and how to do so, including providing information about relevant external second stage complaints procedures.
- The trust reviewed and acted on information about the quality of care that it received from patients, their relatives and those close to them and the public.

Summary of findings

- Staff said they directed patients to support services if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- In 2014/15, this trust received 660 complaints. The number of complaints has risen each year since 2010/11 by around 5-6% each year. Between 1st October 2014 and 30th September 2015 the average timeframe to process closed complaints was 36 days which was in line with the trust's policy of 35 days.
- Patients were given advice of how to contact the Patient Advisory Service (PALS) or use the Friend and Family Leaflets for formal and informal complaints.
- Feedback captured through friends and family testing was sent to departments. Senior staff told us that the trust forwarded details of concerns via email and requested confirmation of actions or comments to prevent reoccurrence. The detail of feedback was discussed with the team during meetings and displayed on department whiteboards. During inspection we noted that the services displayed the number of positive, negative comments and common themes.
- The trust operated a complaints' board which was implemented in 2013 which maintained an effective oversight of complaints' processes.

Are services at this trust well-led?

Outstanding ☆

Overall, we rated leadership at the trust as outstanding.

For well led the hospital had three outstanding ratings, four good ratings and one core service that required improvement, against our aggregation rules this would be rated as good, however, during our quality review in order to reflect the positive findings this was overruled and well led was rated as outstanding.

The services rated outstanding were urgent and emergency care, children and young people and outpatients and diagnostics. Critical care was rated as requiring improvement and the others as good.

Overall the trust board were a stable team and the chief executive officer (CEO) particularly was seen by staff as highly visible and approachable to the majority of staff. Visibility amongst the rest of the board was reported as good. Actions were taken by the trust leadership team immediately during inspection to address areas that were identified as a significant risk and those needing improving.

The trust had developed a strategic planning document to lead their approach to care delivery from 2014-2019. This was well embedded but knowledge amongst a minority of staff was limited.

Summary of findings

There was a trust vision, this was underpinned by objectives and plans that the majority of staff understood and were able to describe. Understanding of the trust's vision was good amongst the staff we spoke with. The trust had engaged with the wider community in 2015, with the focus on the plans for hospital development.

The trust had a well-developed set of values that were recognised by the majority of staff.

The trust had a widely distributed model of medical leadership that was understood by all medical staff we spoke with and showed, on the whole, excellent engagement with the consultant body.

The leadership team in the emergency department (ED) over the past five years had transformed the service from one of the worst performing ED's in the country, to one of best performing nationally. This significant improvement in performance, despite a continuing rise in year on year attendances, had been recognised at a national level by senior NHS and government leaders.

There were governance systems in place to escalate issues and risks to the trust board. The effectiveness of these processes was mostly consistent between divisions.

There were comprehensive systems in place to report and learn from risk with effective systems for identifying, capturing and managing issues and risks at team, directorate and organisation level in most services.

Significant issues that threatened the delivery of safe and effective care were identified, and risks management including assessment, mitigating action and review was demonstrated.

The trust had recognised the rise in HMSR and there had been significant actions taken to develop the process in place to review and address mortality rates.

Potential risks to patient safety and the quality of care and treatment in the high dependency unit had not been promptly addressed. The trust, however, took immediate action to address these concerns after we had raised this during the inspection.

Whilst the emergency department had gathered data for national audits in the past three years, twice this data was not submitted. However, the trust undertook a benchmarking exercise to compare the service's performance against both the Royal College of Emergency Medicine standards and against the national outcomes and put plans in place to drive improvements.

Summary of findings

Performance in national audits was used to drive improvements in services.

The standard of the divisional risk registers to be consistent and were assured that there was effective divisional ownership and scrutiny. There was a clear understanding between the risks and issues within the divisions and those that were on the trust board risk register. Action plans following serious incidents were adequately completed and monitored effectively

The trust was very proactive in engaging with staff. The majority of staff were very positive about the leadership of the board.

There was clarity about authority to make decisions and how individuals were held to account.

Overall, the majority of staff expressed high levels of satisfaction and were proud to work for the trust.

Staff reported feeling respected, valued, supported and appreciated.

Full and effective fit and proper person checks were not in place at time of inspection but the trust took immediate action to address this concern.

Whilst there were comprehensive mechanisms in place for the Fit and Proper person test for newly appointed executives and board members the trust had not undertaken new disclosure and barring checks on longstanding staff members. The trust took immediate action to address this concern.

