



LUTON &
DUNSTABLE
UNIVERSITY
HOSPITAL



Quality Account

for the period April 2014 to March 2015

Luton and Dunstable University Hospital
NHS Foundation Trust





What is a Quality Account?

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

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

A review of our quality of services for 2014/15 is included in this account alongside our priorities for quality improvement in 2015/16. This report summarises how we did against the quality priorities and goals that we set in 2014/15. It also tells you those we have agreed for 2015/16 and how we intend to achieve them.

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

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

- patient safety,
- the effectiveness of treatments that patients receive,
- how patients experience the care they receive.

About our Quality Account

This report is divided into six sections. The first section contains a statement on quality from the Chief Executive and sets out our corporate objectives for 2015/16.

The second section looks at our performance in 2014/15 against the priorities that we set for patient safety, clinical effectiveness and patient experience.

The third section sets out our quality priorities and goals for 2015/16 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.

The fourth section includes statements related to the quality of services that we have provided and this includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.

The fifth section is a review of our quality performance and includes performance against national priorities and local indicators. It also provides examples of how we have improved services for patients.

The sixth section of the report includes a statement of Directors' responsibility in respect of the quality report.

The seventh section contains comments from our external stakeholders.

Some of the information in the quality account is mandatory; however most is decided by our staff and Foundation Trust Governors.

About Our Trust

The Luton and Dunstable Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for the people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 68,000 admitted patients, over 360,000 outpatients and ED attendees and we delivered over 5,200 babies.

We serve a diverse population most of which are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of Equality and Diversity have a high profile. There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 Luton Annual Public Health reports states that in many cases, Black and Minority Ethnic (BME) communities have poorer health

outcomes when compared to the overall population and these are linked to infant mortality, access to services due to awareness, language and cultural barriers, early onset dementia and diabetes.

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

All inpatient services and most outpatient services are provided on the Luton and Dunstable Hospital site. The Trust provides community Musculo-skeletal services (MSK) at three locations across the catchment area and Chronic Obstructive Pulmonary Disease (COPD) and Diabetes services for South Bedfordshire.

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

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

Division	Specialties	
Diagnostics, Therapeutics & Outpatients	Pathology Services <ul style="list-style-type: none"> - Blood Sciences - Cellular Pathology - Microbiology - Phlebotomy Haematology Care Pharmacy Physiotherapy and Occupational Therapy	Imaging Musculoskeletal Services Dietetics Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2014/15 Divisional Directors, General Managers and Executive Directors met weekly in the Executive Board. Twice a month the Board reviewed the operational activities and discussed the strategic issues. The other Executive meetings were dedicated to the Clinical Operational Board and Re-Engineering programmes.

In June 2014, the Luton and Dunstable University Hospital NHS Foundation Trust published a new five year strategic plan.



1. A Statement on Quality from the Chief Executive

Part 1

Each year, improving clinical outcome, patient safety and patient experience underpins everything that is done in L&D. This can be seen by reading our corporate objectives and understanding the progress that we are making year on year delivering sustained improvement.

During 2014/15 the organisation began the transformation from being a traditional District General Hospital to becoming a Hyper Acute Emergency Hospital, a Women's and Children's Hospital and an Elective Centre supported by an Academic Unit. This will also enable us to build on the achievements of recent years.

As in previous years we consistently delivered against national and local quality and performance targets, we:

- Achieved 90% compliance with the Acute Kidney Injury (AKI) Bundle for those patients with stage 3 AKI.
- Made significant progress with both Clinical Commissioning Groups towards the provision of Integrated Care.
- Achieved over 70% of patients assessed by a consultant within 14 hours of admission.
- Achieved a further 35% reduction in the falls resulting in severe harm
- Achieved a further 30% reduction in hospital acquired pressure ulcers
- Reduced the number of cardiac arrests across the Trust.
- Implemented an electronic Prescribing and Medicines Administration System to reduce the risk of prescribing and administration errors.
- Achieved an improving outpatient experience with a reduction in short notice appointments rescheduled and a reduction in patients who do not attend their appointments.
- Reduced our diagnostic waits.
- Reduced the mortality rate of those with a fractured neck of femur from 84 in March 2014 to 61 in March 2015.
- Achieved all of the national waiting time targets in A&E, 18 weeks and cancer.
- Reduced the number of C Diff to only 10 against a ceiling of 19.
- Further strengthened the governance arrangements for raising patient safety concerns and transforming quality.
- Launched 'Patient Safety Rules' to enable the organisation to learn from error and experience.
- Reviewed and revisited our governance and Board arrangements.

This quality account focuses on how we will deliver and maintain our progress against our key quality practices in the coming year.



Pauline Philip
Chief Executive
27th May 2015

Corporate Objectives 2015/16

The Trust's corporate objectives for 2015/16 were selected in 2014 as part of a two year plan developed following consultation with the Board of Directors, our Governors, our patients and our staff to ensure the implementation of our vision, aims and values.

In 2014-16 the Trust's Strategic Direction was underpinned by seven corporate objectives detailed in the 2014-2016 Operational Plan. These objectives have been reviewed and objective 6 has been changed to reflect the challenges the Trust is now facing in securing and retaining a competent workforce.

1. Deliver Excellent Clinical Outcomes

- Year on year reduction in HSMR in all diagnostic categories

2. Improve Patient Safety

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

3. Improve Patient Experience

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

4. Deliver National Quality & Performance Targets

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

5. Implement our New Strategic Plan

- Deliver new service models:
 - Emergency Hospital (collaborating on integrated care and including hospital at home care)
 - Women's & Children's Hospital
 - Elective Centre
 - Academic Unit
- Implementation of preferred option for the re-development of the site.

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

- Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.
- Ensure a culture where all staff understand the vision of the organisation and are highly motivated to deliver the best possible clinical outcomes.
- Deliver excellent in teaching a research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

7. Optimise our Financial Plan

- Deliver our financial plan 2014-2016 with particular focus on the implementation of re-engineering programmes

2. Report on Priorities for Improvement in 2014/15

Part 2

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

We had key priorities each for patient safety, patient experience and clinical outcome. Our remaining priorities are detailed in the annual plan.

Priority 1: Clinical Outcomes

Key Clinical Outcome Priority 1

Continue to monitor overall hospital mortality and investigate any condition or procedure where there are unexpected deaths

Why was this a priority?

The Mortality Board monitors the overall Hospital Standardised Mortality Rate (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). At the time of reporting in March 2014 there were no diagnoses where the HSMR was outside of the expected range. Acute kidney injury (AKI) is however, a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. It is associated with many conditions and is prevalent in emergency admissions. AKI can also be viewed as an index condition for assessing the quality of the totality of care for all people with acute illness. Earlier recognition of illness severity and earlier senior clinical involvement in the care of unwell patients is therefore key to improving the safety, effectiveness and experience of care for patients admitted to hospital as an emergency. This was therefore a priority for 2014/15 and was agreed as a CQUIN scheme.

What did we do?

- We have developed and implemented a Trust-wide electronic alert system to detect changes in serum creatinine that may be indicative of Acute Kidney Injury (AKI).
- We have implemented an eLearning programme and multidisciplinary training for all grades of Doctors and Nurses to support early identification of patients with AKI in all clinical specialities.
- Improved management of patients with a diagnosis of AKI by the implementation of an AKI management care bundle which has been rolled out across the Trust.

How did we perform?

We have achieved 90% compliance rates with the bundle for those patients with Stage 3 AKI.

Key Clinical Outcome Priority 2

Implement a new model of integrated care for older people

Why was this a priority?

The current service configuration within Central Bedfordshire and Luton for the management of older people often results in the frail and elderly population being admitted to hospital when they could be cared for in the community. Key stakeholders within the Central Bedfordshire health economy (L&D, Central Beds Council, CCG, Primary Care, SEPT and the voluntary sector) have recognised this issue for some time but to date accountability to drive and lead the required change has not occurred. Poor patient experience and the ever increasing need to reduce bed pressure has led the Trust to recognise that driving the right care in the right setting is a vital requirement to delivering operational sustainability. The Trust has therefore taken the lead working with stakeholders within the Central Bedfordshire health economy to progress a new integrated model of care for the elderly population. The Better Care Fund (BCF) which has been identified as a key enabler for change, encouraging CCGs and local authorities to work together to improve seven day access to services for patients will enable this work to commence.

What did we do?

- A dedicated team was set up in Luton and South Bedfordshire to manage the project.
- The cohort of patients that are 75 plus were identified.
- We initiated a process for getting explicit consent from patients to share their information across Health and Social Care.
- We aligned an Elderly Care Consultant to a group of GP practices (Cluster) to be part of the MDT.
- Coordinators were appointed for the pilot Cluster of GP practices.
- Pathways that support a more coordinated and integrated approach were developed.

How did we perform?

Significant progress has been made in taking forward the integration and coordination of care for patient in Luton and South Bedfordshire. A number of issues; information governance, patient consent, system governance and IT, have impacted on the delay to implementation in

2014/15 and the benefit realisation. There is ongoing commitment from all stakeholders to overcoming these issues and move forward at scale and pace to deliver the benefits in the coming 12 month.

Key Patient Safety Priority 2

Roll out the Perfect Day across the hospital

Why was this a priority?

During 2014/15, the Trust took the principles of perfect day to develop a new model of care within the ward environment to develop the support worker role (Bands 1 to 4).

This innovative model involves a workforce design review with the main aim of getting the nurse back to the bedside. It supports the reduction of unnecessary bureaucratic documentation and tasks that a registered nurse does not need to undertake thus significantly increasing the amount of nursing time spent with the patient. This objective also has an impact on the patient experience. To enable this, the further development of the support staff element of the workforce has required a radical review.

What did we do?

Part of our plans to review and redesign elements of the nursing workforce involved a major focus on developing the Bands 1-4 care support roles.

- In line with the recommendations of the Cavendish review and the Francis Report, the Trust has implemented a revised training programme for all Health Care Assistants (HCAs) to meet the 'basic care certificate' level. All HCAs now undertake a 2 week induction followed by completion of the standardised national competencies within the first 12 weeks of commencing employment.
- All HCAs are offered a permanent position upon successful completion of the 'higher care certificate', within their first year. This will ensure all support workers have a generic basic training and can choose to progress to senior support worker roles.
- Other roles have evolved and expanded using the intelligence gained from the Perfect Day project. The discharge coordinator role and ward administrator role has supported the reduction in documentation and other administrative duties enabling nurses to spend more time at the bedside. Other areas have seen further development of the housekeeper role, ensuring the ward environment is kept in line with the cleaning standards and supporting patients' nutritional requirements.
- Work has continued on developing key roles for the

Assistant Practitioner role (Band 4). This role has been introduced to compliment the work of the Registered Nurse as these individuals have undertaken a Foundation degree and are trained to the level of first year nursing student. We have developed a Band 4 role within our elderly care wards. We have also developed support roles in areas such as theatres, diabetes, outpatients and screening.

How did we perform?

The ward performance indicators should continue to see an improvement over the next 12 months as the large numbers of Health Care Assistants continue to join the organisation and complete the care certificate. It is early days to evaluate the impact of the new standard training on patient outcomes or experience.

The benefits of training support staff were outlined in an RCN (2010) Assistant Practitioner Scoping Report.

- Improved education and training with a clearly defined career pathway will improve job satisfaction and reduce turnover rates. Although it is too early to demonstrate this, early indications reflect the greater satisfaction from staff and retention is starting to improve
- The ward based supervision and teaching of generic band 2 support workers by Band 4 Assistant Practitioners is starting to reduce this function for Registered nurses thus freeing up Registered nurse (RN) time to improve patient contact time.

Key Patient Safety Priority 3

Ongoing development of Safety Thermometer, improving performance year on year

Why was this a priority?

The NHS Safety Thermometer continues to provide nurses with a point of care survey tool to check fundamental levels of care, identify where things go wrong and take prompt action. It is used by frontline healthcare workers to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, VTE and falls.

The continued use of the monthly safety thermometer during 2014/15 has provided ongoing measurement of harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE. The Trust has consistently delivered above 95 % harm free care against these four harms. This work also supported our CQUIN quality initiatives.

What did we do?

- We have sustained use of prevalence data from the Safety Thermometer as an improvement tool to continue to reduce the amount of harm patients experience
- **Pressure Ulcers.** A 30% reduction in hospital acquired pressure ulcers at grades 2 & 3 has been achieved this year. This has been supported by the establishment of a 'Stop the Pressure' and Wound Forum' focussed on improving the education and support to all levels of staff with an interest in pressure ulcer and wound care. The group has met monthly to support the improvement to practice required.
- **Falls.** We do recognise that some falls are avoidable but reducing falls in an ageing and more frail population with complex health needs, remains very challenging. We have successfully reduced the overall number of falls and those falls that resulted in severe harm. During 2013-14 we reported 27 falls with harm, this has reduced to 17 during 2014-15, an overall reduction of over 35%.

We have been focusing our attention on the national guidance from NICE (CG 161, 2013) and the RCP (Inpatient falls pilot audit, 2014) and using this to direct the development of a new Inpatient Falls prevention policy. This has also involved updating the initial assessment documentation and creating a multidisciplinary falls management and intervention plan.

Collaborative working continues between the Falls, Dementia and Continence Nurse specialists to support ward staff in recognising and reducing risk in this particularly vulnerable group of patients.

• Catheter related Urinary Tract Infections.

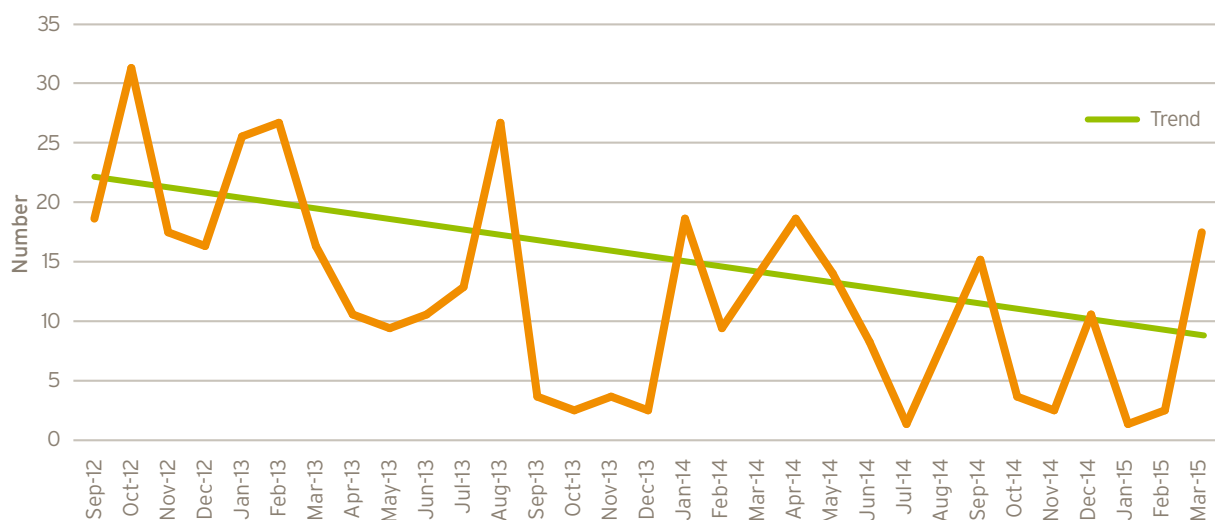
Throughout the year we have strived to reduce the use of urinary catheters across the Trust. This focused effort has resulted in An overall reduction in catheter usage of 4.24%. Our work has been assisted by the continued development of the Enhanced Recovery Programme although the number of catheters used varies according to the complexity of the surgical procedures. In partnership with the Countywide Harm Free Care group we have also co authored a 'Urinary Catheter Passport' for healthcare professionals to use aiming to improve the patient's catheter management across the health sector.

- **VTE.** Hospital acquired Venous Thromboembolism (VTE) remains an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. VTE manifests as either deep vein thrombosis (DVT) or pulmonary embolism (PE), and can be difficult to diagnose. All relevant patients have been risk assessed, prescribed and administered appropriate preventative treatment. A root cause analysis (RCA) has been undertaken on all hospital associated thrombosis. Engaging clinicians in the root cause analysis process has supported shared learning across the organisation.
- The Trust has actively participated in a Countywide 'Harm Free Care' and 'Pressure Ulcer' groups which aim to share learning to enable a further reduction in patient harms.

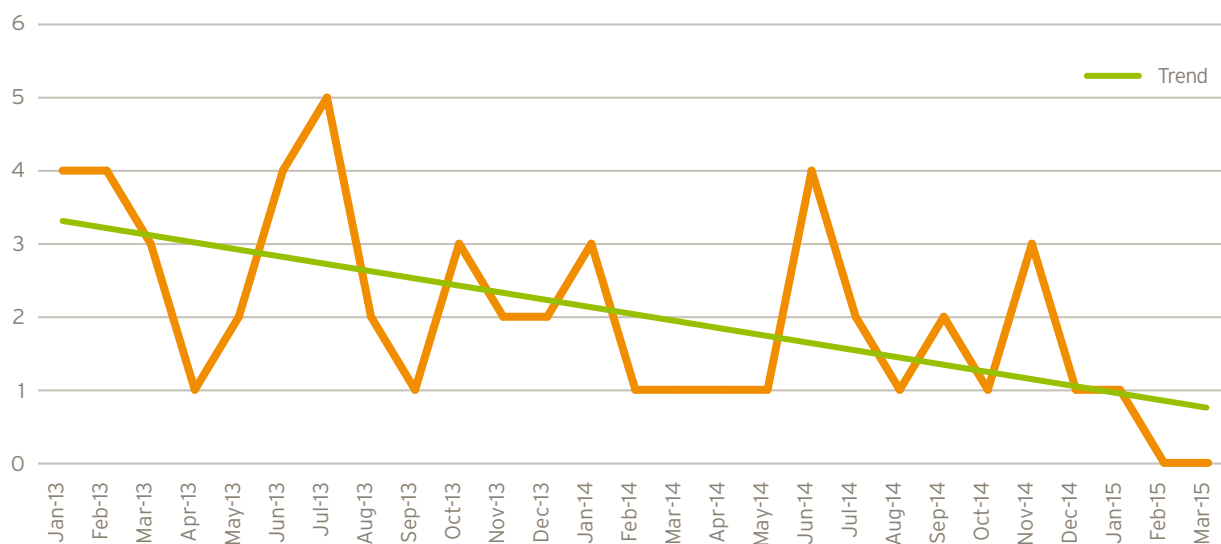
How did we perform?

- We achieved a 30% reduction in the prevalence of hospital acquired, avoidable grade 2 and 3 pressure ulcers
- There was a 35% reduction in the proportion of patients with harm from a fall
- We delivered a 4.24% reduction in the proportion of patients with a urinary catheter
- We ensured that 95% of our patients have had a VTE risk assessment on admission and a RCA has been completed on all cases of hospital associated thrombosis where known.

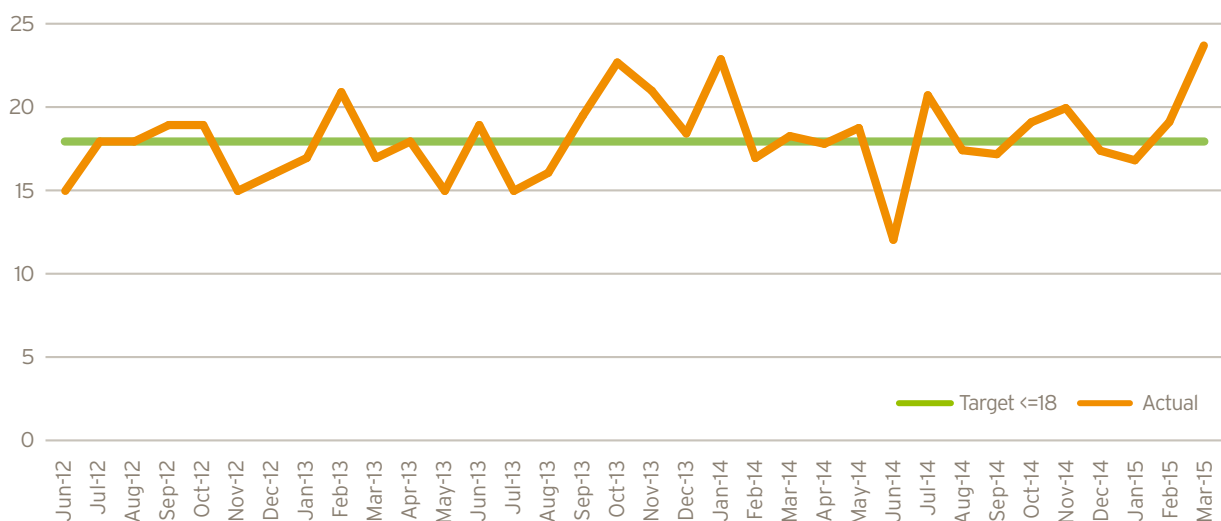
Incidence of Hospital Acquired Grade 2,3 and 4 Pressure Ulcers



Falls prevalence - number of falls with harm



Use of Urinary Catheter



Key Patient Safety Priority 4

Improve the management of the deteriorating patient

Why was this a priority?

The recognition of acute illness can be delayed and its subsequent management may be inappropriate. This is because clinicians may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This leads to further deterioration in clinical condition and potential avoidable death. 'Wardware', the electronic observation system, has been introduced to assist with addressing these issues. Wardware provides details on a ward by ward and day to day basis regarding the performance of observations. Analysis of the cardiac arrests has highlighted some areas for improvement regarding nursing and medical response to abnormal observations.

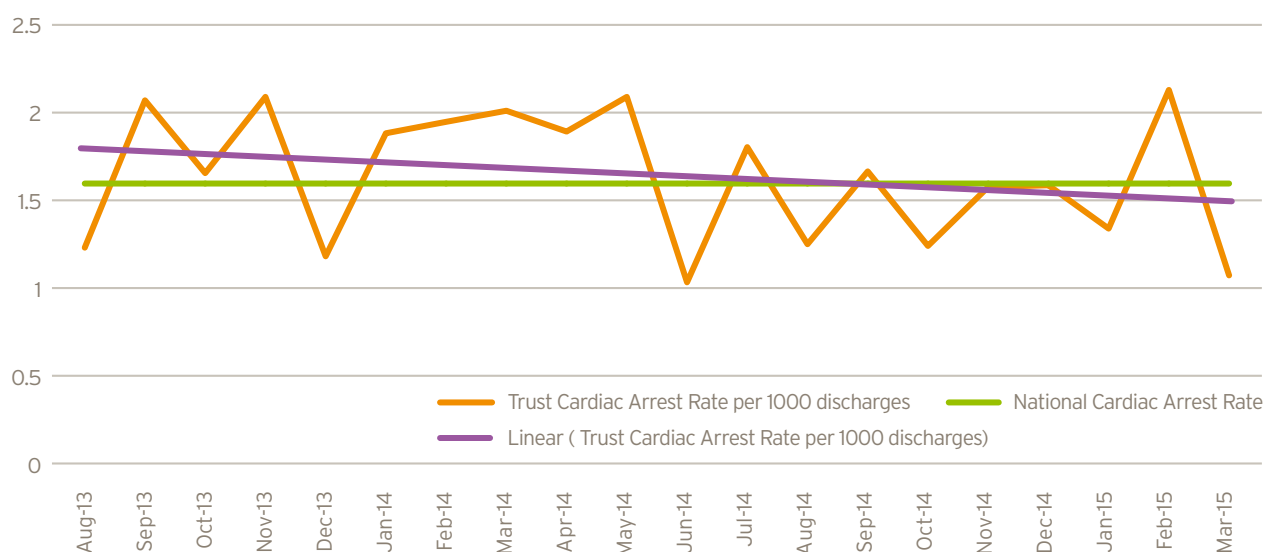
What did we do?

A primary focus of this improvement work was the establishment of a multi-disciplinary analysis of cardiac arrests. This has been instrumental in gaining clinical engagement and has highlighted areas for improvement. A Deteriorating Patient Steering Group has been set up and this group includes key medical and nursing staff from all divisions in addition to the outreach and resuscitation team and meets regularly to plan and review progress against the Improvement Plan.

How did we perform?

Our analysis of the cardiac arrests has shown that the actions implemented have reduced the frequency of potential issues within the process related to observations, timely escalation, medical response times and failure to take appropriate action to prevent further deterioration. This is believed to have contributed to a reduction in the overall cardiac arrest rate from 1.69 to 1.44 per 1000 discharges over the last six months.

Cardiac Arrest Rate



Key Patient Safety Priority 5

Reduce Avoidable Harm caused by prescribing and administration processes by implementing an electronic Prescribing and Medicines Administration (ePMA) system:

Why was this a priority?

Work had been completed to build and test an Electronic Prescribing and Medicines Administration system which made the Drug Chart electronic, with all the attendant safety and process benefits. In 14/15 we planned to complete an initial deployment to an Elderly Medicine

ward for 3 months, and move to the roll-out of this system across all areas, which will take 9-12 months.

What did we do?

- The ePMA system was fully configured for L&D adult patients by the ePMA team, through the building of our unique drug profiles and drug order sets and administration protocols.
- The ePMA pharmacist devised and developed a bespoke e-learning package tailored to the specific needs of nursing, medical and pharmacy staff. This was used for the training of all staff in the relevant ward areas as roll out progressed together with 1:1

- support during the roll out week until all staff were competent and confident in using the system.
- Ward areas were fully scoped and process mapped to identify hardware and equipment needs prior to go live to ensure ePMA supported efficient ward processes for prescribing and administering.
- A schedule of planned benefits realisation was agreed with the Department of Health and audit work to measure the before and after was initiated.

How did we perform?

- The ePMA system was implemented across all wards in Medicine of the Elderly and Surgery as well as Theatres 1-6.
- The implementation has ensured the elimination of transcribing errors
- The implementation has reduced the time taken for doctors to prescribe medications to take away from hospital on discharge
- We have achieved 100% compliance with the requirement to document the allergy status for patients on ePMA
- We are now able to derive accurate patient level drug costs for patients on ePMA.
- The wards will be completed by mid-May 2015.

Priority 3: Patient Experience

Key Patient Experience Priority 1

Revolutionise the outpatient experience for our patients

Why was this a priority?

The Outpatient Transformation programme continued to build on service developments throughout 2014/15. The move to an outpatient operating model where care can occur without the need for a paper record has taken many years to navigate and was delivered during 2014. This will enable a fundamental redesign of supporting processes around outpatients. Further work is ongoing with training and development and in enhancing administrative check in processes to enable clinic reception staff more time to dedicate to delivering a better service and improving the patient experience. This latter innovation was a major focus of development in 2014.

What did we do?

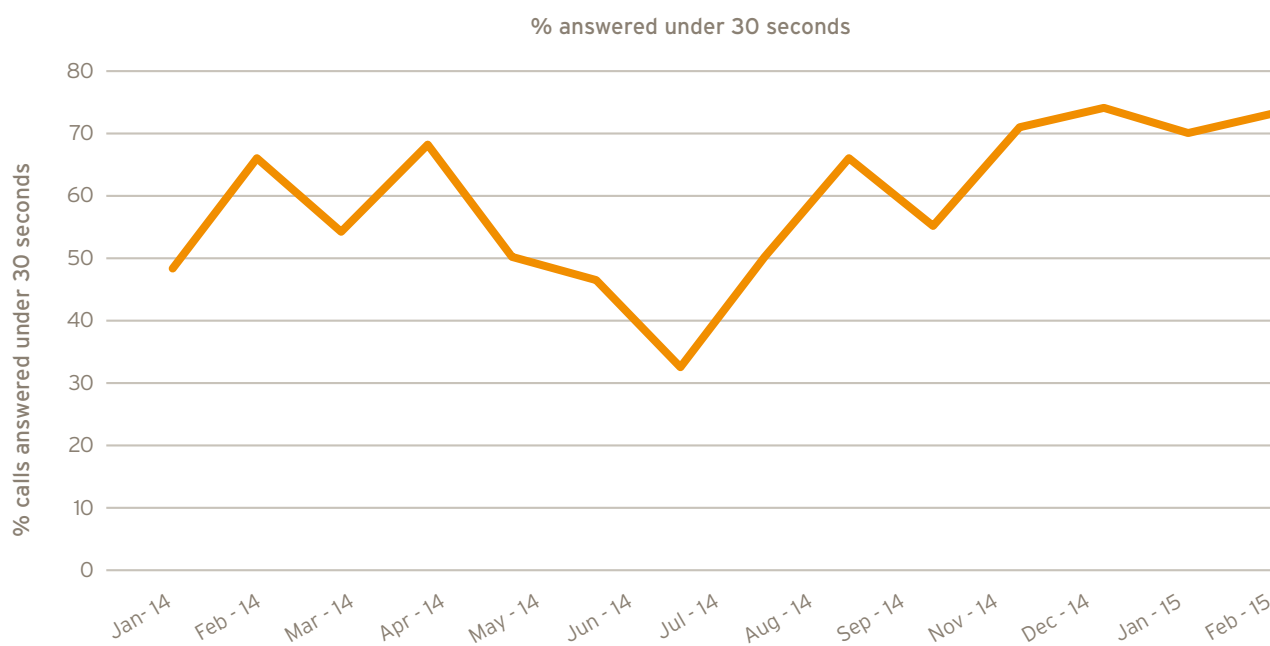
- We commenced the tender to procure remote check-in
- We implemented Bookwise, a room scheduling system to improve access and utilisation of outpatient clinic rooms across the Trust

- We procured an unified communications system to improve telephony and communications within the Trust, to be implemented Q1 15/16
- We introduced partial booking in several specialties, to reduce hospital
- initiated rescheduling of patient appointments, to be further extended in 2015
- We introduced some evening and Saturday clinics
- We introduced electronic transfer of outpatient correspondence to GPs

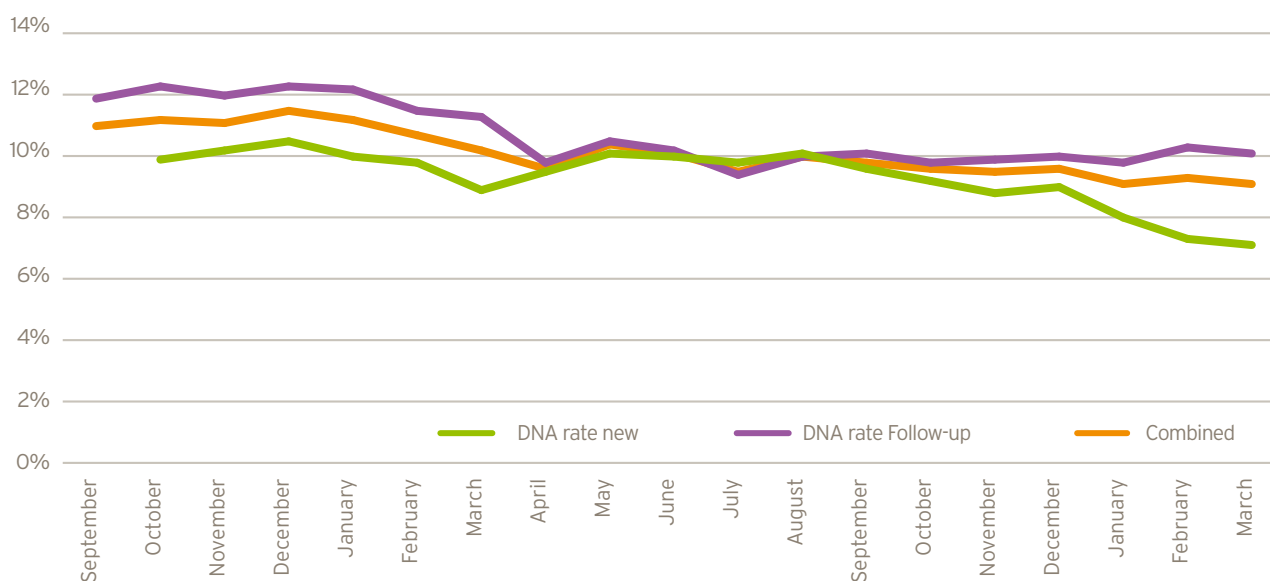
How did we perform?

- We improved performance against the Friends and Family test with 93% of patients reporting that they would likely or highly likely to recommend the Trust
- The Luton Healthwatch survey conducted in Outpatient in November 2014 stated 85% of respondents would recommend the outpatient clinic to their friends and family.
- We have reduced DNA rates during the course of the year This results in the Trust being able to re-assign appointments to other patients when people say they cannot attend resulting in a better patient experience.
- Improvement in the re-booking of appointments cancelled by patients has been consistently achieved
- An outpatient Phlebotomy service has been established in Zone C, the Outpatients area
- Fracture clinic appointment scheduling and waiting times have been dramatically improved
- Partial booking of follow up appointments has been introduced in some specialty areas to reduce multiple rescheduling and improve attendance rates
- Delays to clinic start times are being provided to Divisions for management action as necessary
- Call centre response times are improving

Outpatient Department Call centre performance:



Outpatient DNA rates:



Outpatients Friends and Family score 2014/15 -

% patients attending who are likely and highly likely to recommend the Trust's Outpatient services to friends and family

April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
89%	87%	83%	83%	85%	77%	93%	87%	86%	84%	93%

Key Patient Experience Priority 2

Decrease diagnostic wait times

Why was this a priority?

Fundamental to delivering safe, efficient and effective patient care pathways, reducing length of stay and improving patient experience, is improving the access time to diagnostic services within the Trust. The Imaging department had the challenge of meeting increased demand year on year as new and improved diagnostic services are introduced. In 2014 the imperative was to expand services to meet 24/7 Keogh recommendations and reduce waiting times in line with Trust and Departmental strategic objectives.

What did we do?

- Expanded access to Imaging services, including computerised tomography (CT), Magnetic Resonance Imaging (MRI) and ultrasound was delivered in the last year, improving timely access to services for both inpatients and outpatients 7 days a week.

Both CT scanners were replaced with high specification equipment to enable expanded CT service applications such as CT Coronary Angiography.

- The CT department was refurbished to provide an improved patient environment and facilities.
- The implementation of an outsourced overnight reporting service to protect next day consultant led service continuity
- The review of administrative processes in Imaging demonstrated opportunity to deliver improved service efficiency with the planned introduction of outsourced mailing and self-service check-in facilities.
- The improved reporting resilience at reduced cost with the introduction of a second supplier to provide additional capacity. Consultant's also reconfigured job plans to improve same day in-patient reporting at weekends in tandem with improved in-patient access to scanning 7 days a week.
- We commenced CT coronary angiography test sessions in Q4 in collaboration with Cardiology in preparation of service go-live in April 2015, facilitating service repatriation and improved patient diagnostic and treatment pathways.

How did we perform?

- Waiting times for routine scans have been significantly reduced in year across modalities, with typical waits of around 3 weeks.
- Two week wait performance has largely been achieved throughout the year with increased capacity and expanded development of one stop services.
- Outsourcing of overnight reporting has enabled the department to achieve one hour reporting turnaround times to meet Trauma Network requirements for accreditation purposes.

Key Patient Experience Priority 3

Improve the experience and care of patients at the end of life (EOL) and the experience for their families

Why was this a priority?

End of life care was a priority for the whole health economy in 2013/14. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. However, such decision making is important and engaging patients where they are able, puts them back at the centre of their care. Once these decisions are made, it is crucial that our patients receive optimum end of life care. This year, the focus was on implementing a new care plan and providing training for doctors and nurses.

What did we do?

A multidisciplinary EOL group has redesigned the documentation to ensure patients' wishes and concerns are addressed and recorded. Part of this documentation is the medical care record which has simple prompts that enables the patients' physical, social and psychological needs to be clearly defined. The documentation also encourages the recording of the family's involvement in discussions and ongoing management regarding the patient's care at the most crucial points of their journey.

The nursing care plan ensures that symptom control is regularly reviewed and the plan of care is discussed with the patient and family daily. There has been a wide communication and teaching programme to ensure as many staff as possible are familiar with the revised documentation, the underlying principles of recognition of the dying phase, appropriate communication with and to, the patient and their family and symptom control.

How did we perform?

Six months after the baseline audit, has demonstrated a marked improvement in many aspects of the care of patients at the end of life.

- The three main objectives were to see an improvement in symptom assessment and control. This has improved significantly. Of the fourteen items measured, eleven showed an improvement.
- The second objective was to assess the management of Do Not Attempt Cardiopulmonary Resuscitation (DNAR CPR) and use of the personal resuscitation plans (PRPs) There is evidence that PRPs are increasingly being used.
- The last objective was to demonstrate evidence the patient and their families were supported and conversations recorded. Four out of the five audit standards showed a marked improvement and the remaining one remained the same.

There are still further improvements to be made particularly increasing the recognition of the dying phase and implementing the appropriate assessment of symptoms and anticipatory prescribing. In addition there needs to be an increase in the documenting of conversations regarding advanced care planning with families regarding their wishes and choices. The training has had a positive impact on clinicians being able to discuss some of the concerns they have in dealing with assessment of the dying phase and how they communicate this with families. One area that has been highlighted by the project is to further develop a strategy to ensure all medical staff are updated on changes such as documentation taking into account the rotation of junior staff in training.

3. Priorities for Improvement in 2015/16

Improving clinical outcomes, safety and experience for our patients while delivering value for money is key to the Trust's overarching quality strategy. To meet the short term challenges that we face, we have developed a number of ambitious trust-wide quality priorities. These are based on local as well as national priorities including the need to ensure ongoing CQC compliance and to implement the recommendations from our own internal review of the Francis, Berwick and Keogh reports.

An additional focus on transforming our workforce to deliver our new ways of working and quality priorities will be performance managed across clinical divisions to ensure improvements. The Trust is cognisant that this transformation of services will be challenging and the overall plan and key risks for achieving these quality priorities will be monitored by the Trust Board's Quality Committee.

We have key priorities each for clinical outcome, patient safety and patient experience

Priority 1: Clinical Outcome

Key Clinical Outcome Priority 1

Implement a process for identifying patients with Acute kidney injury (AKI) illness severity and reporting thorough the discharge summaries

Why is this a priority?

AKI is a sudden reduction in kidney function. In England over half a million people sustain AKI every year with AKI affecting 5-15% of all hospital admissions. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. It is a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. AKI can also be viewed as an index condition for assessing the quality of the totality of care for all people with acute illness. There is evidence that care processes can be improved to provide better outcomes. Earlier recognition of illness severity and earlier senior clinical involvement in the care of unwell patients is therefore key to improving the safety, effectiveness and experience of care for patients admitted to hospital as an emergency. This was a key priority for the Trust last year where we focused on implementing a Trust-wide electronic system to improve detection and development of an AKI management care bundle. Building on this work, there are two key priorities for this year. These will focus on improved AKI diagnosis and treatment in hospital, and the provision of a plan of care to monitor kidney function after discharge. This priority is also part of the CQUIN quality initiatives for 2014/15.

What will we do?

- Further develop the current AKI Alerting system which detects when a patient has AKI supporting early clinician recognition
- Support the continued use of the AKI clinical management bundle (evidenced based clinical interventions) which provides clear guidance on the steps to take in managing patients presenting with AKI
- Provide a plan of care for the GP to monitor kidney function after discharge
- Provide Multidisciplinary team (MDT) education and training to support early recognition and effective management of patients presenting with AKI

How will improvement be measured and reported?

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

Success Criteria

- Continued and improved use of AKI Alerting system
- Maintain and improve the 2014/15 90% compliance with AKI care bundle (audit)
- Provision of a plan of care to monitor patient after discharge (CQUIN target)
- Development and uptake of training and educational programme for clinicians

Key Clinical Outcome Priority 2

Implement a new model of integrated care for older people

Why is this a priority?

'Integrated care' is a term that reflects a new way of working that improves patient experience and achieves greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease

During 2014/15, the Trust worked with stakeholders within the Luton and Central Bedfordshire health economy to progress a new integrated model of care for the local elderly population. Progress has been made in the past year in designing a new model of care that will ensure patients receive care that is coordinated and delivered in the most appropriate setting. The work has focused on identifying the population group, gaining consent from patients, finding technical solutions to the sharing of information, reorganising Primary Care

into “Clusters” of GP practices and aligning elderly care consultants to the Clusters. We are now ready to introduce new pathways of care to test the model and implement it across Luton and South Bedfordshire.

What will we do?

- Align our Elderly Care Consultants to the GP Clusters
- Redesign the patient pathway within the hospital to provide continuity of care from one admission to the next
- Consider moving to a Needs Based model of care
- Develop an elderly assessment unit
- Provide daily “hot” clinic facility

How will improvement be measured and reported?

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

Success Criteria

- Continuity of care at Consultant level will be available for elderly patients requiring admission under an Elderly Care Consultant.
- Integrated Teams will have a named Elderly Care Consultant that can provide advice and support to patients whether they are in hospital or the community
- Length of stay within Elderly Care will be reduced from a 2014/15 baseline.
- An increased number of Elderly Care patients will be discharged from the Assessment Unit.

Key Clinical Outcome Priority 3

Implement processes for screening patients for sepsis and ensuring that intravenous antibiotics are initiated within 1 hour of presentation for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock

Why is this a priority?