There was an understanding of the Duty of Candour amongst the majority of staff, and the trust had a being open policy. There were effective systems in place to deliver the requirements consistently.

Vision and strategy

- The trust was undergoing a major site redevelopment programme which will result in a significant reconfiguration of services across the hospital site consisting of a staged block by block refurbishment of all main areas of the hospital. The redevelopment programme had been designed by clinical and supporting teams and the trust had worked closely with all key stakeholders to develop the plan. Additional funding had been secured from the department of health and the business case for the hospital redevelopment had been signed off by the board in October 2015. The extensive redevelopment plans were to be completed by 2019.

Summary of findings

- The trust had a vision to be amongst the best for patient safety and experience and the best clinical outcome and had a range of strategies to maximise harm free care for all patients. The trust vision was for the hospital to become on the very best district general hospitals in the country.
- The trust had developed a strategy to lead their approach to care delivery from 2014 to 2019. This was well embedded and knowledge amongst staff was generally good. This strategy included focussing on the trust becoming a major emergency centre and a teaching and academic centre.
- The divisions had a separate divisional strategy that supported the trust vision. All staff we spoke with demonstrated an understanding of plans to develop both within division and across the hospital and what was required to enable the process to be completed. Strategic plans were in place and reviewed for progress during monthly divisional meetings.
- The trust had established three clinical safety priorities as part of the national NHS Sign up for Safety campaign:
    - Improving the management of the deteriorating patient
    - Improving the management of patients presenting with acute kidney Injury (AKI)
    - Improving the management of patients presenting with sepsis
- The trust had a well-developed set of values that were recognised by the majority of staff. These values were:
    - putting patients first
    - focus for excellence and continuous Improvement
    - seeing diversity of staff as a strength
    - valuing the contribution of all staff, volunteers, members, governors, stakeholders
    - managing resources in a co-ordinated way
    - accept responsibility for our actions, individually and collectively.
- The children and young people's service demonstrated a clear vision and strategy for paediatrics which was led by a strong management team. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.
- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

- The service regularly took part in national research programmes which resulted in the service developing innovative and new ways of working and improving standards of care for children, leading to being a regional centre for some complex conditions.

Governance, risk management and quality measurement

- The trust had a committee and subcommittee structure to enable the board to be sighted on the issues within the trust and external impact factors.
- Members of the leadership team confirmed the commitment of the non-executive directors and commented that they were well prepared for meetings, having reviewed the reports beforehand and so were able to give strong challenges.
- We found that there were governance systems in place to escalate issues and risks to the trust board. The effectiveness of these processes was mostly consistent between divisions. We found the standard of the divisional risk registers to be consistent and were assured that there was effective divisional ownership and scrutiny.
- There were regular clinical outcome safety and quality committee's chaired by one of the non-executive directors which fed directly into the trust board. There was a trust wide focus on providing harm free care and in most areas; the trust's regular "Patient Safety Newsletters" were cascaded effectively throughout staff teams to ensure focus on harm free care initiatives.
- Patient safety breakfasts also took place regularly which involved presentations from clinical staff to discuss and share learning from safety and quality of care and treatment issues.
- The trust had a range of quality improvement strategies in place, including transformation of quality through technology and had made significant progress with the implementation of electronic patient records in most areas.
- Significant issues that threatened the delivery of safe and effective care were generally identified, and risks management including assessment, mitigating action and review was demonstrated.
- The trust had recognised the rise in the HMSR and there had been significant actions taken to develop the process in place to review and address mortality rates. The trust's mortality board was established in 2013.
- Risks to patient safety and the quality of care and treatment in the high dependency unit had not been promptly addressed. The trust, however, took immediate action to address these concerns after we had raised this during the inspection.