Sepsis is a common and potentially life threatening condition where the body’s immune system goes into overdrive in response to infection. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 deaths could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis. Early detection and effective management of patients presenting with sepsis will reduce morbidity and mortality of patients presenting as

an emergency admission with this condition. This priority is also part of the CQUIN quality initiatives for 2014/15.

What will we do?

- Implement sepsis screening tools for all patient groups (adult and paediatric) presenting as emergencies to the hospital
- Implement the sepsis care bundle (evidenced based clinical interventions) to all patient groups to support effective and rapid management of all patients presenting with this condition

How will improvement be measured and reported?

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

Success Criteria

- Compliance with appropriate sepsis screening (audit)
- Timely Compliance with sepsis bundle delivery (audit)

Priority 2: Patient Safety

Key Patient Safety Priority 1

Ensure that we have the appropriate level of clinical expertise available to deliver consistent inpatient care irrespective of the day of the week

Why is this a priority?

The Trust believes that patients should be able to access urgent and emergency care services, and their supporting diagnostic services, seven days a week. There is considerable evidence linking poorer outcomes for patients admitted to hospital as an emergency at the weekend, and this variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates. Delivering this ambition in a clinically and financially sustainable way requires transformational change and collaboration between providers of services across the health and social care system.

In line with the Keogh Report standards, the Trust began an implementation programme during 2014/15 and successfully implemented the recommendation in relation to consultant reviews being undertaken within 14 hours of arrival.

A whole system steering group has been established to ensure that efforts to increase service availability seven days a week work in partnership. The National Self-

Assessment tool kit has been completed and 5 areas for focus selected for this financial year. The priorities align with the 10 Keogh clinical standards and will need to be delivered across all organisations.

What will we do?

1. Patient experience - continue to increase senior doctors presence at weekends to support patients and families having access to clinical teams for decision making seven days a week.
2. Diagnostic availability - work towards the availability of x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology seven days a week to achieve the diagnostic test goals.
3. Mental health - improve on the current provision of psychiatric liaison in the Emergency Department and inpatient wards to meet the required standards over seven days.
4. Transfer to community, primary care and social care - continue to work with community colleagues to ensure discharge from hospital is over seven days.
5. Quality improvement - continue to review patient outcomes through the Trust quality governance frameworks.

How will improvement be measured and reported?

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

Success Criteria

- Improvement on the number of emergency patients seen and reviewed within 14 hours of arrival
- Increase in the number of teams providing seven day services
- Increase in patient satisfaction with the services
- Percentage of patients undergoing diagnostics within:
 - 1 hour for critical patients
 - 12 hours for urgent patients
 - 24 hours for non-urgent patients in hospital.
- Complete the baseline audits against the suggested National Key Performance Indicators for 7 day services.

Key Patient Safety Priority 2

Ongoing development of Safety Thermometer, improving performance year on year

Why is this a priority?

The NHS Safety Thermometer continues to provide nurses with a point of care survey tool to check fundamental levels of care, identify where things go wrong and take prompt action. It is used by frontline healthcare workers to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, VTE and who have incurred a fall and sustained harm

We will continue in our use of the monthly Safety Thermometer audits during 2015/16 which will provide on-going measurement of harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE. During 14/15 the Trust consistently delivered above 97 % new harm free care against these four harms

What will we do?

We will continue to use the prevalence data from the Safety Thermometer as an improvement tool to continue to reduce the amount of new harm our patient's experience

- **Pressure Ulcers.** The Trust will continue to reduce the numbers of category 2&3 hospital acquired avoidable pressure ulcers. This will be achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. The Tissue Viability team will also develop their relationship and working with the community Tissue Viability team developing more integrated working and pathways of care. The Trust will continue to participate in a countywide pressure ulcer group to share learning to enable a further reduction of both community and hospital acquired pressure ulcers.
- **Falls.** Whilst some falls are avoidable, reducing falls in an ageing and more frail population with complex health needs, is very challenging. To date the Trust has been successful in reducing the overall number of falls and those falls that result in severe harm. We aim to maintain our current prevalence level focusing our attention on our management of the frail elderly and working with the dementia nurse specialist on at risk dementia patients.
- **Catheter Related Urinary Tract Infections.** We will aim to reduce the number of patients with a urinary catheter to below 15% of all inpatients. The focus

during the year will be targeting areas where high use is noted and challenging practice as well as focusing attention on the Emergency Department to ensure that catheters are used appropriately.

- **VTE.** Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. VTE manifests as either deep vein thrombosis (DVT) or pulmonary embolism (PE), and can be difficult to diagnose. All relevant patients will be risk assessed, prescribed and administered the appropriate preventative treatment. A root cause analysis (RCA) will be undertaken on all hospital associated thrombosis. Lessons learnt will be shared in practice.

How will improvement be measured and reported?

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

Success Criteria:

- The data set from the Safety Thermometer tool will be collected, collated and reported on providing the Trust with a snapshot (prevalence) of the four key 'harms', occurring on a particular day each month in the Trust. These data in conjunction with additional incidence data will then be used to drive improvements in practice and will be reviewed bi monthly as part of the nursing quality assurance framework. Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and reported to the Board.
- Deliver a further overall percentage reduction in harm free care greater than 97% (95% in 2013/14, 97% in 2014/15)
- Deliver a further 10% reduction in the prevalence of hospital acquired, avoidable grade 2 and 3 pressure ulcers
- Maintain the current prevalence of patients who experience a fall and incur harm
- Aim that no more than 15% of all inpatients will have a urinary catheter
- Maintain 95% (minimum) patients to have had a VTE risk assessment and those that are identified as at risk of developing a thrombosis are provided with appropriate prophylaxis

Key Patient Safety Priority 3

Improve the management of the deteriorating patient

Why is this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians' may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2014 -15 has highlighted areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. This was a key priority for the Trust last year where we established a deteriorating patient steering group and an innovative training programme to support improved management of the deteriorating patient. It is now essential to build on this work to achieve further improvements in clinical outcomes.

What will we do?

- Monitor the effectiveness of the new training programme and amend and develop to effectively manage the deteriorating patient pathway.
- Continue measuring the effectiveness of the management of the deteriorating patient
- Address any emerging clinical themes and incorporate into the revised training programme.
- Continue to support the use and development of technology to improve the management of the deteriorating patient
- Improve the identification of the deteriorating patient that is dying. This will be enabled by Increasing and improving the use of the Personal Resuscitation Plan and an appropriate, timely DNAPR in the patient record thus reducing the number of patients with an avoidable cardiac arrest

How will improvement be measured and reported?

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

Success Criteria:

- Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline

- Achieve 20% reduction in avoidable cardiac arrests
- Using 2014-15 data as a baseline achieve 20% reduction in the following elements of the deteriorating patient pathway:
 1. Undertaking timely and appropriate observations
 2. Timely escalation of concerns to medical staff
 3. Timely medical response times,
 4. Failure to take appropriate action to prevent further deterioration

Key Patient Safety Priority 4

Reduce Avoidable Harm by ensuring patient's current medicines are correctly identified, communicated and prescribed at admission

Why is this a priority?

Considerable evidence exists to demonstrate that mistakes are often made in correctly identifying and recording patients' current medicine history when they transfer from one care setting to another. This can lead to patients missing critical medicines which can require extra interventions during their inpatient stay and lead to a longer hospital stay.

What will we do?

- Refine the existing clinical tool for identifying patients at the highest risk of medication related adverse events at admission
- Ensure that patients identified as at high risk of medication related adverse events get pharmacy- led medicines reconciliation within 24 hours of admission Monday to Friday and within 72 hours of a Saturday or Sunday admission.
- Expand provision of pharmacy- led medicines reconciliation for all emergency patients within 24 hours of admission, 7 days a week as part of the Medical Division's project to move to a Keogh compliant 7 day working medical model.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis. Success Criteria:

- Implementation of a reviewed clinical tool for identifying patients at the highest risk of medication related adverse events at admission
- 80% of patients identified by the tool as at high risk of medication related adverse events getting pharmacy- led medicines reconciliation within 24 hours of admission Monday to Friday.

- Approval of a business case to provide pharmacy-led medicines reconciliation for all emergency patients within 24 hours of admission, 7 days a week as part of the Medical Division's move to a Keogh compliant 7 day working medical model

Priority 3: Patient Experience

Key Patient Experience Priority 1

Implement patient focussed booking systems including self check-in and partial booking of outpatient clinics

Why is this a priority?

Patient experience is currently impacted by manual 'checking in' processes when attending Outpatient appointments, involving patients queuing at busy reception desks, potentially leading to delays and clinic inefficiencies. There is opportunity to modernise booking systems through introducing self-check-in and to improve access and choice in scheduling patients' follow up appointments by introducing partial booking.

What will we do?

We will reorganise Outpatient clinic administration processes and develop pathway co-ordinator roles aligned to clinical specialties to best support the roll-out of partial booking and improve timely follow-up.

We will introduce modern automated self check-in kiosks to enable faster patient check-in and to support improved outpatient information, patient tracking and clinic efficiency

How will improvement be measured and reported?

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

Success Criteria

- Roll out of partial booking to at least 50% of clinical specialities in 15/16
- Reduction of DNA rates in each of these clinical specialties, and globally across Outpatients by a further 1%
- Reduction in the volume of patients experiencing multiple clinic rescheduling where partial booking has been implemented
- 70% of patients will utilise self check in by the end of 15/16
- Reduced patient waiting times in clinic

Key Patient Experience Priority 2

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

Why is this a priority?

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. This was a key priority for the Trust last year where we re-designed the multidisciplinary documentation and delivered a Trust-wide communication and teaching programme to nurses and doctors. This year, the focus will be on advanced care planning, improved communication with patients and families and improved symptom management and spiritual care.

What will we do?

- Work with Consultants, the Palliative Care team and Resuscitation team to improve the way we use our 'Personal Resuscitation Plans' more effectively. This will enable the identification of triggers for recognising those patients who may be dying thus allowing for more timely discussions with patients and families regarding DNACPR (Do not attempt Cardio-pulmonary Resuscitation).
- Review and improve the quality of written information that is available for patients and families. This will supplement key discussions regarding End of Life decisions and care.
- Drive improvements in the quality of care through optimum symptom control management. This will focus on ensuring medication is prescribed and administered appropriately for the 5 key symptoms.
- Improve the assessment of individual spiritual needs

How will improvement be measured and reported?

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

Success Criteria

- Increased and improved the use of the Personal Resuscitation Plan and an appropriate, timely DNAPR in the patient record (audit)

- Evidence of the support of dying patients and their families as demonstrated by conversations recorded in the medical notes (audit)
- Reduction in the number of inappropriate cardiac arrests (performance data)
- Portfolio of revised patient and family information (Test the effectiveness of this communication through the Bereaved Relatives survey)
- Improved symptom assessment and control (audit)
- Increased the number of patients who have had an assessment of their spiritual needs (audit)

Key Patient Experience Priority 3

Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with dementia and delirium

Why is this a priority?

Patients with Dementia and Delirium can experience some or all of the following: memory loss, language impairment, disorientation, changes in personality, which leads to difficulties with activities of daily living, and complex care needs. In the later stages of the disease, there are high levels of dependency and morbidity. These care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge. This priority is also part of the CQUIN quality initiatives for 2014/15.

What will we do?

- Continue to assess all emergency patients over the age of 75 yrs for memory problems
- Undertake further assessments to identify patients who have cognitive dysfunction working with primary care to ensure that these patients are appropriately followed up in the memory services
- Work with the primary care services to devise and implement a pathway to ensure patients presenting with memory problems have a care plan after their discharge from hospital.
- Ensure that appropriate dementia training is available to all staff and work with the commissioners to deliver a collaborative training programme across the local health and care economy
- Work with commissioners to devise and implement a survey for carers of patients with dementia, which enables them to provide feedback of their experience across the whole health and social care economy.

How will improvement be measured and reported?

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

Success Criteria

- Improve % compliance regarding the number of patients who are assessed for memory problems on admission from the 2014/15 baseline.
- Improve % compliance regarding the number of patients identified as having cognitive dysfunction referred for further diagnostic advice in line with local pathways and who have a care plan on discharge from the 2014/15 baseline.
- Robust training programme with clarity regarding the level of training for specific staff groups. Improved numbers of staff who have completed the training.
- Survey the carers of patients with dementia to obtain their feedback on their experience as carers of patients with dementia across the whole health economy - feeding back any concerns to the appropriate organisation



4. Statements related to the Quality of Services Provided

4.1 Review of Services

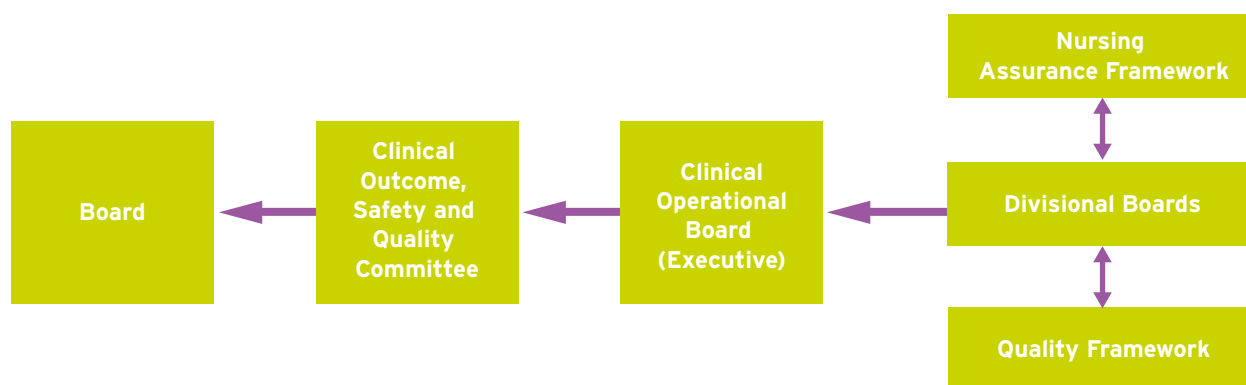
During 2014/15 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes. The Board of Directors considers performance reports every two months including progress against national quality and performance targets. The Board also receives reports from the Clinical Outcome, Safety and Quality sub committee. Quality is managed by the Divisional Boards and the Clinical Operational Board providing assurance to the Clinical Outcome, Safety and Quality Committee.

These reports include domains of patient safety, patient experience and clinical outcome. During 2014/15 the Executive Board commissioned a number of external experts and external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- Medical Equipment Management
- Independent Review of Maternity Services
- Review of Serious Incidents reported in Maternity
- External CQC style peer review as part of the Nursing Quality Framework

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

Quality Assurance Monitoring



The income generated by the NHS services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2014/15.

4.2 Participation in Clinical Audits and National Confidential Enquiries

During the period the Trust was eligible to participate in 32 of the 52 National Clinical Audits that met the Quality Accounts inclusion criteria

The Trust participated in 30 (94%) of the eligible national audits

Clinical audits are a mixture of National and local priorities which each directorate is responsible for as part of their Clinical Audit Forward programme. The data collected for Quality accounts includes mandatory audits on the National Clinical Audit and Patient Outcomes Programme which directorates must participate in. Other audits whether local or national may not have been deemed as high priority or reflects the audits which directorates have prioritised.

Details are provided within the table 1 below.

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	National Institute for Cardiovascular Outcomes Research	Eligible Yes Participated Yes	01/04/2014- 31/03/2015	All	100%
Adherence to (BSCN) /(ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	Association of Neurophysiological Scientists (ANS)/British Society of Clinical Neurophysiologists (BSCN)	Eligible Yes Participated Yes	April 2014 to June 2014	20	100%
Adult Bronchiectasis (not conducted in 2014-15)	British Thoracic Society	Eligible No			
National Adult Cardiac Surgery Audit	National Institute for Cardiovascular Outcomes Research	Eligible No			
Adult Community Acquired Pneumonia	British Thoracic Society	Eligible Yes Participated Yes	Dec-14 to Jan-15	20 consecutive patients	100% +
Adult critical care - Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	Eligible Yes Participated Yes	01.04.2014 - To Date (13.03.15)	All ITU admissions	100% - 399 cases
Bowel cancer (NBOCAP)	Health and Social Care Information Centre	Eligible Yes Participated Yes	Ongoing	All	100%
Fitting child (care in emergency departments)	The College of Emergency Medicine	Eligible Yes Participated Yes	Ongoing	Ongoing	Ongoing
Chronic kidney disease in primary care*	BMJ Informatica	Eligible No			
National COPD (Secondary care audit)	BTS	Eligible Yes Participated Yes	February 2014 - April 2014	187	34
Congenital heart disease (Paediatric cardiac surgery) (CHD)	National Institute for Cardiovascular Outcomes Research	Eligible No			
Coronary angioplasty	National Institute for Cardiovascular Outcomes Research	Eligible Yes Participated Yes	September 2014-March 2014	100%	100%
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)* (not undertaken in 2014/15)	Health and Social Care Information Centre	Eligible Yes Participated Yes			
- NDFA (footcare audit) - July 2014 to Jul 2015		Participated Yes	Footcare July 2014 - July 2015	NDA foot care audit = all	NDA footcare = 37 so far

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	2013-2014	All	100% - 126 cases
Epilepsy 12 audit (Childhood Epilepsy)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	Patients identified during 2013. Data collected retrospectively during 2014	All	100% - 31 cases
Falls and Fragility Fractures Audit Programme (FFFAP)	Royal College of Physicians (London)	Eligible Yes Participated Yes	May-15	100%	100%
Familial hypercholesterolaemia* (not undertaken by the organisation in 2014-15)	Royal College of Physicians (London)	Eligible No			
Mental health (care in emergency departments)	The College of Emergency Medicine	Eligible Yes Participated Yes	Ongoing	50	100%
Head and neck oncology (DAHNO)	Health and Social Care Information Centre	Eligible Yes Participated Yes	Ongoing - however DAHNO de-functioned from Nov 2014	All	100%
Older people (care in emergency departments)	The College of Emergency Medicine	Eligible Yes Participated Yes	Ongoing	Ongoing	Ongoing
Inflammatory bowel disease (IBD)* (Biological Therapies part) Royal College of Physicians (London)	Royal College of Physicians (London)	Eligible Yes Participated Yes	Continuous	10	100%
National Lung Cancer	Health and Social Care Information Centre	Eligible Yes Participated Yes	Continuous	All	100% (131)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	MBRRACE-UK, National Perinatal Epidemiology Unit	Eligible Yes Participated Yes	Jan 14- Dec 14	All Cases	100%
Cardiac Rhythm Management (CRM) (not related to Arrhythmia audit)	National Institute for Cardiovascular Outcomes Research	Eligible Yes Participated Yes	April 2014 to March 2014	All	100% (288)

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Centre for Mental Health and Risk, University of Manchester	Eligible No			
National Audit of Dementia (NAD) (not undertaken by the Organisation in 2014-15)	Royal College of Psychiatrists	Eligible No			
National audit of intermediate care	NHS Benchmarking Network	Eligible Yes			
		Participated No* (1)			
(NCAA)- Audit of In hospital Cardiac Arrests	Intensive Care National Audit & Research Centre (ICNARC)	Eligible Yes	Continuous	All	100%
		Participated Yes			
National Comparative Audit of Blood Transfusion programme:	NHS Blood and Transplant	Eligible Yes			
- Sickle Cell Audit		Participated No* (2)			
- Patient blood Management April 2015 , re-audit 2016,2017					
- Audit of lower gastrointestinal internal bleeding. Sep 2015 -					
National emergency laparotomy audit (NELA)	Royal College of Anaesthetists	Eligible Yes	Ongoing (started 07.01.14 planned to continue until at least end of 2015, possibly another 2 years)	All cases	181 to date (90% submission rate)
		Participated Yes			
National Joint Registry	HQIP	Eligible Yes	2014/15	All cases	100% (1212)
		Participated Yes			
National Vascular Registry*	Royal College of Surgeons of England	Eligible No	NA	NA	NA
Neonatal intensive and special care (NNAP)	The Royal College of Paediatrics and Child Health	Eligible Yes	2014/15	All cases	100%
		Participated Yes			
National Audit of Non invasive ventilation in adults (not conducted in 2014-15)	British Thoracic Society	Eligible No			
Oesophago-gastric cancer (NAOGC)	Royal College of Surgeons of England	Eligible Yes	Ongoing	All	100%
		Participated Yes			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
(NICOR)- National Audit of Heart Failure Data entry to CCAD.	National Institute for Cardiovascular Outcomes Research	Eligible Yes Participated Yes	Jan 14 - Dec 14	All	100% (138)
Ophthalmology	Not yet appointed	Eligible No			
Paediatric intensive care (PICANet)	University of Leeds	Eligible No			
Paediatric pneumonia	British Thoracic Society	Eligible No			
Parkinson disease (National Parkinson's Audit)	Parkinson's UK	Eligible Yes	For 2015/16	100%	100%
		Participated Yes			
Pleural Procedures	British Thoracic Society	Eligible Yes	June 2014 to July 2014	5	100%+ (10)
		Participated Yes			
Prescribing Observatory for Mental Health (POMH)	Royal College of Psychiatrists	Eligible No			
Prostate Cancer	Royal College of Surgeons of England	Eligible Yes	Ongoing	All	100%
		Participated Yes			
Pulmonary hypertension (Pulmonary Hypertension Audit)	Health and Social Care Information Centre	Eligible No			
Renal replacement therapy (Renal Registry)	UK Renal Registry	Eligible No			
National Rheumatoid and early inflammatory arthritis	Northgate Public Services	Eligible Yes	February 2014 to February 2017	All	100% (26)
		Participated Yes			
Sentinel Stroke National Audit Programme (SSNAP)	Royal College of Physicians (London)	Eligible Yes	Jan 14- Dec 14	All	100% (526)
		Participated Yes			
Severe trauma (Trauma Audit & Research Network, TARN)	University of Manchester	Eligible Yes	Ongoing	Ongoing	Ongoing
		Participated Yes			
Specialist rehabilitation for patients with complex needs*	Not yet appointed	Eligible No			

* 1- Funding Issue - The audit incurred a cost for the Trust to participate.