Summary of findings

- Whilst the emergency department had gathered data for national audits in the past three years, twice this data was not submitted. However, the trust undertook a benchmarking exercise to compare the service's performance against both the Royal College of Emergency Medicine standards and against the national outcomes and put plans in place to drive improvements.
- The trust had recognised that the performance in the Sentinel Stroke National Audit programme (SSNAP) regarding care and treatment for patients with a stroke indicated that there were issues with the stroke pathway and the service was taking a series of actions to improve performance indicators.
- Performance in national audits was used to drive improvements in services.
- Plans were in place to provide a seven day service, but not all patients were being reviewed by consultants on a daily basis. Consultant reviews were inconsistent on some medical wards. The mortality review report for December 2015 recommended a standardisation of consultant ward rounds within the medicine service. On most wards consultants visited their patients every two or three days which was in the progress of being addressed by the trust.
- Whilst the medicine service had generally recognised the risks to patient safety and the quality of care and treatment, actions were not always clearly defined and therefore progress was variable as not all outcomes were clearly defined. Learning from mixed performance at national audits was not always effectively used to drive forward improvements in a timely manner. Some staff said they felt the pace of change had been implemented too quickly and they needed time to ensure recent changes had been fully embedded.
- The maternity service had an action plan in place to implement change and address long standing priorities.
- Services had a quality dashboard for each service, and this was available on the trust's intranet site. It showed how the services performed against quality and performance targets. Members of staff told us that these were discussed at team meetings. The ward areas had visible information about the quality dashboard.
- The trust used a range of tools to monitor the pharmacy service which had helped them identify areas which needed improvement. We saw minutes of meetings which showed that the team kept up to date with current clinical guidelines, and reviewed and acted on patient safety issues. Ten members of the pharmacy team were qualified as pharmacist independent prescribers, including one working as an arrhythmia

pharmacist practitioner. This pharmacist told us that they ran a cardiology clinic to support people with atrial fibrillation and that they could give patients time to take in information which would allow them to manage their condition.

Leadership of the trust

- The chair had a clear understanding of the risks and opportunities for the trust and was very visible, known to staff and was well respected.
- The non-executive directors had different backgrounds and there had been conscious decisions made to appoint people with certain areas of expertise. There was a good balance of those with clinical and non-clinical backgrounds with one of the non-executive directors taking a lead role for quality and safety.
- The majority of the staff we spoke with felt the trust board provided good, approachable leadership and both the director of nursing and medical director were recognised as strong and effective leaders.
- Visibility of the trust board was good with the chief executive officer (CEO) being recognised as very visible and accessible by the majority of the staff we spoke with.
- The executive team employed a “hands on” operational approach to manage service pressures when required and the majority of staff greatly valued this approach. A minority of staff considered this top down approach to decision making was not always effective in facilitating full staff engagement.
- The executive team were well respected by the broader board it was recognised that there was strong clinical leadership amongst the executive at the same time there was acknowledgment that there was a need to ensure all executives had an equal voice.
- The CEO was widely regarded by external stakeholders as being a visionary leader who took swift, appropriate actions to manage service pressures without compromising the safety and quality of patient care and treatment as well as actively driving forward the trust’s improvement agenda.
- Visionary leadership from the Board to all areas of the emergency department (ED) resulted in the ownership of the emergency pathway throughout the hospital. The leadership team in ED over the past five years had transformed the service from one of the worst performing ED’s in the country, to one of best performing nationally. This significant improvement in performance, despite a continuing rise in year on year attendances, had been recognised at a national level by senior NHS and government leaders.

- The ED had been recognised nationally with senior NHS and Government leaders spending time in the service analysing how the department was run and the way it interfaced with the rest of the hospital to understand how the department had been able to consistently deliver against the four hour standard whilst at the same time maintaining its quality indicators. The department's leaders had undertaken presentations at national conferences and had hosted visits from other NHS trusts to share learning at a national level.
- The leadership and the whole department's ethos was that the Department of Health standard for measuring performance (the four hour performance measure) was not an arbitrary timescale, and was based upon evidence of delivering quality care within a safe and realistic time. Fundamental to this was the fact that patients who waited for a long time had worse clinical outcomes and a poor patient experience. The department had been instrumental in conveying this message to the rest of the trust and the wider health economy. This had enabled effective patient flow through and out of the hospital, in order that the ED could see the new patients quickly, safely and effectively.
- The outpatients' division had very clear leadership, governance and culture which were used to drive and improve the delivery of quality person-centred care. Divisional leads were frequently involved with patient care and problem solving to ensure smooth patient pathway through departments.
- We found there was a real commitment to work as a multidisciplinary team delivering a patient centred and high quality service in the children's and young people's service. Neonates, children and young people were at the centre of the service and the highest quality care was a priority for staff and the strong, focused leadership team.
- The trust had a widely distributed model of medical leadership that was understood by all medical staff we spoke with and showed, on the whole, excellent engagement with the consultant body. The chief medical advisor was most senior medical leader in the trust and was accountable to the trust board and reported to the CEO. There were four medical directors, all accountable to the trust board via the CEO and all reporting to the chief medical advisor. These posts were generic with trustwide duties, and were not divisional. All the post holders were senior medical staff having held previous senior posts in the trust. There were clinical chairs for each of the four clinical divisions and these were specifically responsible for the clinical governance arrangements in each division and worked closely with their respective divisional directors as well as the

clinical directors in their divisions. Each of the four divisions was divided into functional service speciality groups, the medical leadership in each service area coming from a clinical director who had responsibility for operational performance in their clinical area. This structure gave a very widely distributed leadership structure with shared management and leadership responsibilities.