2- Staff shortage - The Trust had fewer Haematology consultants during 2014/15 and the team were unable to support this audit.

Local Clinical Audits

In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of seventeen local clinical audits were completed during the reporting

period which were project managed by the Trust's Clinical Audit Department (Appendix A).

4.3 National Confidential Enquiries

	Topic/Area	Database/ Organiser	% return*	Participated Yes/No
1	Sepsis	NCEPOD	2/5 - 40% **	Yes
	Alcohol Related Liver Disease	NCEPOD	(1/3) 33%	Yes
2	Gastrointestinal Haemorrhage	NCEPOD	2/4 - 50%	Yes
3	Tracheostomy Care	NCEPOD	Insertion - 7/11 (67%) Critical care - 9/11 (82%) Ward - 3/11 (27%)*	Yes
4	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

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

** This study is still open and returns being made

*** There were fewer returns for the ward care questionnaire as most patients did not have the tracheotomy in place by the time they reached the ward.

4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2014/2015 and who were recruited during that period to participate in research approved by a Research Ethics Committee was **708**. This research can be broken down into **143** research studies (**124** Portfolio and **19** Non-Portfolio).

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

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

A proportion of Luton and Dunstable University Hospital income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between the Luton and Dunstable University Hospital NHS Foundation Trust and NHS Luton as lead commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed improvement work. Through discussions with our commissioners we agreed a number of improvement goals for 2014/15.

Goals and Indicators

No	Indicator Name	No	Description	% of the Value
1	Friends & Family Test	1.1	Implementation of Staff FFT	3.0
		1.2	Early Implementation OPD & Daycase	1.5
		1.3	Increased Response Rate FFT in Acute Providers A&E	1.5
		1.4	Increased Response Rate in Acute Inpatient Services	4.0
2	NHS Safety Thermometer	2	Reduction in the prevalence of pressure ulcers Median = 35	5.0

No	Indicator Name	No	Description	% of the Value
3	Dementia	3.1	Find, Assess, Investigate and Refer	2.5
		3.2	Clinical Leadership	0.5
		3.3	Supporting Carers	2.0
4	Acute Kidney Injury	4.1	Prevention (FY1 and FY2 Education)	10.0
		4.2	Detection	10.0
		4.3	Management (training for other healthcare professionals)	10.0
5	Medicines Management	5.1	Medicines Administration Record (MAR) Chart	10.0
		5.2	Medicine Reminder Chart	10.0
6	End of Life	6	Improving End of Life Care	15.0
7	Seven Day Working	7	Assessment by a consultant within 14 hours of admission	15.0

The Trust monetary total for the associated CQUIN payment in 2014/15 was £4,800,000 and the Trust achieved 77.6% of the value.

4.6 Care Quality Commission Registration

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

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

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

No enforcement action has been taken against the Trust during the reporting period April 1st 2014 and 31st March 2015 and we have not participated in special reviews or investigations by the CQC during the reporting period.

The last formal CQC inspection was in September 2013. Two areas of improvement were identified;

record keeping and maternity staffing. We declared full compliance with the standards in January 2014 and the CQC conducted a follow up inspection in August 2014. To date we have not received a formal report back from the CQC against these criteria. However, correspondence indicated that we were assessed as being compliant with the standard for record keeping.

CQC Assessments

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

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

the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

We have in place a CQC self assessment programme for all wards and clinical areas. This involves a three month cycle of self assessment, peer assessment and external peer assessment to support the delivery of performance and the implementation of corrective action in a timely manner. We have reviewed our CQC assessment programme to reflect the revised CQC inspections and these assessments are reported to each Board of Directors meeting.

Intelligent Monitoring

CQC has developed a model for monitoring a range of key indicators about NHS acute and specialist hospitals. They have taken the results of their intelligent monitoring work and grouped the 161 Acute Trusts into six bands based on the risk that people may not be receiving safe, effective, high quality care, with band 1 being the highest risk and band 6 the lowest risk.

During 2014/15, we have received two Intelligent Monitoring Reports in July and December 2014. Both of these reports placed the Trust in band 5. The reports identified PROMs (patient rated outcome measure) for Hip Replacement as an elevated risk and stroke data collection, GMC monitoring and one safeguarding concern as a risk. The Trust responded to and reviewed the issues raised by the CQC and undertook the following actions:

- A review of the PROMs patient level data was undertaken by the lead surgeon for PROMs. No issues of concern were identified.
- The Trust implemented a number of actions to address the issues raised by the GMC. This action plan has been completed and the Deanery have provided the Trust with positive assurance that the concerns have been addressed.
- Any safeguarding concerns identified have been responded to by the Trust and no further action has been required by the CQC.

Non-Executive Assessments (3x3)

The assessment process is further enhanced by Executive and Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.

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

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

During 2014/15 we have taken the following actions to improve data quality:

- Continued our extensive programme of data quality checks and initiatives involving staff and managers at all levels
- Used automated reporting to increase the visibility of any data quality problems.
- Continued to work with Commissioners to monitor and improve data quality in key areas.

NHS Code and General Medical Practice Code Validity

Luton and Dunstable University Hospital NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99.3% for admitted patient care; 99.7% for outpatient care and 97.1% for A&E care.

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

- 99.9% for admitted patient care; 99.9% for outpatient care and 100% for A&E care

Clinical coding error rate

The Luton and Dunstable University Hospital NHS Foundation Trust was subject to an audit carried out by the Trust's accredited auditor with support from an established coding agency.

An error rate of 6.5% was reported for diagnosis coding (clinical coding) and 10% for Procedure coding. This demonstrates good performance when benchmarked nationally.

Information Governance toolkit attainment levels

The Luton and Dunstable University Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2014/15 was 73% and was graded as Achieved - met at least level 2 on all standards. This is satisfactory (green).

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

5. A Review of Quality Performance

Part 3

5.1 Progress 2014/15

A review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness indicators selected by our stakeholders. These indicators were selected in 2009/10 through a survey and the most popular indicators were selected. For 2010/11 to 2012/13 we have continued to follow the selected data sets and any amendments have been described below the table.

Performance Indicator	Type of Indicator and Source of data	2011* or 2011/12	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	2	2	3	3 *****	N/A	The Trust has a zero tolerance for MRSA. During 14/15 the cases were isolated and were due to the clinical cases presented.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	94.6*	97.2*	96*	106*	100	The HSMR scores were 'rebased' in August 2014. The score is not considered an outlier.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	34	17	19	10	N/A	Demonstrating an improving position.
Incidence of avoidable hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	N/A	51**	30	19	N/A	Demonstrating an improving position.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	0	4	4	3	N/A	Demonstrating an improving position.
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.5	1.8	1.6	1.6	N/A	Maintain the good performance.
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	4.2 days	3.7 days	3.6 days	3.4 days	N/A	Demonstrating an improving position in line with the Trust plans.

Performance Indicator	Type of Indicator and Source of data	2011* or 2011/12	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	National Average	What does this mean?
Rate of falls per 1000 bed days	Clinical Effectiveness Trust Board Report	5.92	5.5	4.87	4.25	N/A	Demonstrating an improved performance.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (n)	Clinical Effectiveness	77.7%	78.3%	84.7%	79.5%	Target of 80%	Narrowly missed the target for 2014/15, plans are in place to ensure that we maintain this target for 2015/16.
% of fractured neck of femur to theatre in 36hrs (n)****	Clinical Effectiveness Dr Foster	N/A	80%	82%	75%	N/A	There has been a slight reduction that has not impacted on the Trust mortality rate of 61 as at March 2015.
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	66.5*	52.5*	76*	79*	100	A rate below 100 is above average performance.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	78.7*	87.7*	91*	109*	100	The HSMR scores were 'rebased' in August 2014. The score is not considered an outlier.
Readmission rates*: Knee Replacements Trauma and Orthopaedics (n)	Clinical Effectiveness Dr Foster	5.5%	11.4%	4.7%	6.7%	N/A	There has been a slight increase. A review of Trust data has been undertaken and no concerns were identified.
% Caesarean Section rates	Patient Experience Obstetric dashboard	26.5%	25.5%	25.7%	27.8%	25%	Ongoing monitoring is in place but the level is reflective of the Trust Level 3 NICU status.
Patients who felt that they were treated with respect and dignity***	Patient Experience National in patient survey response	8.7	8.7	9.0	8.9	Range 8.2 - 9.8	Maintaining a good performance and in line nationally.

Performance Indicator	Type of Indicator and Source of data	2011* or 2011/12	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	National Average	What does this mean?
Complaints rate per 1000 discharges (in patients)	Patient Experience Complaints database and Dr Foster number of spells for the year	3.56	3.62	7.01	7.12	N/A	This is an expected increasing following the work to encourage patients to let the Trust know of any issues.
% patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	7.8	8.0	7.9	7.8	Range 7.1 - 9.2	Ongoing review by the wards with recognition that observation requirements during the night to have to be adhered to that may result in patients being disturbed.
Venous thromboembolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95% by Q4	Achieved >95% all year	Achieved >95% all year	Achieved >95% all year	N/A	Maintaining a good performance.

(n) Denotes that this is data governed by standard national definitions

* Denotes calendar year

** The pressure ulcer metrics have changed for the last 3 years so the data is not comparable year on year. The figure in the 2011/12 quality account represents all hospital acquired grades 3 and 4 pressure ulcers. Therefore these data have been removed. The 2012/13 data represents all **avoidable** hospital acquired grade 3 and 4 pressure ulcers. The judgement about the avoidable/unavoidable classification is undertaken using root cause analysis, based on national criteria and all decisions are validated by the commissioners.

*** Patients who felt that they were treated with respect and dignity is now reported in place of % patients who would rate the service as excellent, very good or good (in-patients). This is no longer asked within the national annual in-patient survey.

**** The data for 2013/14 has measured the % of patients taken to surgery within 36 hours rather than 24 hours in previous years. This is in line with the Department of Health's best practice tariff.

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

5.2 Major quality improvement achievements within 2014/15

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Sir Robert Francis QC was published on 6 February 2013 and made 290 recommendations. The report focussed on the need for clearly understood standards and measures of compliance, the importance of openness and transparency and the need to improve nursing and strong patient-centred healthcare leadership. This was followed more recently by the Don Berwick report, A Promise to Learn - Commitment to act: Improving the Safety of Patients in England.

Since the original report, there have been a number of further reports; the Governments Response to the Francis Report, Cavendish Report, Berwick Report, Keogh Report, Clwyd-Hart Report and 'Freedom to Speak Up'. In response, the Trust has put in place a number of governance changes and improvement initiatives.

Mortality Board

The Mortality Board was established in May 2013 and has continued to meet throughout 2014/15. The Mortality Board oversees a programme of work aimed at supporting reductions in avoidable mortality. The importance of monitoring and understanding mortality is a key part of ensuring the safety and quality of services for patients. The Board, chaired by the CEO and with wide representation from the divisions, focuses on higher than expected mortality rates and uses case note reviews and the IHI Global Trigger tool as the core methodology. During the year, all of the reviews identified that the Trust has no causes for concern regarding the care that was being received by our patients.

Complaints Board

We have always valued the importance of receiving feedback from patients regarding their experience. We do however, believe it is particularly important to listen to patients when they complain about care or treatment and to work quickly to respond and to learn. This was also a key factor in the Francis Report to alert the Board to 'warning signs'.

Over a period of years we have received good feedback on the quality of our response to complaints, however, we have struggled to respond in a timely manner. The Board approved a group to focus on how we manage complaints and most importantly, on how we learn as an organisation when care and treatment has fallen short of the standard that we want to provide to every patient, all of the time.

The Complaints Board continues to see improvements in the management of complaints by the Divisions. The General Managers have reviewed the governance of complaints at divisional level and have identified the appropriate forums to discuss complaints and extract the learning. A small sub group of the Complaints Board is looking at a way of introducing organisational wide learning linked to our complaints, incidents and patient experience feedback.

When the final report, A Review of the NHS Hospitals Complaints System - Putting Patients Back in the Picture by the Right Honourable Ann Clwyd MP and Professor Tricia Hart was published in October 2013. We were encouraged by the number of recommendations we already have in place and the Complaints Board will consider all recommendations for action.

Transforming Quality Initiative

We have established a Trust wide 'Transforming Quality Initiative' reporting to the Executive Board. The initiative is not intended to duplicate our formal governance processes but to support them in ensuring we deliver the highest possible standard of care. The initiative has three components, a core group consisting of managers/leaders, a reference group made up of staff who are well positioned to provide 'reality checks' and a small group of champions who will spread change and improvement across the hospital.

The initiative is developing a number of workstreams, including: raising concerns, communication and engagement, privacy and dignity, engaging junior doctors and estate improvements.

Patient Safety - Raising Concerns

Patient Safety has been at the heart of L&D for many years and we have established numerous initiatives and processes to support staff in delivering harm free care. We have, however, acknowledged that some of our processes relating to reporting incidents and near misses can be time consuming and complex, which means that at times, staff do not speak up and the opportunity to avoid future errors is lost.

During 2015, the Chief Executive Officer therefore decided to write to all our staff asking them to tell her (confidentially) if they believe a patient has suffered harm or if there has been a near miss and they do not feel confident that the incident is being properly addressed. In writing to staff she pledged to provide feedback to those who contacted her. To date, this initiative has led to the establishment of boarder 'listening exercises' focussing on clinical and staff management issues.

Patient Safety Rules

During 2014, we commenced our patient safety breakfasts. Each breakfast focuses on two patient safety incidents and the learning that has occurred as a result of the incidents presented. In March we launched the concept of Patient Safety Rules. A rule will be developed where learning had informed the need for an explicit process change. During 2014 there were two patient safety incidents that fell into that category. We have also decided that where possible, we will name the 'rule' after the patient involved, providing that the patient or the patient's family find this acceptable. We believe that this will help to keep the learning active within the hospital. Our first two rules are: 'The Allnutt Rule' relating to the removal of peripherally inserted central catheter 'PICC' lines and the 'Marek Rule' relating to consultant reviews during holiday periods.

The implementation of Patient Safety Rules will be monitored closely and reported to the Board of Directors and the Clinical Outcome, Safety and Quality Committee.

Responding to the Cavendish Report

From February 2015, all HCA's have been undertaking an induction certificate in line with the Care Standards outlined in the Cavendish Report. They will then be put on an apprenticeship to meet the Certificate of Fundamental Care standards. The job offer letters all now include that permanent jobs will only be offered to those who have completed the Certificate and the Induction programme has been amended to meet the standards of the certificate.

5.3 Friends and Family Test

The Friends and Family Test (FFT) is a national initiative that gives patients the opportunity to provide us with real time feedback about their experience of our services. It gives the Trust the opportunity to rectify problems quickly. Information is analysed to identify recurring themes at ward or departmental level, as well as issues that appear to affect services across the whole Trust.

FFT was first introduced at the L&D during 2012/13, seeking feedback from adults who had been inpatients. This was extended to both the Accident and Emergency Department and Maternity Services, followed by inclusion of patients who had received Day Case procedures and those who had been seen in Outpatients. Since October 2014 we have implemented the FFT across the entire Trust with the aim of ensuring that all our patients are given the opportunity to identify whether or not they would recommend our service to their friends or family. FFT results for these additional areas will be included in the reports, which are publicly available, to be published from April 2015.

At the L&D, the FFT feedback is collected in a variety of ways: on paper forms; online through the hospital website and through telephone calls made to patients by staff from our Patient Experience Call Centre. The call centre staff gather information 48 hours after patients are discharged using a semi-structured survey approach, and which includes the FFT question.

The FFT question posed to patients is:

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

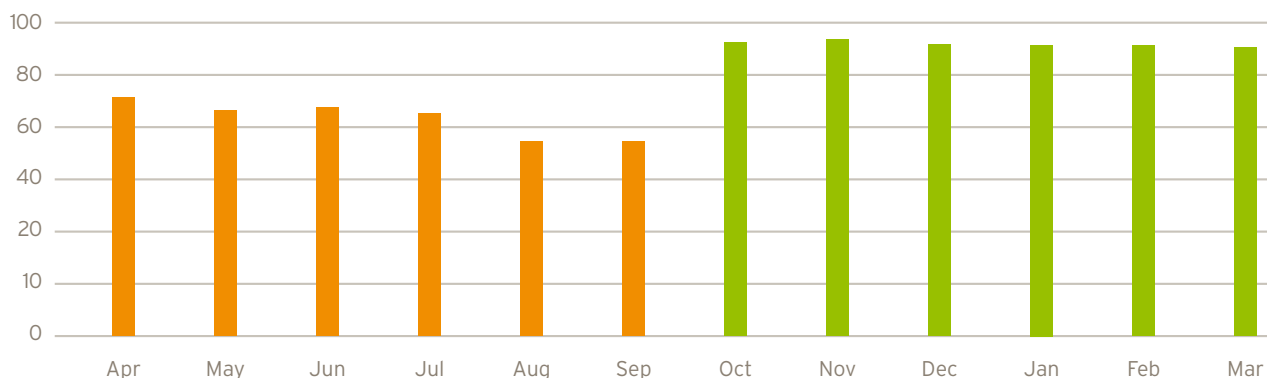
The question is adapted slightly for children's areas and an easy read version is available if required. There are free text boxes on the form providing patients with the opportunity to leave comments.

A quarterly report of the patient experience feedback is reviewed at the Clinical Outcomes, Safety and Quality Committee and by the Patient and Public Participation Group. Results are reported monthly to NHS England and locally on the Trust website and NHS Choices.

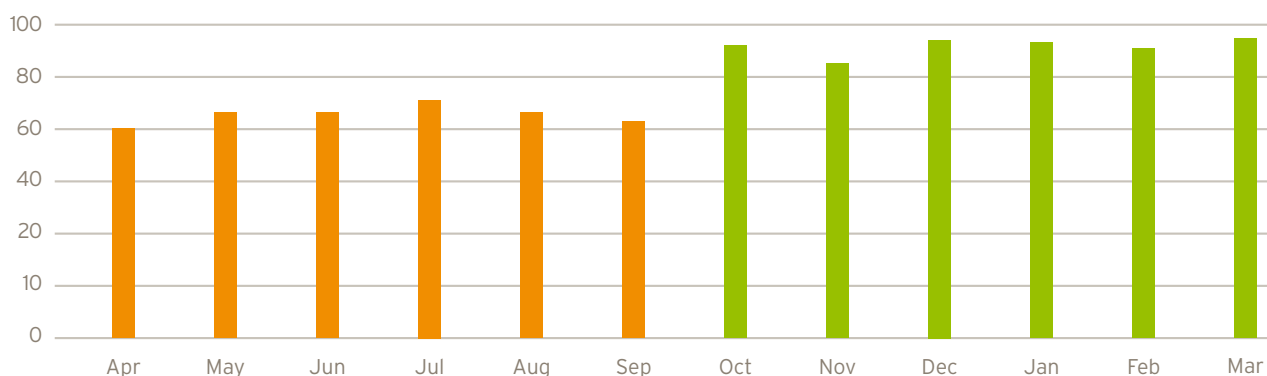
Previously, the results for FFT were published as a Net Promoter Score (NPS). However, the score was difficult to understand and this led to a review by NHS England. The scores are now shown as a percentage of people who would or would not recommend the Trust. Tables 1-3 show the monthly headline scores. This is reported as NPS until September 2014, and as a percentage of patients who would recommend from October 2014.