Culture within the trust

- In August 2015, the trust's sickness absence rate was 3.6%. The trust's monthly sickness absence rate was consistently below the England average.
- As at 20 January 2015, 85.2% of nursing staff and 88.7% of medical staff had received an up to date appraisal. This was below the trust target of 90%.
- We saw evidence of a "Say No" to bullying at work campaign which included organisational pledges for staff in relation to conduct and behaviour.
- Staff morale was generally good with effective engagement throughout staff teams.
- The trust had recently outsourced facilities management including catering and domestic services: systems were in place to ensure learning from transition processes were cascaded to ensure effective delivery of these services.
- The majority of staff felt confident to use the trust's whistleblowing procedures and that swift action would be taken to minimise risks to patients.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a new regulation that intends to make sure senior directors are of good character and have the right qualifications and experience
- There were comprehensive mechanisms in place for the Fit and Proper person test for newly appointed executives and board members.
- We reviewed eight director's files to assess compliance against Fit and Proper Person legislation. Whilst almost all the required checks had been carried out, the trust had not undertaken new disclosure and barring checks on longstanding staff members. This was on the basis of legal advice the trust had sought about the implementation of the new regulations.
- This was brought to the attention of the trust during the inspection who took immediate steps to address this to ensure effective checks were in place.

Public engagement

Summary of findings

- The trust's Friends and Family Test performance was worse than the England Average between December 2014 and November 2015. In November 2015 the trust performance was 94.6% compared to a national average of 95.4%.
- In the Cancer Patient Experience Survey 2013/14, performance at the trust was within the top 20% of trusts in answers to 22 questions. The trust performed about the same as other trusts for the remaining 12 questions.
- The trust's performance across all of the four 2015 Patient Led Assessments of the Care Environment (PLACE) indicators was better than the England average (Food, Privacy/dignity/ wellbeing and Facilities).
- PLACE performance at the trust was better for cleanliness and food in 2014 and 2015 when compared to 2013. Trust performance declined from 95% to 90% between 2013 and 2015 for privacy, dignity and wellbeing and from 95% to 94% between 2013 and 2015 for facilities.
- Consultation events were held with the wider community in 2015, with the focus on the plans for hospital development.

Staff engagement

- In the NHS staff survey the trust had four negative findings and four positive findings out of 31 indicators. The remaining indicators were within expectations. The response rate was 35% compared to a national response rate of 42%.
- We saw evidence of excellent engagement with staff using a variety of mediums.
- Engagement / Staff ownership. 'Good – better – best' staff events took place in June/July 2015 and December 2015. 68% of staff attended a session to give feedback on how to improve the quality of care for patients.
- The staff survey results put the trust in the top 50 for NHS employers.
- There was a strong culture of teamwork and staff spoke of being proud of their service.
- The majority of staff spoke highly of the leadership by the executive team.
- Staff engagement processes were in place, including regular staff forums and whole team events that highlighted areas of achievement and focused on the trust's strategy and visions and values. The majority of staff spoke highly of these events and felt valued by the trust, and that their views were listened to.
- Staff were involved with the consultation of the hospital redevelopment plans during 2015 and in most areas; clinicians were actively involved in the design of new facilities.

Summary of findings

Innovation, improvement and sustainability

- The Parliamentary review 2014/15 highlighted the trust as providing excellence in emergency medicine due to consistent performance above comparable trusts.
- There was an innovative, clear vision and strategy for the department which looked to transform patient access to urgent and emergency care across the whole health economy;
- The ED had been the centre of attention nationally with senior NHS and Government leaders spending time in the service analysing how the department was run and the way it interfaced with the rest of the hospital to understand how the department had been able to consistently deliver against the four hour standard whilst at the same time maintaining its quality indicators.
- We asked staff at different levels how they felt that they were able to meet the four hours to discharge target consistently. All staff we spoke to felt that it was a combined effort and the emphasis on patient flow and the function of the operations centre room (OCR) allowed them to concentrate on patient care.
- The department had strong links in operational delivery networks in the East of England; this included East of England trauma network and East of England Urgent and Emergency care network.
- Streaming at the ED reception and working with the external providers at the Urgent GP Centre had an impact on reducing avoidable admissions and with continuous monitoring and feedback at all levels involved, new pathways had been developed and continuous learning implemented.
- The trust has had a financial surplus for the past 16 years, putting it amongst the top performing trusts nationally with regard to financial management and sustainability.
- The outpatient division leads told us of development plans relating to clinic utilisation, equipment replacement and extended clinic hours and had an action plan in place on how this could be managed. This included the identification of additional resources within estates and personnel which would affect the treatment and management of patient care throughout the services. The clinical leads had promoted the development of staff internally to meet demands of increased speciality services (such as sonography) and as a result had fully established teams that shared competence.
- There was children's assessment knowledge and examination skills (CAKES) course which was accredited by the Royal College of Nursing (RCN) and RCPCH and took place three times a year. This was a multi-professional educational course which

ensured competency/confidence of staff in all settings to recognise sick children needing urgent hospital treatment and appropriately assess/manage children safely outside-of-hospital settings and at home. This had been developed by the PAU staff and was open to staff from outside the organisation.	

Overview of ratings

Our ratings for Luton and Dunstable Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Requires improvement	Good	Good	☆ Outstanding	☆ Outstanding	Good

Our ratings for Luton and Dunstable University Hospital NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Good	☆ Outstanding	☆ Outstanding	Good

Notes

Outstanding practice and areas for improvement

Outstanding practice

- The ED department had a robust process for managing the access and flow in the department which was a multi-disciplinary approach to patient care and had helped to achieve the four hour target consistently since 2012 which had been recognised at a national level.
- The dementia nurse specialist for the hospital was licensed to deliver the virtual dementia tour to hospital trust staff. The virtual tour gives staff an experience and insight to what it is like living with dementia. The nurse specialist said this was very popular and gave staff an understanding of people's individual needs.
- We saw strong, committed leadership from senior management within the surgical division. The senior staff were responsive, supportive, accessible and available to support staff on a day to day basis and during challenging situations.
- Implementation of Super Saturday for elective surgery lists helped to reduce waiting lists. Two separate general surgeons were on call to meet patient needs for both upper and lower conditions.
- The hospital had an Endometriosis Regional Centre, which was accredited for advanced endometriosis surgery within the region.
- Paediatric services had developed new models of care for the child in the right place, with the right staff, across tertiary, secondary and primary care boundaries. This included the most chronically unwell children having an open passport to access the right tier of care and prevent unnecessary escalation using urgent GP access, paediatric assessment unit, ambulatory support from the community paediatric nursing team and a seven day rapid response team enabling safe care at home.
- We found there was a real commitment and passion to work as a multidisciplinary team delivering a patient centred and high quality service. Neonates, children and young people were at the centre of the service and the highest quality care was a priority for staff.
- There were a range of examples of how, as an integrated service, children's services were able to meet the complex needs of children and young people. The level of information given to parents was often in depth and at times complex staff managed to communicate with the parents in a way they could understand.
- The NNU had been at the forefront of introducing new treatments and procedures including nitrous oxide therapy, high frequency ventilation and cooling therapy which had resulted in a significant reduction in its mortality and morbidity. The use of innovative ways of working with almost 24/7 consultant cover due to the introduction of new consultants and meeting European Working Time Directives had led to the team being able to treat more complex babies.
- There was a range of examples of working collaboratively and the service used innovative and efficient ways to deliver more joined-up care to people who used services. We observed the service prided itself on meeting the transitional needs of young people living with chronic conditions or disabilities through engagement with adult and community services to improve transition from children and young people's services to adult services.
- The outpatients' division had very clear leadership, governance and culture which were used to drive and improve the delivery of quality person-centred care. Divisional leads were frequently involved with patient care and problem solving to ensure smooth patient pathway through departments.
- Involvement of clinical staff in the development and design of the orthopaedic hub and breast screening unit have enabled clinical needs to be met and promoted a positive patient experience.
- Joint ward rounds with pharmacy staff and ward based clinicians promoted shared learning promoting an improved patient experience and possibly improved outcome.