In March 2015 the Trust achieved a response rate of 44.6% for inpatients, 17.1 % for A&E and 33.6% for Maternity. In response to the lower response rates in A&E, the Trust implemented a number of actions to improve:

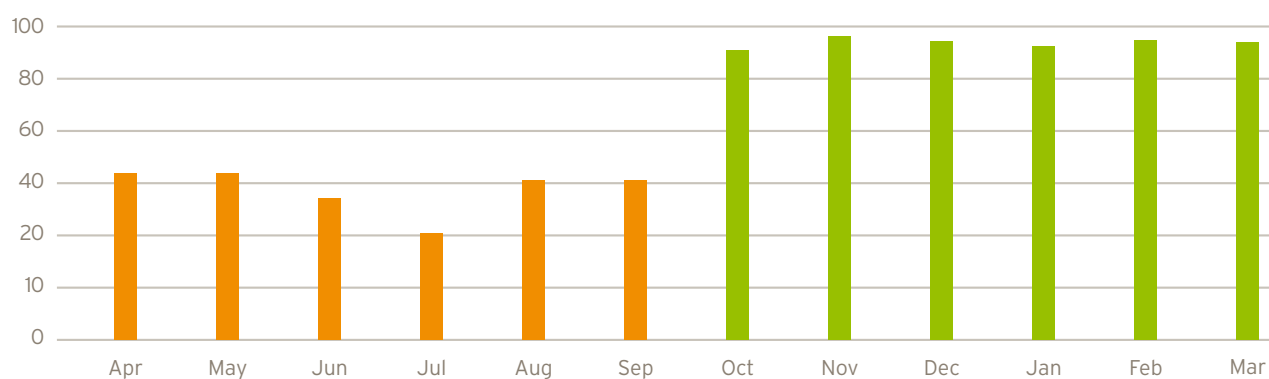
- Chief Nurse and Matron leadership of the importance of the cards and feedback
- Consistent reporting back to the team the comments feedback and the positive scores to reinforce the learning opportunities
- Support from the Patient Experience Manager in ensuring the processes in place in A&E enable the completion of the cards

Table 1 Inpatients**Inpatient FFT Scores 2014/15****From April to September show NPS Score. From October to March shows % Recommend**

* Tables 1 shows the monthly headline score, reported as NPS until September 2014, and as a percentage of patients who would recommend from October 2014.

Table 2 Accident and Emergency**A/E FFT Scores 2014/2015****From April to September shows NPS Score. From October to March shows % Recommend.**

* Tables 2 shows the monthly headline score, reported as NPS until September 2014, and as a percentage of patients who would recommend from October 2014.

Table 3 Maternity**Maternity FFT Scores 2014/15****From April to September shows NPS Score. From October to March shows % Recommend.**

* Tables 3 shows the monthly headline score, reported as NPS until September 2014, and as a percentage of patients who would recommend from October 2014.

The following are examples of action taken in response to feedback about individual wards received through the Patient Experience Call Centre:

- An appointment system for relatives to speak to the Consultant so that the patient and relatives know that when they arrive on the ward they will be able to speak to a Doctor at that time.
- Shelves have been installed in bathrooms for patients to place their possessions.
- A range of initiatives have been implemented to support the needs of our patients living with dementia and which also help to provide a more restful environment for all patients on the wards.
- Additional armchairs have been purchased in one ward in response to feedback about uncomfortable seating.
- Nursing safety briefings have been introduced along

with a communication book for recording questions for doctors. This was in response to feedback which raised poor communication between doctors and nurses as a specific concern.

National Inpatient Survey 2014

The report of the L&D inpatient survey was received on the 13th April 2015 and the results detailed in the table below are published by the Care Quality Commission. Detailed management reports are shared internally and action plans developed by divisions and reviewed and monitored at Clinical Outcomes, Safety and Quality meetings. Patients who were treated in July 2014 were surveyed. 850 patients were invited to participate and 330 responded, representing a response rate of 41%.

Results of the national in-patient survey 2014

Results of the national in-patient survey 2014

Category	2010	2011	2012	2013	2014	Trust year on year comparison	Comparison other NHS hospitals
The emergency / A&E department, answered by emergency patients only	7.3	7.1	8.4	8.4	8.2	Decreased	The same
Waiting lists and planned admission, answered by those referred to hospital	6.7	6.3	9.0	9.1	8.9	Decreased	The same
Waiting to get to a bed on a ward	7.3	6.6	7.0	6.5	7.1	Increased	The same
The hospital and ward	8	7.8	8.1	8.1	8.0	No change	The same
Doctors	8.4	7.9	8.2	8.4	8.4	No change	The same
Nurses	8.3	7.9	8.1	8.2	8.1	No change	The same
Care and treatment	7.3	7.1	7.5	7.6	7.6	No change	The same
Operations and procedures, answered by patients who had an operation or procedure	8.1	8.3	8.3	8.2	8.4	Increased	The same
Leaving hospital	6.8	6.8	7.0	7.1	6.8	Decreased	The same
Overall views and experiences	6.5	6.0	5.5	5.5	5.5	No change	The same

Note all scores out of 10

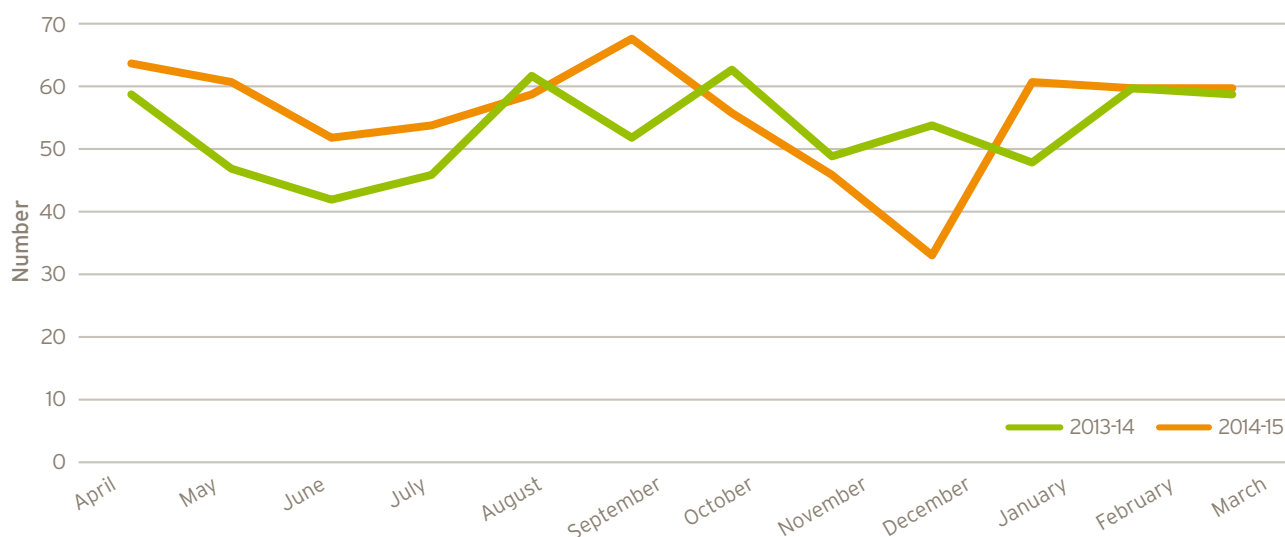
Hospital and Ward category asks questions about cleanliness, hospital food and sleeping areas. The category Doctors and Nurses includes questions on confidence and understanding staff and Care and Treatment covers privacy, information on treatment and decisions about care.

5.5 Complaints

During 2013/14 it was recognised that whilst the quality of responses was good, continued work was required to reduce the length of time taken to provide a response. This was made a quality priority and is reported within part 2 of the quality account.

During 2014/15 we received formal complaints 663 compared to 639 in 2013/14. Reviewing the numbers by month identifies that on six occasions the level of complaint activity was higher than the previous year, partly due to the impact of reports such as Francis, Berwick and Keogh, but also due to the Trust's ongoing drive to encourage patients to 'speak up' and provide information about their concerns.

Complaints per Month



Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. During the reporting period, we received 675 formal complaints. A breakdown of complaints (by month, by category) is contained within the Quality Account.

All complaints were thoroughly investigated by the General Manager for the appropriate division involved and a full and honest response letter was sent to the complainant.

The majority of our complaints were resolved at local resolution level; however, seven complainants asked the Parliamentary and Health Service Ombudsman to review their complaints. Following the Case Manager's Assessment (the first stage of the process) the Ombudsman declined to investigate one complaint; two complaints are awaiting a decision for an investigation and four complaints are currently being investigated by the Ombudsman.

The data collated throughout the year highlights that there is further action that needs to be undertaken to improve the consistency of achieving the timescales for responding to complaints. However, the quality of the investigations being carried out and the standard of those responses remain very high.

As a result of the concerns raised by patients or relatives through the complaints process, improvements have been made – for example:

- The Early Pregnancy Clinic is now able to perform scans at weekends.
- The creation of 144 additional car parking spaces

for staff and an additional 100 spaces for patients and visitors.

Compliments

During the reporting period over 5000 compliments were received which, if not received directly by the staff or service, are cascaded to the staff and/or service involved by their respective manager.

Below are some extracts from compliment letters received recently:

"I thought I would write to you and express my great feelings of gratitude and joy at the way I was cared for in the Stroke Unit, Ward 17, by all the staff, night and day."

"Please convey our most grateful thanks to the surgeons, doctors, nurses and ward assistants who cared for us during the ... period that we were in your hospital. Their skill, dedication and good humour played a major part in our recovery. We are also most grateful for the high standard of the meals provided and the excellent choices available."

"We were dealt with efficiently and courteously by all staff we came in contact with throughout our stay. The NHS is under severe pressure and subject to criticism, particularly A&E. In view of our outstanding treatment we felt we ought to write to you in order to make you aware and also ask that you pass on our thanks to your staff in the front line."

"I would like to say how impressed we both were with the care and attention my mother received. It is understandably a worrying time when you are asked to return to have a further investigation. Everyone at the (Breast) Clinic were so professional in their approach to us, and at the same time showing my mother care and kindness."

Complaints related to patients who have a learning disability (LD):

There have been 2 complaints in 2014/15 related to the care of patients with a learning disability, compared to 4 in the previous Financial Year. The Trust has implemented key processes to support patients who have a learning disability and their families:

- A record of all patients who are in the Trust is kept. These patients are visited daily by a senior nurse who liaises with the family/carers and ensures that all care needs are planned, delivered and clearly documented.
- The learning disability nurses receive a daily LD Patient Activity report, and in addition they receive a weekly report of upcoming learning disability outpatients; this enables them to be present to support at these appointments or to assist with planning admission.
- At the end of each week, the LD Nurses forward a report to the Corporate Nursing Team to keep them informed of patient activity and highlight areas of good practice or areas of concern.
- The elective care pathway for adults with a learning disability has been developed that has involved significant work with teams to ensure that all aspects of the pathway meet the needs of this patient group. This has included diagnostics, pre-assessment, admission, theatres, recovery, post surgery care and discharge. Working with partners in the community to influence pre-admission communication and preparation has been extremely beneficial.
- Quarterly 'coffee mornings' are also held where our patients with a LD have the opportunity to discuss their experience as in-patients and outpatients that continues to be influential in changing practice. Feedback from these are reported directly to the Safeguarding Adults Board in the hospital to ensure it remains high profile.
- The introduction of LD Champions throughout the Hospital was a key target for 2014/15; the LD Nurses have developed a 'Guide to the role of LD Champion' and are engaging with ward and department managers to encourage staff to enrol as a LD Champion.



5.6 Performance against Key National Priorities 2014/15

		2011/12	2012/13	2013/14	2014/15	Target 14/15
Target 1: Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	34	17	19	10	19
Target 2: MRSA	To achieve contracted level of 0 cases per annum	2	2	3	3*	0
Target 3: Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	98.3%	99.6%	99.8%	100%	96%
Target 4: Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	87.5%	90.3%	91.5%	91%	85%
Target 5: Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	96.7%	95.6%	95.7%	95.5%	93%
Target 6: Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	98%	98.9%	100%	98.9%	94%
	Anti-cancer Drugs	98.2%	99.8%	100%	100%	98%
Target 7: Patient Waiting Times	Referral to treatment -percentage treatment within 18 weeks - admitted	NA	Target achieved in all 12 months of the year	93.6%	94.1%	90%
Target 8: Patient Waiting Times	Referral to treatment -percentage treatment within 18 weeks - non admitted	NA	Target achieved in all 12 months of the year	97.1%	96.8%	95%
Target 9: Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	NA	Target achieved in all 12 months of the year	96.5%	96.9%	92%
Target 10: Accident & Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	96.6%	98.5%	98.4	98.6%	95%
Target 11: Learning Disability	Compliance with requirements regarding access to healthcare for people with a learning disability	Achieved	Achieved	Achieved	Achieved	Achieved

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

5.7 Performance against Core Indicators 2014/15

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

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

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
Value and banding of the SHMI indicator	Published Apr 13 (Oct 11 - Sep 12)	102.78	100	68.49	121.07	2
	Published Jul 13 (Jan 12 - Dec 12)	103.35	100	70.31	119.19	2
	Published Oct 13 (Apr 12 - Mar 13)	102.12	100	65.23	116.97	2
	Published Jan 14 (Jul 12 - Jun 13)	102.80	100	62.59	115.63	2
	Published Oct 14 (Apr 13 - Mar 14)	102.10	100	53.90	119.70	2
	Published Jan 15 (Jul 13 - Jun 14)	102.40	100	54.10	119.8	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level (<i>The palliative care indicator is a contextual indicator</i>)	Published Apr 13 (Oct 11 - Sep 12)	12.4%	19.2%	0.2%	43.3%	N/A
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 - Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 - Jun 13)	12.6%	20.6%	0%	44.1%	N/A
	Published Oct 14 (Apr 13 - Mar 14)	13.7%	23.9%	0%	48.5%	N/A
	Published Jan 15 (Jul 13 - Jun 14)	14.7%	24.8%	0%	49%	N/A

The Luton and Dunstable University Hospital considers that this data is as described for the following reason:

- This is based upon clinical coding and the Trust is audited annually.
- The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- Improving mortality rates, including HSMR remains one of the Trust quality priorities for 2014/15 and the Mortality Board maintains ongoing oversight of any indicators that flag as an outlier.

Indicator: Readmission rates

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 - 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2010/11	10.16	11.17	13.00	0.0%
	2011/12	10.64	11.26	13.50	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:

- This is based upon clinical coding and the Trust is audited annually.
- The hospital participated in a 2 day system wide audit with GP's, consultants and other clinical staff to review hospital readmissions and establish causes of the readmissions.
- The Trust does not routinely gather data on 28 day readmission rates

The Luton and Dunstable University Hospital has taken the following actions to improve this percentage, and so the quality of its services, by:

- We will continue to work with our commissioners to prevent unnecessary readmissions to hospital through admission avoidance services available for patients to access. These include Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team, the Hospital at Home service, provider support in the Emergency Department and the integrated models of care

*The most recent available data on The Information Centre for Health and Social Care is 2011/12

Indicator: Patient Reported Outcome Measures (PROMs) scores

PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Groin hernia surgery	2010/11	0.110	0.085	0.156	-0.020
	2011/12	0.12	0.087	0.143	-0.002
	2012/13	0.09	0.085	0.157	0.014
	2013/14	0.079	0.085	0.139	0.008
	2014/15*	0.088	0.081	0.125	0.009

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Varicose vein surgery	2010/11	**	0.091	0.155	-0.007
	2011/12	**	0.095	0.167	0.049
	2012/13	**	0.093	0.175	0.023
	2013/14	**	0.093	0.15	0.023
	2014/15*	**	0.1	0.142	0.054
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14	0.369	0.436	0.545	0.342
	2014/15*	**	0.442	0.51	0.35
Knee replacement surgery	2010/11	0.325	0.299	0.407	0.176
	2011/12	0.313	0.302	0.385	0.181
	2012/13	0.321	0.319	0.409	0.194
	2013/14	0.297	0.323	0.416	0.215
	2014/15*	**	0.328	0.394	0.249

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- Results are monitored by the Clinical Audit and Effectiveness Group
- Results are monitored and reviewed within the surgical division

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- Reviewing these results in both high level committees and within the surgical division.
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings.
- Patient level data is scrutinised and surgical team performance reviewed.
- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

* Relates to April to September 2014 (most recent data published in February 2015 by HSCIC)

** Score not available due to low returns

Indicator: Responsiveness to the personal needs of patients during the reporting period

This measure is taken from the National Inpatient Survey and is scored based on the response to five key questions:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Responsiveness to the personal needs of patients.	2010/11	74.1	75.7	87.3	68.2
	2011/12	71.7	75.6	87.8	67.4
	2012/13	73.5	76.5	88.2	68
	2013/14	74.2	75.9	87	67.1
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The source of the data is the National In-Patient Survey.

The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:

- The Trust has introduced Electronic Prescribing system and that has improved timeliness of available medications for patients to take home
- The Patient Experience Team now visit clinical areas to support patients whilst they are in hospital with any issues to improve their experience and resolve issues quickly.
- Reviewing the capital programme to assess the high risk environmental areas that need attention.

*The most recent available data on The Information Centre for Health and Social Care is 2013/14

Indicator: Staff recommendation

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of staff who would recommend the Trust as a provider of care to family and friends when compared to other acute providers.	2010/11	57%	66%	95%	38%
	2011/12	57%	65%	96%	33%
	2012/13	61.5%	63%	94%	35%
	2013/14	67%	67%	89%	38%
	2014/15	67%	65%	89%	38%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The source of the data is the National Staff Survey.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- The hospital runs with a clinically led, operating structure.
- The Chairman and Non-Executive Directors have a programme of 3 x 3 clinical visits [3 hours every three months] and the experiences of each visit is reported to the Clinical Outcomes, Safety and Quality Committee.
- Transforming Quality Core Group in place working on a number of workstreams to support staff engagement.

Indicator: Risk assessment for venous thromboembolism (VTE)

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of patients who were admitted to hospital and who were risk assessed for VTE.	2010/11 - Q4	90.3%	80.8%	100%	11.1%
	2011/12 - Q4	96.1%	92.5%	100%	69.8%
	2012/13 - Q4	95.3%	94.2%	100%	87.9%
	2013/14 - Q4	95.1%	96.1%	100%	74.6%
	2014/15 - Q4	95%	96%	100%	74%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- There is a robust process for capturing the evidence of completion

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- The hospital has and will continue to ensure that all clinical staff are aware of the importance of timely VTE risk assessment of patients. This is undertaken at induction and through clinical bedside teaching.
- There is daily clinical review and for any patient that have not been risk assessed, there is a follow up action to ensure that this is undertaken; this has resulted in achieving 95% and throughout 2014/15.
- We are reviewing the possibility of an electronic solution to the risk assessment process.
- We undertake root cause analysis on all patients that develop a VTE.

Indicator: Clostridium difficile infection rate

The rate for 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score(best)
Rate for 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	4.9+	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The accuracy of the data is checked prior to submission. The data is also cross checked with laboratory data and verified before reporting to the Board.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- maintaining C.difficile high on the training agenda for all healthcare staff
- rigorously investigating all cases of C.difficile through the RCA mechanism and actioning all learning points identified
- assessing all patients suspected of C.difficile infection when alerted
- uncompromisingly isolating suspected cases of C.difficile when first identified
- attending the CCG Infection Control Network with its potential for shared learning
- monitoring high standards of environmental cleaning (including equipment) and exploring other mechanisms of reducing C.difficile contamination further

*Data not available on Health and Social Care Information Centre + Local Data

Indicator: Patient safety incident rate

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.

	Reporting period	L&D Score	National Average	Lowest score (worst)	Highest score (best)
Total number and rate of patient safety incidents (per 100 admissions) when benchmarked against medium acute trusts	2010/11	6.62	5.9	2.14	12.87
	2011/12	8.56	6.4	2.21	13.01
	2012/13	10.79	7.2	1.68	16.73
	2013/14	8.7	7.8	1.2	17.1
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*

	Reporting period	L&D Score	National Average	Lowest score (worst)	Highest score (best)
Total number and rate of patient safety incidents resulting in severe harm or death (per 100 admissions) when benchmarked against medium acute trusts	2010/11	0.03	0.04	0.17	0
	2011/12	0.03	0.05	0.31	0
	2012/13	0.03	0.05	0.26	0
	2013/14	0.03	0.05	0.38	0
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The hospital reports incident data and level of harm monthly to the National Reporting and Learning System
- 46 serious incidents were reported in 2014/15 compared to 36 in 2013/14 and 47 for 2012/13.
- 19 avoidable and unavoidable grade 3 and 4 pressure ulcers were reported through the serious incident process during 2014/15 a reduction from 30 in 2013/14.
- The Trust had no never events reported.
- The Trust is required to provide a formal report to the commissioners about each serious incident within 45 days. During 2014/15 12 reports did not meet this deadline. The Trust has reviewed their processes in line with new guidance issued in March 2015 and have plans in place to address this target.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- The hospital has a low level of serious harm or death, however strives to continue to improve this through improved falls prevention, pressure ulcer avoidance mechanisms and improved learning from serious incidents.
- The hospital is a high reporting organisation and this demonstrates a culture of patient safety and openness. The hospital continues to ensure that patient safety is a quality priority and will continue to drive improvements through

*Data not available on Health and Social Care Information Centre

5.9 Embedding Quality - Workforce factors

Staff continue to be our most valuable asset when it comes to delivering a high quality, safe and efficient service to the patients. Therefore, there is a continual focus to ensure that the right staffing levels are in place, together with ensuring that there is a skilled, motivated and appropriately rewarded workforce. In order to achieve this it is necessary for the Trust to invest in staff and to support this.

Recruitment and Resourcing

2014/15 was another busy year for recruitment. There were 700 posts advertised which resulted in 563 new starters and 466 leavers (excluding medical recruitment, staff transferring from bank to permanent posts and existing staff being promoted). All new staff attend a comprehensive corporate induction which ensures they have up-to-date information in respect of the Trust and its policies and procedures. Our standards for both induction and statutory training (which is covered during induction) comply with the requirements laid down by the NHS Litigation Authority.

Nurse Recruitment

The recruitment of nurses continues to be a major focus. As well as continuing to recruit locally; recruiting newly qualified student nurses and recruitment open days, the Trust has undertaken recruitment in Europe including Spain, Portugal and Italy. In addition we have also taken part in Recruitment Fairs in both Scotland and Northern Ireland.

During the year 184 qualified nurses and 170 Health Care Assistants were recruited. In addition to this, the overseas nursing campaigns have also resulted in a further 85 qualified nurses being recruited from Portugal, Spain and Italy. This is a significant increase when compared with 2013/14.

Health Care Assistants (HCAs)

Part of our plans to review and redesign elements of the nursing workforce involved a major focus on developing the Bands 1-4 care support roles. This includes HCAs

- In line with the recommendations of the Cavendish review and the Francis Report, the Trust has implemented a revised training programme for all Health Care Assistants (HCAs) to meet the 'basic care certificate' level. All HCAs now undertake a 2 week induction followed by completion of the standardised national competencies within the first 12 weeks of commencing employment.
- All HCAs are offered a permanent position upon successful completion of the 'higher care certificate', within their first year. This will ensure all support workers have a generic basic training and can choose to progress to senior support worker roles.

Medical Agency Locums

Since the appointment to the Divisional based Rota-Co-ordinator roles across the Surgical, Medicine and Women's and Children's Divisions in 2013, the Divisions have been able to put in place a more structured approach to managing medical rotas and better controls in the co-ordination of leave and absence. These roles have helped ensure the maximum use of internal bank locum resources whilst minimising the need to use agency locums.

Medical Productivity

The Trust has adopted a productivity driven approach to consultant job planning based on an annualised commitment and delivery model linking job plans to service delivery with the aim of increasing the efficiency of available sessions, clinics and theatre/procedure lists.

Divisions have made significant progress during the year to ensure that all consultants have an up-to-date job plan.

Medical Education

Medical education has remained a high priority for us during 2014/15. We have strengthened the governance supporting both undergraduate and postgraduate training.

Undergraduate

Our undergraduate medical training continues to develop and increase in the number of clinical specialties supporting studies. We continue to receive high satisfaction rating from UCLH students. We have also approved the appointment of a new Director of Undergraduate Training

Postgraduate

We are committed to ensuring that the quality of training for postgraduate medical trainees delivers the requirements of the curriculum. During 2014/15, we received a Health Education East of England LETB (Deanery School of Medicine) visits for Acute Medicine, and Obstetrics and Gynaecology. Both visits resulted in some required actions for us and these are outlined below:

Medicine

A Director of Education for Acute Medicine and a Clinical Director for Acute Medicine were appointed to work with the trainees and College Tutor to make the required changes. A Trust Steering group was set up with Trust Executive Board representation to provide support and direction. The changes were further supported by the introduction of Human Factors training to maximise teamwork and collaboration. This training was delivered by the Associate Medical Director for Human Factors and the Head of Organisational Development.

A joint visit from the Schools of Postgraduate Medicine and Emergency Medicine took place on the 14th April 2015 to evaluate progress. There was recognition of the significant improvement to the trainee experience and acknowledgment of the further work to be undertaken.

Obstetrics & Gynaecology

During 2014/15, a Transformational team worked with the Clinicians to review the training needs and aspirations for training improvement, create a vision and get individual and team commitment for improvement. Focus groups were held for previous trainees and sessions organised for current trainees.

Verbal and written feedback from trainees was collected throughout the process and demonstrated educational requirements were being increasingly fulfilled.

The visit from the Post Graduate School of Obstetrics & Gynaecology took place on the 26th March 2015 and they were pleased with the significant progress the team had made against the requirements.

The team will continue to progress any further requirements and agree a continuous programme of development for the O&G team.

Sickness Absence Project

The sickness absence project has been in place for 15 months, during which time there has seen a significant reduction in sickness absence levels across the Trust.

The project has delivered a cultural shift towards managing sickness absence with a more proactive action orientated approach being adopted by line managers to address sickness absence caseloads. This has included coaching and training of line managers and also delivering the message that sickness absence management is for all employees. In addition, it has reached across other areas to change the culture within the Trust realigning mindsets and behaviours, including Recruitment & Resourcing, ensuring that the right people are recruited with the right skill set for the right positions with the appropriate controls and processes.

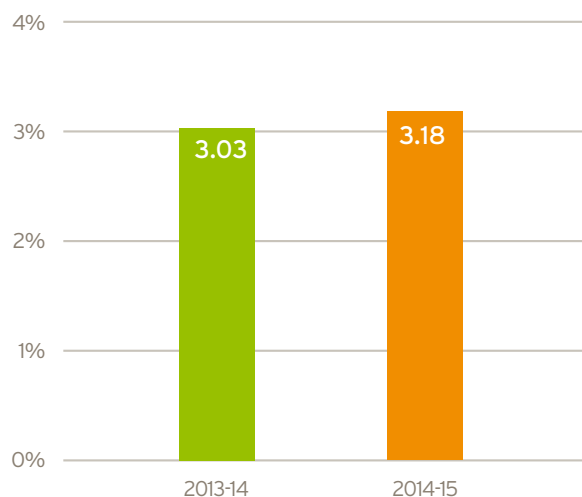
The action orientated approach to managing caseloads has seen a significant increase in conducting formal meetings in line with the Trust Managing Sickness Absence policy. Within the last financial year we have conducted around 400 formal sickness absence meetings across the Trust from a historical rate of approximately 70 per annum.

As a result of this focus the Trust is at the forefront of Trusts in the East of England region and one of the leading Acute Trusts across NHS England when it comes

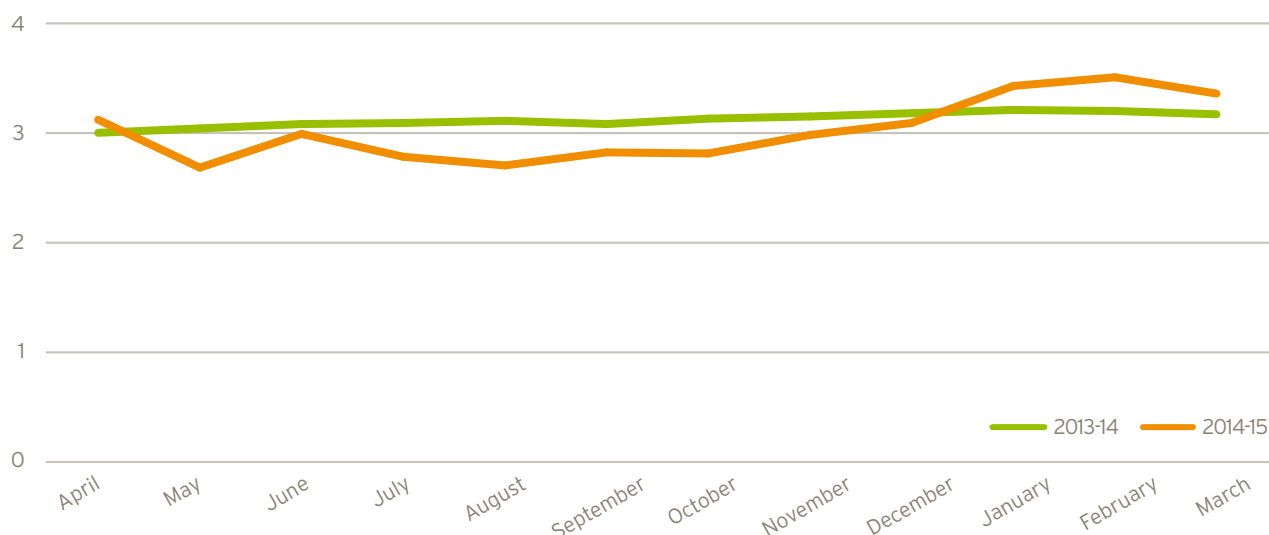
to sickness absence rates.

We are now moving into a phase of sustainability and this is very much aimed at ensuring the gains made during the project are maintained and sickness absence does not regress to pre-project norms.

Full Year Sickness Absence Rates 2013/14 and 2014/15



Percentage Sickness Absence Rates 2013/14 and 2014/15



eRostering

The delivery of high quality, compassionate care relies on having the right people, with the right skills, in the right place at the right time. To enable the effective and efficient use of staff resources the Trust has purchased an integrated rostering solution called HealthRoster.

The implementation of the new rostering solution not only focuses on maximising the governance, qualitative and financial benefits associated with the technology but has acted as a catalyst to develop the Trusts

culture ultimately changing the fundamental way the Trust approaches rostering. The project commenced in January 2014 and as at March 2015 41 areas are successfully using the system for rostering. All nursing bank shifts and payments are managed within the system and employees can view their roster and manage annual leave from home via the internet. The programme will continue into the 2015/16 financial year, with a view to including other staff groups, for instance medical staff and Allied Healthcare Professionals.

Publishing of nursing and midwifery staffing data

NHS England and the Care Quality Commission (CQC) published guidance on the delivery of the Hard Truths commitments associated with publishing staffing data regarding nursing, midwifery and care staff. As a result the Trust now publishes a monthly report containing details of planned and actual staffing on a shift-by-shift basis at ward level. This information is presented at the bi-monthly meeting of the Board of Directors and published on the Trust website.

In addition, we provide a six-monthly report describing the staffing capacity and capability following an establishment review. By doing this we provide assurance to both the Trust Board and externally that the nursing and midwifery establishments are safe and that staff can provide appropriate levels of care. This is particularly important in light of the key recommendations following the publication of the Francis report (2013), Compassion in Practice (2013) and the National Quality Board publication (2014); "How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability"

Employee Relations and Staff Engagement

Staff Engagement and Consultation

The L&D takes pride in having a healthy and productive relationship with staff and this is reflected in the staff engagement scores in the Staff Opinion Survey, where this year was higher than the national average. In addition, the Trust scored in the top 20% of Trusts across the country with staff reporting good communication between senior management and staff. Partnership working is demonstrated in many varied ways for example:

Staff Involvement Group

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

Joint Staff Management Council (JSMC)

The JSMC is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change

management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

Staff Recognition

There have been a number of opportunities over the year to thank staff and volunteers for their contributions. In particular:

- Again this year the Trust provided a free Christmas lunch to all staff and volunteers at which the Chief Executive took the opportunity to give her personal thanks and that of the Board of Directors for all their hard work and commitment to the hospital
- In recognition of their long service, 86 staff were invited to an awards event at Luton Hoo on 13th November 2014. This was the Trust Board's way of thanking staff who made a significant contribution to the Trust over the last 25+ years.
- On 22nd December 2014, the Trust recognised the long service given by volunteers who had devoted their time to the Trust over a time span of 40 years.

Communication

The Trust recognises that communicating with staff is a key to success which results in a workforce who are committed and engaged with the Trust. Messages are delivered in many ways, both at Department and Trust level. Some Trust wide examples of this are outlined as follows:

- Town Hall meetings with the Chief Executive to share information in respect of strategic plans and also operational issues
- Weekly Executive Briefings are undertaken to share key operational issues
- Divisions, departments and wards have established newsletters in their areas to share good practice and learning
- The nursing team have established a newsletter that is distributed every two weeks
- A bi-monthly L&D Staff Newsletter developed by the Staff Involvement Group but very much involving staff in ensuring stories
- The Intranet/E-mail system is used to communicate key message to staff in a timely way
- Regular meetings with Divisional representatives to share information and to receive feedback.
- Monthly meetings of Trust Board members with the Council of Governors which includes elected staff representatives

- Staff Governors actively speak directly to staff about their thoughts and ideas
- The CEO conducted a communication survey with staff and held meetings to understand directly from staff how they would like to be communicated with
- The Trust commissioned a piece of work during the summer of 2014 to explore how easy staff felt it was to (safely) raise concerns in the workplace. In addition, information gathered from the 2013 survey results and feedback from other sources, suggested that bullying and harassment may be taking place in some areas of the Trust. Because we wanted to understand more about this and also to find out how effectively staff felt that they are communicated with we engaged the services of a company, Public World, to speak to staff about their experiences of working in the hospital and to see what works well and what could be better, particularly in relation to the areas outlined. All staff were invited to participate either face to face by telephone or via survey monkey questionnaire. Also, former employees were written to and given the opportunity to participate. During the period May to August 2014, we received feedback from 32 staff/former staff/governors in total. Feedback from this piece of work has been considered and actions taken as appropriate.

Staff Involvement Group Newsletter

The first edition was produced in February of 2014. The newsletter is produced every two months and is full of news and stories for staff, by staff and about staff. The aim is for staff to be involved in something that is purely for them, and is a method for individuals to share their stories such as personal achievements, smoking cessation, weight loss, hobbies/interests or a new fitness regime that could inspire others to take action to live healthier lifestyles.

5.10 Improving the Quality of our Environment

At its extraordinary Board Meeting, held in public on the 1st October 2014, the Board of Directors ratified the Finance, Investment and Performance (FIP) Committee's recommendation to develop a detailed business case to redevelop of the L&D site. In making the recommendation FIP reviewed the various options including the development of a new hospital site, do nothing or do minimum. Upon reviewing the options and the associated financial consequences FIP agreed the wider site re-development option offered the most clinical and operational benefit and whilst the scheme requires the Trust to access a loan the associated re-payments would be affordable assuming a range of income generation opportunities and a detailed cost

improvement plan. In 2015, the Board will consider the Outline Business Case for Hospital-Redevelopment.

The option selected will cost in the region of £130 - 150m and has been designed to facilitate the Trust's clinical strategy by enabling the re-invention of the DGH into a campus of four distinct centres: major emergency, Women's and Children's, Elective and Teaching and Training. It will comprise both new build and refurbished accommodation. The new building will contain: an integrated Critical Care Unit, a Neonatal Unit, a Delivery Suite and a new theatre suite incorporating an ambulatory surgical facility. The existing Emergency Department will be expanded and a number of wards will be re-furnished or re-decorated. The outpatient facility will be re-organised to meet the changing needs of these services.

A number of developments have been undertaken in year as part of an overall plan to deliver an improved patient environment linked to the major redevelopment of the hospital site.

During 2014/15 a number of areas were improved across the site:

- Modernisation of the Neonatal Intensive Care Unit
- Expansion of the Ophthalmology outpatients area to provide additional treatment rooms
- Expansion of the Emergency Department with a new waiting area and additional treatment cubicles
- Major refurbishment of corridors in the Medical Block to include new floor coverings, handrails, ceilings and energy efficient lighting
- Delivery of the final 2 elements of the current car park strategy - this included provision of additional car parking spaces and reorganising car parks to increase the number of spaces available for visitors and patients. This has led to a significant reduction in complaints from patients about car parking

Further schemes of improvement are planned for 2015/16 to include a brand new clinic for Urology.

The Trust is committed to sustaining a high quality patient experience; this is monitored by way of self-assessment inspections involving members of the PLACE (Patient Led Assessment of the Care Environment) Committee. The Committee is made up of Non Executive Directors, Governors and staff. The same team also lead the Annual PLACE inspection; this took place on 24th February 2015 and the results will be published in September. The overall results from the previous year's inspection were positive in regard to hospital cleanliness and patient food but did comment about the poor condition of the existing returned estate - the redevelopment of the hospital site seeks to address these concerns.

5.11 Quality and Business Strategy

One of our key approaches to delivering high quality sustainable care is our Reengineering programme focussed on delivering care more efficiently and effectively. This was launched as formal programme in the last year, Analysis suggests the Trust's overall systems and processes are not functioning to a maximum level of efficiency and that potential improvements represent a key opportunity to improve both quality and efficiency.

The overarching governance is through monthly dedicated Executive Board, and at Board Committee level through the Finance, Investment and Performance Committee. The Trust has also appointed a dedicated Executive Director to ensure delivery. Each scheme is described below and has its own project structure and quality impact assessment.

Outpatient Re-engineering is our Re-Engineering focus for the year 15/16. We are aiming to substantially improve staff and patient experience in our busiest area of clinical activity.

This year has been focussed on what we have described as a "Partial Booking" implementation. This means that for patients requiring an appointment more than 6 weeks in advance a waiting list is maintained. Partial Booking is now live in Rheumatology, ENT, and is going live T&O and Respiratory. However, this year we will consolidate our learning to launch a corporate solution to this across all specialities. We will also complete detailed work to examine the flow of activity within clinic using improvement science techniques to refine our approach speciality by speciality. Combining an understanding of the pathway, the balance of capacity and demand for a pathway, and also optimised support and flow we will make outpatients our priority.

During the past year we have tendered for a Patient Self-Check-In and Flow solution for Outpatients. This tender is close to award and will mean that in the coming year we will transform our patients' journey from arrival at the site, to arrival in the clinical room for the appointment. Screens will guide the patient, and manage expectations around timing in a similar manner to the flow through an airport. This will reduce anxiety, and also allow patients to manage their time to best effect whilst onsite waiting for the appointment. It will also allow us to carefully manage the flow of patients through outpatients in real-time and refine our capacity to meet demand in a more scientific manner.

Theatre Re-Engineering was a priority for the programme in 2015/16. The launch of the new revised operating timetable in December 2014, and the first standard operating Saturday on the 10th January 2015, represented substantial milestones achieved this year. This has now embedded well but the next year will focus on improving start times, minimising turnarounds and increased utilisation.

Length of Stay: Optimised usage of our ward areas has been focussed on two key interventions to reduce our hospital bed utilisation. The scaling up of our Ambulatory Care Centre (ACC), and the launch of a Hospital at Home (H@H) service. The ACC has seen steady growth in the number of conditions that can be managed effectively, and the process will continue in the coming year. The programme this year will focus on rapid access to faster diagnostics particularly in Imaging.

7 Day Services: The initial focus has been on developing the strategy and establishing our baseline. The in-year priority was on improving the Keogh standard of a 14 hours consultant review for all emergency patients from time of arrival. This has seen a step change in performance across the year with a quarter on quarter increase to over 70% of patients now being reviewed. This ongoing improvement will continue in the coming year as we focus on the rapid turnaround of diagnostics in end to end pathways, and further improvement of our 14 hour Consultant review target.

eRostering: Rapid roll-out of eRostering to Nursing continued at great pace and as at March 2015, 41 areas have implemented the system. The effectiveness of established staff utilisation has seen consistent improvement across the year. The Trust has also scoped and designed an extension of this system to cover the entire workforce, including Medical staff. Therefore, in 15/16 we will complete the deployment of eRostering across all staffing groups within the Trust.

Clinical Correspondence/ Administration: The transfer of clinic letters electronically to GP Practice achieved last year will be built upon to determine a standard operating model for the Trust. There will be pilots of voice recognition, and increased use of templates, as well as improved support for transcription.

Business Development: The Trust has continued to market its services to GP's and held a range of events to promote our services, where expert speakers have drawn consistently good attendances. These will continue, but will take place on the margin of our traditional catchment areas. Focussing on the key priority areas of Cardiology, General Surgery and Trauma and Orthopaedics we will

build on the output from our GP Enquiry to ensure we are the easiest place to refer to clinically, the quickest place to see patients, and can clearly evidence and promote the quality of our services. This will involve enhanced investment in marketing materials, but will require careful alignment with capacity released by re-engineering our processes. This year will begin to influence real changes in referral patterns.

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

The hospital agreed the Corporate Objectives for 2014 - 2016, and these include the quality objectives. The Trust Governors were engaged with the development of these objectives.

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

Amendments to the quality priorities have been considered by staff in management executive based on performance and improvement needs.

Quality is discussed and monitored at quarterly monitoring meetings with our local Clinical Commissioning Groups. There remains a high level of agreement

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

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

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2014 to March 2015
 - papers relating to Quality reported to the board over the period April 2014 to May 2015
 - feedback from commissioners dated 27/05/2015
 - feedback from governors dated 18/03/2015
 - feedback from local Healthwatch organisations (not received as at 27/05/2015)
 - feedback from Overview and Scrutiny Committee (not received as at 27/05/2015)
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/04/2015
 - the 2014 national patient survey 21/05/2015
 - the 2014 national staff survey 24/02/2015
 - the Head of Internal Audit's annual opinion over the trust's control environment dated 20/5/15
 - CQC Intelligent Monitoring Report dated July 2014 and December 2014

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

27th May 2015



Chairman

27th May 2015



Chief Executive

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate; We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

7. Comments from stakeholders

It is positive to see that priority areas around the implementation of a new model of integrated care for older people is a priority area. It is disappointing that this work could not be rolled out however we are hopeful that in the coming year the issues that have delayed its implementation will be resolved.

We support the work across the perfect day and are happy to see the recruitment of more health care assistants. We look forward to being able to assess the impact of this on the patient experience in the future.

Whilst there is mention of VTE there are no statistics that we can analyse to determine how many patients suffered from VTE and if these were isolated to a particular ward or were trust wide. It would be really helpful if this information could be made available.

The implementation of ePMA is a very good step and we hope the implementation across all wards can be completed in a timely fashion.

We are pleased to note that the findings of our Outpatient review have been included in the Trust's Outpatient Transformation Programme. We look forward to working with the trust to implement some of the more challenging and complex recommendations from our review. We are hoping that the introduction of the electronic patient check in kiosks will further enhance the patient experience. The trust's willingness to introduce appointments in the evenings and weekends across some areas is welcomed and we will continue to monitor the impact this has on patient experience.

We were pleased to note last year that improving the experience and care of patients at the end of life and the experience for their families had been identified as a priority area. We understand that the Trust is working on improving this and work has already begun however there is still room for improvement. We hope that this continues to be a priority for the trust in the coming year and that information around this can be shared with Healthwatch Luton as progress is made.

We are happy to see that reducing harm by ensuring patient's current medicines are correctly identified, communicated and prescribed at admission is now a priority area for the coming year. We hope that as ePMA is further rolled out and with the introduction of electronic prescribing for Luton, this will make this task far easier.

It is really positive to see that partial booking for outpatient clinics will be a priority area. It is important to note that our Outpatient Review provided strong evidence to demonstrate patients want choice over appointment bookings. If the Trust can work with GP clusters to ensure that the "choose and book" scheme is being offered to patients, this will improve the overall patient experience at the outpatient clinics. This facility is already available, however it is not being utilised and the Trust should encourage GPs to ensure the choose and book scheme is being offered to patients.

Whilst there is a slight increase in complaints made from the previous year, it would be helpful if the complaints could be categorised and presented by wards/ departments so that we can begin to understand if there are any trends or emerging themes.

It is positive to see that L&D is meeting the majority of its targets and is well within the national indicator for many targets. This is especially positive for the A&E waiting times which have been very positive. We hope this can continue to be the case.

We would like to take this opportunity to thank all the staff at L&D for their continued hard work. We look forward to working closely with the L&D in the coming year.

Healthwatch Luton



Statement from Bedfordshire Clinical Commissioning Group to Luton & Dunstable Foundation Trust Quality Account 2014/15

Bedfordshire Clinical Commissioning Group (BCCG) acknowledges receipt of Luton and Dunstable NHS Trust's (L&D) Quality Account 2014/15, which has been shared by Luton Clinical Commissioning Group (LCCG) for comment. The Quality Account has been shared with BCCG's Lead patient safety Non-Executive, Executive Directors, Performance, Quality and Safety Team and reviewed at the Patient Safety and Quality Committee as part of developing our assurance statement.

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account which was submitted as part of the Trust's contractual obligation. We believe all data provided corresponds with data used as part of the on-going contract monitoring process.

The L&D is required to include in their Quality Accounts the Trusts' performance against National quality indicators. The accounts demonstrate this data has been included.

The account clearly details the quality priorities for 2014/15 and expected Quality priorities for 2015/16. In line with this the supporting CEO statement demonstrates the organisational commitment to quality and delivery against National and local quality and performance targets. .

The Trusts corporate objectives reflect a position that spans 2014/2016 and implementation of a vision that includes safety, experience and outcomes for patients. Securing and retaining a competent workforce is now reflected as a priority within this vision.

2014/15 Priorities

BCCG acknowledges the improvement work of the mortality board in reviewing unexpected deaths. The work around Acute Kidney Injury recognition is of significant value and in line with NICE guidance 169. Positively work on AKI CQUIN will continue to be developed in 2105/16 national CQUIN scheme.

BCCG recognises the involvement of L&D in working up a new model for integrated care for Luton and south Bedfordshire patients. It is acknowledged that progress has been made over the course of 14/15 in establishing the benefits of this model to patient care. We look forward to being part of the engagement with other partners in securing this models a new way of delivering services to or patients in 15/16 and beyond.

BCCG is pleased to see the ongoing commitment to 7 day working and urgent senior clinician review for all unscheduled patients. This supports the national drive for 7 day working and responds to Sir Bruce Keogh plan to drive 7 day services across the NHS.

Development of support workers, an innovation to bring nursing care back to the bedside, appears to have demonstrated some benefits, however BCCG will look forward to working



with the Trust in unpicking the impact of this model and any share learning for the wider health economy.

Ongoing work in safety priorities for fall's prevention and pressure ulcers reduction is recognised by BCCG. The collaborative approaches to reviewing falls in line with specialist nursing expertise from dementia to continence has it appears led to significant improvement in falls reduction.

It is encouraging to see Venous Thromboembolism continue as a quality priority in both risk assessment and assurance of patients at risk receiving prophylactic treatment

BCCG recognises the significant improvements in patient experience at L&D in particular in outpatients and effect in diagnostic waiting times. Importantly some of these achievements will go to support the commitment to 7 day working and learning from these processes may be valuably shared in further transformation to deliver ongoing quality services.

The quality achievements under the NHS outcome framework domains in L&D for 2014/15 demonstrate clear value for our patients. The work within the Trusts Mortality and complaints board supports the requirement of the Francis and later Berwick reports on safety and experience in NHS care in England.

Whilst many achievements have been made in quality provision in 2014/15 it is encouraging to see L&D quality priorities for 2015/16 have not changed significantly. Many of these are supported also by National or local CQUIN schemes which will enhance the potential deliverability of these priorities. BCCG welcomes the opportunity to work with our colleagues in Luton Clinical Commissioning Group (LCCG) in 2015/16 in the ongoing engagement and discussion with L&D regarding progression and achievement of the list of priorities outlined in this quality account.

Bedfordshire Clinical Commissioning Group welcomes the opportunity to comment on this report and looks forward to a new year of working with colleagues at Luton and Dunstable Hospital to monitor the continued Quality and Safety of patients.



Nick Robinson
Accountable Officer (Interim)
Bedfordshire Clinical Commissioning Group
May 2015

Statement from Luton Clinical Commissioning Group to Luton and Dunstable University Hospital NHS Foundation Trust Quality Account 2014/15

Luton Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the 2014/15 Quality Account* for Luton and Dunstable University Hospital NHS Foundation Trust (LDH).

We have been working closely with the Trust during the year, gaining assurance on the delivery of safe and effective services. In line with the NHS (Quality Accounts) Regulations 2011, Luton CCG have reviewed the information contained within the LDH annual account and checked this against data sources, where this is available to us as part of our existing monitoring discussions, and confirm this to be accurate.

We acknowledge the work undertaken by LDH in 2014/15 in response to national quality initiatives regarding the provision of services 7 days a week. The increased access to diagnostic and pharmacy services, along with a consultant review within 14 hours of emergency admission for a large majority of patients, has contributed positively to patient experience and safety. We look forward to working with the Trust as they continue with this quality priority in 2015/16.

We recognise the commitment of the Trust in implementing recommendations from national enquiries and guidance including the work on safe staffing levels within in-patient wards. We particularly acknowledge the increase in staffing levels within the maternity service following a Care Quality Commission (CQC) inspection in 2013 and look forward to seeing this supported further by Birthrate Plus and the NICE (National Institute for health and Care Excellence) workforce guidance in 2015/16.

Luton CCG had been concerned about the poor quality and timeliness of Serious Incident investigations and reports which was compounded by the slow progress of the Trust in making improvements. Luton CCG would, however, like to take this opportunity to commend LDH for the improvements seen during the latter part of 2014/15. Luton CCG will work closely with LDH to ensure continued progress with adherence to the national framework and contractual requirements throughout 2015/16.


Current NHS reforms emphasise the need to integrate care more effectively between acute hospitals and the community. LDH have been key to the Integrated Care Strategy and, whilst progress has been made in taking forward the integration and coordination of care, success will be demonstrated by fewer admissions, shorter stays in hospital and improved patient experience. Throughout 2015/16 Luton CCG expects to see LDH and its partners enabling less fragmented, better coordinated, person centred care for the local population.

Over the last year LDH have not managed to meet and maintain the necessary level of compliance required for the stroke programme. We look forward to seeing the necessary improvement in patient related outcomes throughout 2015/16 and will continue to monitor closely.

We welcome the Trust's commitment to participation in national and local audits and we will continue to support the Trust to ensure that their services use the outcomes of these audits to drive further quality improvements.

Luton CCG fully supports the Trust's quality priorities and indicators for 2015/16 as set out in this annual account. The focus on improving the experience for patients accessing outpatient clinics, approaching end of life and for those with dementia and delirium is evident in the initiatives outlined. Luton CCG will monitor the progress of the Trust in driving forward these initiatives and improvements to ensure high quality healthcare and outcomes for the people of Luton.

At the time of writing this commentary we are unable to validate the final figure for the Commissioning for Quality and Innovation (CQUIN) scheme as we are awaiting further information but it is anticipated that the Trust have achieved approximately 80% of their 2014/15 CQUIN.



Carol Hill
Chief Officer
Luton Clinical Commissioning Group

*It should be noted that these comments were made on an early draft of the LDH Quality Account.

Comments from Overview and Scrutiny Committees

The Luton Health Scrutiny Committee and Central Bedfordshire Council's Social Care, Health and Housing Overview and Scrutiny Committee did not comment on any Quality Accounts for 2014/15 due to the elections on 7th May 2015.

Comments received from the Trust Stakeholders

Comment	Response
Ensure all the terminology is included in the glossary.	More terminology was added.
Ensure that the graphs were clear and include trend lines.	The graphs were amended.
Include more information on: <ul style="list-style-type: none"> • 7 day working achievements • Whole system working • Complaints • The Luton JSNA (2011) within the Trust profile • Action taken following the Intelligent Monitoring Report • Action taken on actions to address response rate of A&E Friends and Family • Detail of the Deanery Visits in 2014/15 • Reference which quality priorities are related to CQUIN • Reason for not participating in a national clinical audit 	More information was added.

8. Independent Auditor's Assurance Report

Independent auditor's report to the council of governors of luton and dunstable university hospital nhs foundation trust on the quality report

We have been engaged by the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Luton and Dunstable University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (see section 5.6, Target 9); and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers (see section 5.6, Target 4).

We refer to these two national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the specified documents in the Guidance, as set out in Section 6, 'Statement of Directors' responsibilities in respect of the Quality Report'.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Luton and Dunstable University Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Luton and Dunstable University Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
London
28 May 2015

9. Glossary of Terms

Anticoagulation	A substance that prevents/stops blood from clotting
Arrhythmia	Irregular Heartbeat
Aseptic Technique	Procedure performed under sterile conditions
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
CCG	Clinical Commissioning Group.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
Continence	Ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.
DME	Division of Medicine for the Elderly
Elective	Scheduled in advance (Planned)
EOL -End of Life	
Epilepsy	Recurrent disorder characterised by seizures.
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow.
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
HSMR	Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate.
Laparoscopic	Key hole surgery
Learning Disability	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
Meningococcal	Infection caused by the meningococcus bacterium
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
MUST	Malnutrition Universal Screening Tool is a nutritional assessment that is carried out on inpatients to ensure that they are maintaining their body weight
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged
Myringotomy	A surgical procedure of the eardrum which alleviates pressure caused by the build up of fluid
Neonatal	Newborn - includes the first six weeks after birth
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	Degenerative disorder of the central nervous system

Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
Safety Thermometer/Harm Free Care	Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
SEPT	South Essex Partnership University NHS Foundation Trust
SHMI	Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply
Syncope	Medical term for fainting and transient loss of consciousness
Two week wait	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins

Research - Glossary of terms

Portfolio - studies which are eligible and have been accepted onto the National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio Database.

Non-Portfolio - studies which do not meet the eligibility criteria to be accepted onto the NIHR CRN Portfolio Database. (note: these are very worthwhile studies but are usually own account, smaller single centre studies, student research etc.

Appendix A - Local Clinical Audits

Title/Topic	<p>Annual General Surgery/Urology Record Keeping Audit 2013/2014</p> <p>N=20</p>
Directorate/Specialty	General Surgery Urology
Project Type	Audit
Completed	March 2015
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings. Identify areas where compliance needs to be improved <p>Findings:</p> <ul style="list-style-type: none"> Ninety four standards: Full compliance in 45%, high compliance in 13%, moderate compliance in 21% and low compliance in 21% <p>Key recommendations:</p> <ul style="list-style-type: none"> Discuss areas of poor compliance at next Surgical Clinical Governance meeting

Title/Topic	Record Keeping Audit -Maternity Intrapartum Notes 2014 N=27
Directorate/Specialty	Obstetrics & Gynaecology
Project Type	Audit
Completed	February 2015
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • Measure compliance with standards set out by NHSLA, CHKS, NMC and local guidelines Identify areas requiring improvement <p>Findings:</p> <ul style="list-style-type: none"> • The 2013 results demonstrated that the Intrapartum notes were not being used to their full advantage. The notes were introduced to aid and assist the midwife and doctors in the care they give to the women. Prompts and checklists were included to help. Adhere to firm guidance • The 2014 results have demonstrated a slight improvement. The number of standards fully compliant has increased from 7 to 13 and the number of standards with high compliance has increased from 19 to 26. However, significant improvement is still required in certain areas. • The 2014 audit has demonstrated that full compliance (100%) was identified against 13 (11%) standards. High compliance (91% - 99%) was recorded against 26 (21%) standards, whilst 28 (23%) standards were proved of moderate compliance (75% - 90%). Low compliance (<75%) was identified against 45 (37%) standards. <p>Key recommendations:</p> <ul style="list-style-type: none"> • Areas of poor compliance highlighted in the newsletter and discussed at monthly Obstetric study day. • Areas of poor compliance and importance of documentation to be discussed at Normality Study Day • Intrapartum notes to be updated to include boxes for each check • Alerts to be put in weekly newsletter • Alerts to be sent to staff regarding the checking procedures

Title/Topic	Trustwide Consent Policy Survey 2014 N = Patient Survey = 11 Staff Survey = 27
Directorate/Specialty	Corporate
Project Type	Patient & Staff Survey
Completed	February 2015
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • To collect information about patients' experiences of providing consent for a procedure/operation during their hospital visit/stay • To receive feedback from medical/nursing staff (Trustwide) to identify awareness of current consent procedures/guidance & to identify gaps in education and training needs • Identify improvements following the 2012 survey <p>Findings:</p> <p><u>Patient Survey:</u></p> <ul style="list-style-type: none"> • There has been an improvement in percentage of patients (from 87% - 100%) reporting a member of staff explaining the advantages of the procedure. • The 2012 audit demonstrated ninety one percent of patients reported that disadvantages/risks were explained to them as part of the consent process. This year 90% of patients reported that disadvantages/risks were explained. • The number of patients who were advised of the type of anaesthetic/sedation which would be used during their procedure/operation has remained the same (90%). • Ninety one percent of patients felt they were able to ask further questions before giving consent. The previous audit demonstrated 96% of patients felt they were able to ask further questions. • Ninety one percent of patients felt they were given enough time to consider the information provided before being asked to sign the consent form. The previous audit showed 96% of patients felt they were given enough time to consider the information provided. • There has been a slight decline in the percentage of patients (from 98% to 91%) reporting that the nature and purpose of the procedure was explained to them by the member of staff obtaining consent. • There has been a slight decline in the percentage of patients (91%) who felt they were given enough information (verbal/written) to help them make their decision. The previous audit demonstrated 98% of patients were given enough information. • Eighty two percent of patients felt they fully understood what the operation/procedure entailed. This has declined since the previous audit (95%). • One patient (9%) felt they would have benefitted by having information provided in other formats. Results are similar to the previous audit (11%) • Forty six percent of patients reported they had not been given a copy of the signed consent form. The previous audit demonstrated just under half of the patients (49%) reported they had not been given a copy of the signed consent form. <p><u>Staff Survey:</u></p> <ul style="list-style-type: none"> • Fifty four percent of staff reported they were either somewhat aware or not at all aware of published national/local guidance relating to patient consent. The previous audit demonstrated twenty nine percent of staff reported they were either somewhat aware or not at all aware of published national and local guidance relating to patient consent. • Similar to the previous audit, the majority of staff felt patients are able to consent non-verbally, verbally and in writing.

- Staffs were asked which actions must be applied when obtaining consent from an adult who requires significant medical treatment and are assessed as not having capacity. Forty six percent of staff reported the Consultant in charge may override the consent process. Forty two percent of staff felt an independent advocate (IMCA) must be appointed. The remaining 12% of staff felt none of the above would apply. The previous audit demonstrated 21% of staff reported the Consultant in charge may override the consent process. Forty one percent of staff felt an independent advocate (IMCA) must be appointed. Two percent of staff felt both of the above would apply and the remaining 36% felt none of the above would apply. The correct answer to this question is 'both'. The Consultant in charge may override the consent process in cases of emergency, otherwise an IMCA must be appointed.
- There has been a decline in the percentage of staff feeling suitably trained and confident to seek consent from patients. Fifty eight percent of staff (75% in previous audit) felt trained and confident with seeking patient consent. Thirty five percent (16% in previous audit) reported that they do not feel fully confident and 7% (9% in previous) felt they were not suitably trained.
- Almost a third of the sample reported that they have never received any formal training in the consent process. The previous audit demonstrated similar results.
- Staffs were asked how many consent forms were currently available. Only 22% (67% in previous audit) of staff answered correctly stating there were currently 4 consent forms in use. The remaining either answered incorrectly or were unsure.
- Sixteen percent of staff felt they had sufficient knowledge of the range of proposed procedures and treatments undertaken for all procedures in their area of work and 28% had sufficient knowledge for the majority of procedures. The previous audit demonstrated 56% of staff felt they had sufficient knowledge of the range of proposed procedures and treatments undertaken for all procedures in their area of work. Thirty eight percent felt they had sufficient knowledge for the majority of procedures.
- Twenty eight percent of staff always feel able to explain all the risks and benefits of the procedures they are required to obtain consent for. Twenty percent of staff felt able to explain most of the time. The remaining 52% felt able to explain some of the time. The previous audit demonstrated 65% of staff always feel able to explain all the risks and benefits of the procedures they are required to obtain consent for. Thirty one percent felt they were able to explain risks and benefits of procedures most of the time.
- Forty eight percent of staff felt they would benefit from further training in obtaining consent from patients. The 2012 demonstrated 40% of staff felt they would benefit from further training in obtaining consent from patients (verbal & written).
- Levels of confidence in obtaining consent have declined. Thirty one percent of staff (72% in previous audit) feel very confident about obtaining informed consent from patients. However, the remaining 69% feel either somewhat/not at all confident in obtaining consent from patients.

Key recommendations:

- To expand audit sample size in 2015 consent audit
- To reinvigorate training requirements for medical staff in their responsibilities (inc copy of form for Patients)
- To include "consent" within MCA training
- Medics - via Educational Supervisor to include consent in conjunction with Deanery
- Nursing - To explore "e" learning as an option on consent updates for nursing & AHP staff

Title/Topic	Audit Of Acute Kidney Injury (NICE CG 169) N=40
Directorate/Specialty	DME
Project Type	Audit
Completed	February 2015
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • To identify current practice in managing AKI • To compare current practice with the standards set out by the NICE guidance CG 169 • To improve practice <p>Findings:</p> <ul style="list-style-type: none"> • Length of stay varied from 1 day to 65 days with average length of stay being 14.62 • 97.5% of patients had acute illness and 89.8% had risk factor for AKI with acute illness • 13% (5) of patients were offered contrast for nonemergency imaging and 3 % (1) for emergency imaging. Only 17% (1) were assessed for risks of AKI. • 89% of patients had urine output monitored • 95% of patients did have their creatinine monitored regularly • 90% of patients did have recorded cause of AKI in the patient notes. • 55 % (22) of the patients were at risk of obstruction. Only 50 % (11) of patients at risk of obstruction were offered urgent ultrasound. Of these only 55%(6) was performed within 24 hours of detection of AKI • Only 55 % (11) of the cases were discussed with the nephrologists and 91% (10) of these were not discussed within 24 hrs of detection of AKI <p>Key recommendations:</p> <ul style="list-style-type: none"> • All adults should be investigated for chronic kidney disease before being offered iodinated contrast agents for non-emergency imaging. • All adults are assessed for the risks of acute kidney injury before they are offered iodinated contrast agents for emergency or non emergency imaging. • All patients should have the cause of (or likely cause of) AKI to be recorded in patient notes • All patients with suspected urinary tract obstruction should be offered urgent ultrasound of kidneys within 24 hours of assessment. • Where indicated as per NICE all patients to be discussed with the nephrologist and these discussion to be done within 24 hours of detection of AKI • Forty nine percent of patients felt the comfort level during the test was acceptable. Forty three percent felt the comfort level for uncomfortable but unacceptable. Six percent felt the comfort level was unacceptably uncomfortable and 2% of patients could not remember • Thirty three percent of patients felt the test was more uncomfortable than they thought it would be • Thirty five percent of patients stated they were placed in a single sex area, 19% stated they were not placed in a single sex area and the remaining 46% did not know whether or not they were in a single sex area • Ninety percent of patients stated the results of the test were explained to them afterwards and 90% stated they were given written information about the results of their test • For those patients who had a biopsy, 80% stated it was made clear to them how they could get the results

Title/Topic	Audit of Outcomes of Thrombolised Patients In Acute Stroke N = 62
Directorate/Specialty	DME
Project Type	Audit
Completed	January 2015
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • Measure current practice • Compare current practice with the standards • Highlight areas requiring improvement • <p>Findings:</p> <ul style="list-style-type: none"> • Thrombolysis within 0 - 4.5 hours reduces disability among a wide range of patients and promotes independence • Door to needle time is in excess of 90 minutes needs to improve --- Earlier the thrombolysis better the outcome • No differences noted in day / night time thrombolysis because this service is exclusively offered by stroke team • 8%(5) of patients have neuro-negative imaging - only 3%(2) were stroke mimic • Bleeding risk is comparable to national standard-12% • Length of stay in hospital was excellent - 60% less than a week <p>Key recommendations:</p> <ul style="list-style-type: none"> • To address delay in door to needle time by educating and involving staff in Thrombolysis via presentations in various meetings e.g. DME and Medical directorate meetings, Clinical Governance meetings • To address delay in lab results by discussing with Haematology and Chemical lab • To address delay in CT scan by discussing the potential solutions in Stroke directorate meeting • To relocate the CT department closer to A&E department

Title/Topic	Patient Satisfaction Survey – Endoscopy N=49
Directorate/Specialty	MEDICINE
Project Type	Patient Survey
Completed	January 2015
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • To collect information about patients' experiences during their hospital visit to the Endoscopy Unit • To identify patients' level of satisfaction with the Endoscopy Unit • To identify improvements in current practice and levels of patient satisfaction <p>Findings:</p> <ul style="list-style-type: none"> • The majority of patients (98%) rated the booking procedure as either excellent or good • The majority of patients (94%) felt the amount of information given by the Booking office was about right • Ninety two percent of patients felt the test was done quickly enough after being referred • Fifty three percent of patients were offered a choice of dates/times to have the test • Eight patients (16%) were asked to move their appointment, of which 6 patients were given an earlier date • All patients felt they received enough information about what the test involved and all felt the information was easy to understand • The majority of patients (98%) found the instructions about the preparation clear to understand • The majority of patients (94%) rated the courtesy of staff in the Booking Office either very good or good • Twenty seven percent of patients felt the Endoscopy unit was not clearly signposted • The majority of patients (98%) felt they were dealt with promptly and efficiently at the Endoscopy unit reception • All patients rated the courtesy of receptionists in the Endoscopy reception area as either very good (86%) or good (14%) • Thirty one percent of patients stated there was a delay before they had their test and in a large number of these cases, no reason was given for the delay • Ninety six percent of staff rated the courtesy of the nurse preparing them for the test as either very good or good • The majority of patients (96%) felt the amount of information given to them by the Nurse preparing them for the test was either very good or good. The majority (94%) also felt the amount of information given was about right • Most patients (96%) felt they were given enough privacy when changing or being prepared for their procedure • All patients felt their privacy/dignity was respected whilst on the Unit • Ninety four percent of patients stated the Endoscopist introduced themselves to them • The majority of patients (96%) rated the courtesy of the Endoscopist as with very good or good • Forty nine percent of patients felt the comfort level during the test was acceptable. Forty three percent felt the comfort level for uncomfortable but unacceptable. Six percent felt the comfort level was unacceptably uncomfortable and 2% of patients could not remember • Thirty three percent of patients felt the test was more uncomfortable than they thought it would be • Thirty five percent of patients stated they were placed in a single sex area, 19% stated they were not placed in a single sex area and the remaining 46% did not know whether or not they were in a single sex area

- Ninety percent of patients stated the results of the test were explained to them afterwards and 90% stated they were given written information about the results of their test
- For those patients who had a biopsy, 80% stated it was made clear to them how they could get the results
- Sixty three percent of patients stated they or their relative were given written information about the sedative
- Eighty six percent of patients were given a telephone number to ring if they needed advice after the test
- Fifty nine percent of patients were advised about any necessary follow up appointments before leaving the department
- Fifty seven percent of patients felt they would be extremely likely to recommend the Endoscopy Unit to friends and family. Thirty five percent felt they would be likely to recommend the unit

Key recommendations:

- Formulate a procedure for when delays occur, look at information provided to patients in reception
- Review discharge procedure - further training required
- Review signposting and improve
- Improve communication between recovery and reception

Title/Topic	<p>End Of Life Care Cquin 2014/15 Documentation Review Of Deceased Patients</p> <p>Second Phase</p> <p>N=20</p>
Directorate/Specialty	Corporate
Project Type	Audit
Completed	January 2015
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • Review current end of life care • Review evidence of symptom assessment and control • Assess the use of processes relevant to end of life care, i.e. DNACPR and PRP • Examine support of dying patients and their family as revealed by conversations recorded in medical notes and other activities <p>Findings:</p> <p>1. To assess the care by looking at evidence of symptom assessment and control</p> <ul style="list-style-type: none"> • Seventy five percent of patients were identified as being in the last days/hours of life. This is in line with the L&D results of the National Audit of Dying Patients (hospitals) where 76% of patients were identified as dying. • In 70% of cases there was evidence in the notes that a health care professional believed the patient to be dying in the last 3 days of life. • Fifty five percent of cases reviewed had documented evidence that patients complained of pain and of those, all (100%) had actions undertaken to resolve the symptoms. Sixty four percent noted the actions were effective. • Thirty five percent of patients had nausea and vomiting and action was taken in all cases with effectiveness of the intervention noted in 71%. • Sixty percent of patients had breathlessness as a symptom. All (100%) had action taken to resolve the symptom and in 92% of cases effectiveness of action was noted. • Fifty percent of patients were described as having terminal agitation, of which 100% had action taken to resolve it and 90% noted its effectiveness. • Thirty five percent of patients had noisy respiratory secretions, action was taken in 86% of cases and 72% noted the effectiveness of the action. • In 70% of cases there was evidence that usual medications were reviewed when the patient was identified as dying. <p>2. Assess the use of processes relevant to end of life care such as the DNACPR and PRP</p> <ul style="list-style-type: none"> • Ninety five percent of cases reviewed had a DNACPR and 80% of those had been discussed with the family. • Eighty five percent of patients had a personal resuscitation plan and of those 12% were reviewed since it was initiated. • No patients had an advance statement.

3. Examine support of dying patients and their family as revealed by conversations recorded in medical notes and other activities

- In 20% of cases there was evidence the patients preferred place of death was documented. In 10% of cases the patients' preferences and concerns were noted. No patients had an advanced decision to refuse treatment in place
- Advice was sought from the palliative care team in 45% of cases. Spiritual and/or religious wishes were discussed in 20% of cases
- In 70% of cases, there was documented evidence the patient/family's views were discussed. In 95% of cases, there was evidence the family had the plan of care explained and timescales were estimated in 70% of cases
- Hospital facilities were only explained in 25% of cases. In 60% of cases the staff discussed the patients care with family on each of the last 3 days
- Following the patients death, 5% of cases indicated the death was certified by a Nurse and 20% of records indicated information leaflets were offered to the bereaved

Key recommendations:

- Continued education about the recognition of dying. This will be achieved in the education attached to rolling out the Individualised Care Plan for the Dying Patient. Also ward based coaching for medical staff. Further evaluation with audit of 40 sets of notes in quarter 4.
- To continue educating both nursing and medical staff on the importance of prescribing for the 5 common symptoms for the dying patient when introducing the Individualised Care Plan for the Dying Patient. To also capture during ward based coaching sessions.
- To raise awareness when rolling out the Individualised Care Plan for the Dying Patient. At the same time introducing a spot check audit, to be lead by senior nursing staff. Discharge liaison and the Palliative Care team - including the site specific nurses. To nurture ongoing learning and improvement.
- To provide education on the importance of supporting families when an end of life event is evident. Learning will be indicated in the documentation of the Individualised Care Plan for the Dying Patient. Further enforced with spot check audits.
- To increase the evidence of DNACPR being discussed with the family or the next of kin. To be achieved through spot check audits and further education at the point of need

Title/Topic	Audit Of Familial Hypercholesterolaemia N=10
Directorate/Specialty	Biochemistry
Project Type	Audit
Completed	January 2015
Aims, Key Findings, Actions	<p>Main aims: The aims of the audit was to provide evidence against the following Quality Standards from QS41:</p> <ul style="list-style-type: none"> • Adults with a total cholesterol above 7.5 mmol/l before treatment have an assessment for familial hypercholesterolaemia • People who are given a clinical diagnosis of familial hypercholesterolaemia because they have high cholesterol and family history or other signs, are offered DNA testing as part of a specialist assessment • Adults with familial hypercholesterolaemia are offered drugs to reduce the low-density cholesterol (bad cholesterol) in their blood to less than a half of the level before treatment • Treatment with familial hypercholesterolaemia are offered a detailed review of their condition at least once a year <p>Findings:</p> <ul style="list-style-type: none"> • The Trust was compliant with all five standards that were applicable. <p>Key recommendations: No risks were identified from the audit</p>

Title/Topic	<p>An Audit To Establish The Efficacy of Extracorporeal Shockwave Lithotripsy (ESWL) In The Management of Renal Calculi</p> <p>N=89</p>
Directorate/Specialty	General Surgery
Project Type	Audit
Completed	December 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> Evaluate the efficacy of ESWL in the management of renal calculi <p>Findings:</p> <ul style="list-style-type: none"> The audit demonstrated that ESWL is non-invasive and fairly effective in treating renal calculi. Patients should be offered at least 2 sessions of ESWL before considering other more invasive methods. The optimal treatment may be achieved by using shock powers of 70j, with no of shocks of between 2500-3000, causing minimal pain to the patient and reduced by simple analgesia <p>Key recommendations:</p> <ul style="list-style-type: none"> ESWL should be continued to be offered to all suitable patients with renal calculi, and with patient consent, they should have 2-3 sessions offered before considering other more invasive methods. Shock powers of 70j with frequencies of 2500-3000 should be used ideally Simple analgesia e.g. paracetamol, diclofenac should be offered to all patients undergoing ESWL, and if necessary, additional analgesia should be provided

Title/Topic	<p>Mode Of Delivery For Women > 50 Bmi</p> <p>N=20</p>
Directorate/Specialty	Anaesthetics
Project Type	Audit
Completed	October 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • To identify current practice • To propose a relatively safer mode of delivery for pregnant patients with high BMI <p>Findings:</p> <ul style="list-style-type: none"> • 50% of the chosen high BMI patients had a BMI in the range of 50-70 • It took 30 to 70 min to insert the subarachnoid block in 80% of high BMI patients • Surgical time ranged from 50-90 minutes in all the high BMI patients • Total time in theatre ranged from 2-3 hours in all high BMI patients • Complications in high BMI patients ranged from difficult IV access to difficulty in providing spinal anaesthesia, two of them getting converted to GA, with difficult airway. Two consultant's input was required in all cases. Blood loss ranged from 800 to 1500ml in 60% of the patients <p>Key recommendations:</p> <ul style="list-style-type: none"> • Given the above complications in just the elective procedures, when more staff is available, extrapolating this to emergency procedures at odd hours, with limited staff, we think it is prudent to recommend elective LSCS in all patients of BMI of more than 50 • CSE would perhaps be the best available method in them, provided they do not present with any contraindication for them. This would not only made the passage of spinal needle safer, with less chances of them bending or breaking and also provide means of prolonging the Anaesthesia if the procedure were to take longer. Good postoperative analgesia would also make wound healing better

Title/Topic	Audit of Aetiological Investigation of Children With Hearing Impairment N=50
Directorate/Specialty	ENT
Project Type	Audit
Completed	September 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • Assess the efficiency of joint paediatric audiology clinic • Analyse current practice of aetiological investigations for Permanent Childhood Hearing Impairment (PCHI) at Luton & Dunstable Hospital • Highlight areas requiring improvement in Joint Paediatric Audiology Services <p>Key findings:</p> <ul style="list-style-type: none"> • 65% of children were seen in Joint Paediatric Audiology Clinic within 4 weeks of referral. Another 20% were seen within a couple of months of referral • 8% were unnecessary referrals as they had normal hearing. A large proportion of those presenting with conductive hearing loss had glue ear which could have been managed in the General Paediatric ENT clinic • A significant number of patients were not offered appropriate investigations at least on their first visit • MRI requests were frequently rejected by Radiology Department. One child who had his MRI scan request turned down was found to have wide vestibular Aqueduct subsequently • CMV DNA PCR on urine samples was delayed in some cases due to inadequate sample or parents forgetting to provide a sample to lab • Lack of good audiology support resulted in inefficient clinics and multiple outpatient attendances <p>Key recommendations:</p> <ul style="list-style-type: none"> • Develop local protocols for aetiological investigations of hearing loss in children • Meet and agree indications of MRI/CT scan for hearing impaired children with Radiology colleagues • Hearing screeners should take swabs form saliva for CMVDNA PCR at the point of referral to Audiologists • Ensure good audiology support and separate Audiology clinic for routine follow ups of patients with stable hearing loss

Title/Topic	<p>Annual OMFS Record Keeping Audit</p> <p>N=20</p>
Directorate/Specialty	OMFS
Project Type	Audit
Completed	August 2014
Aims, Key Findings, Actions	<p>Main aims: To re-measure compliance with standards set out by NHSLSA, CHKS and local guidelines, and to compare with previous audit findings</p> <p>Findings: The audit identified full compliance (100%) in 63 (68%) areas, high compliance (91% - 99%) in 19 (21%) areas, moderate compliance (75% - 90%) 3% and low compliance (<75%) in 7 (8%) areas</p> <p>Following areas were identified as the worst five</p> <ul style="list-style-type: none"> • Subsequent Clinical coding information 60% • In paediatric cases, co-signing the consent form by the child • Using correction fluid for entries • A filed copy of the A&E record for the patients admitted via A&E • Recording of alerts on the DIVIDER • Updating front sheet • Next of kin details <p>Key recommendations: Results to be presented at CG meeting and to be fed back to Patient's registration department/Clinical Clerks and Clinical coding department</p>

Title/Topic	Audit of Balloon Sinuplasty N=27
Directorate/Specialty	ENT
Project Type	Audit
Completed	July 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • To assess improvement in symptoms following Balloon Sinuplasty with or without standard FESS technique • To analyse post-operative complications <p>Findings:</p> <ul style="list-style-type: none"> • 1/5th (19%) of patients developed stenosis of the maxillary ostia following balloon catheter dilatation. The frontal sinus had no stenosis • Headaches and facial pain resolved in 75% of patients. • One patient had CSF leak following frontal balloon sinuplasty • Minor complications were within acceptable limits and comparable to standard FESS. No major complications were encountered except one case of intraoperative CSF leak • Preop endoscopy was carried out in 63% of patients and postoperatively in 56%. • Only 15% were discharged home same day, most (81%) stayed overnight • Sino-nasal Outcome Test-22 Questionnaire was not filled except for a small number of cases <p>Key recommendations:</p> <ul style="list-style-type: none"> • Balloon catheters for paranasal sinuses should be considered as a useful tool for Endoscopic Sinus Surgery. Their use should be restricted to carefully selected cases of frontal sinus disease • SNOT-22 questionnaire should be filled before and after the procedure in all patients • All patients should have pre and post op endoscopy in outpatient clinic • Balloon sinuplasty should be done as day case procedure to cover the cost of the expensive disposable equipment unless it is not safe due to other medical conditions

Title/Topic	Record Keeping Audit (Anaesthetic Charts) N=39
Directorate/Specialty	Anaesthetics
Project Type	Audit
Completed	July 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> To re-measure compliance with completing anaesthetic charts (includes standards set out by CHKS, formally HQS, and local guidelines) and to compare with previous audit findings <p>Findings:</p> <p>The audit identified full compliance (100%) in the following areas</p> <ul style="list-style-type: none"> Anaesthetic sheet present Patient's name in full Patient hospital number is on sheet Drugs given during anaesthesia documented Dose of drugs documented including units <p>Following areas were identified as the worst five</p> <ul style="list-style-type: none"> Route of drug administration 0% Risk factors 23% All events are timed 41% Antibiotics given on time 62% Urgency of case documented 67% <p>Key recommendations:</p> <ul style="list-style-type: none"> Update the Anaesthetic chart (Change / Electronic chart) Do a detailed re-audit of each consultant's charts to address the areas of concern to particular consultant

Title/Topic	End Of Life Care Cquin 2014/15: Documentation Review of Deceased Patients N=40
Directorate/Specialty	Corporate
Project Type	Audit
Completed	July 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • To review current end of life care • To assess the care by looking at evidence of symptom assessment and control • To assess the use of processes relevant to end of life care such as the DNACPR and PRP • To examine support of dying patients and their family as revealed by conversations recorded in medical notes and other activities <p>Findings:</p> <ul style="list-style-type: none"> • 43% of patients were palliative on admission, 73% of whom were known to the palliative care team • 45% of deaths took place on DME wards, 18% on critical care which influences where the training needs to be focussed first • 63% of cases the patient was identified as being in the last days or hours of life. This is in line with the L&D results of the National Audit of Dying Patients (hospitals) where 76% of patients were identified as dying. The wording used by clinicians to describe this was fairly consistent and in only 13% used different words or phrases entirely • 50% of the notes examined had documented that patients complained of pain and of those 65% had documented actions undertaken, 46% noted the actions were effective • 10% of patients had nausea and vomiting as a symptom and action was taken in all cases with effectiveness of the intervention noted in 75% • 28% of patients had breathlessness as a symptom, 82% had action taken and 33.3% effectiveness noted • 28% of patients were described as having terminal agitation of which 73% had action taken to resolve it and 12.5% noted its effectiveness • 20% of patient had noisy respiratory secretions, action was taken in all cases and 25% noted the effectiveness of the action • Only 33% had all 5 anticipatory medications prescribed. Of the patients recognised as being in the dying phase 55% had their usual medications reviewed. This is similar results to those within the National Audit of Dying Patients (hospitals) in 2014 where 37% of patients had been prescribed anticipatory drugs • 100% of the cases reviewed had a DNACPR and 82% of those had been discussed with the family. 82.5% had a personal resuscitation plan and of those 6% were reviewed however this was due to the patient having died with the 3 days. Only 2% (1 patient) had an advance statement • 22% of patients had a documented preference for place of death and 28% of patients' preferences and concerns were noted. No patients had an advanced decision to refuse treatment in place • Advice was sought from the palliative care team in 40% of cases. Spiritual and or religious wishes were discussed in 18% of cases • 72% of cases the families views were discussed, in 82% the family had the plan of care explained and timescales were estimated in 33% of cases

- Hospital facilities were only mentioned once (2%) of cases. In 50% of the cases the staff discussed the patients care with family on each of the last 3 days
- Following the patient's death 12% of the notes indicated the death was verified by a nurse and 5% of the records indicated information leaflets had been given to the bereaved

Key recommendations:

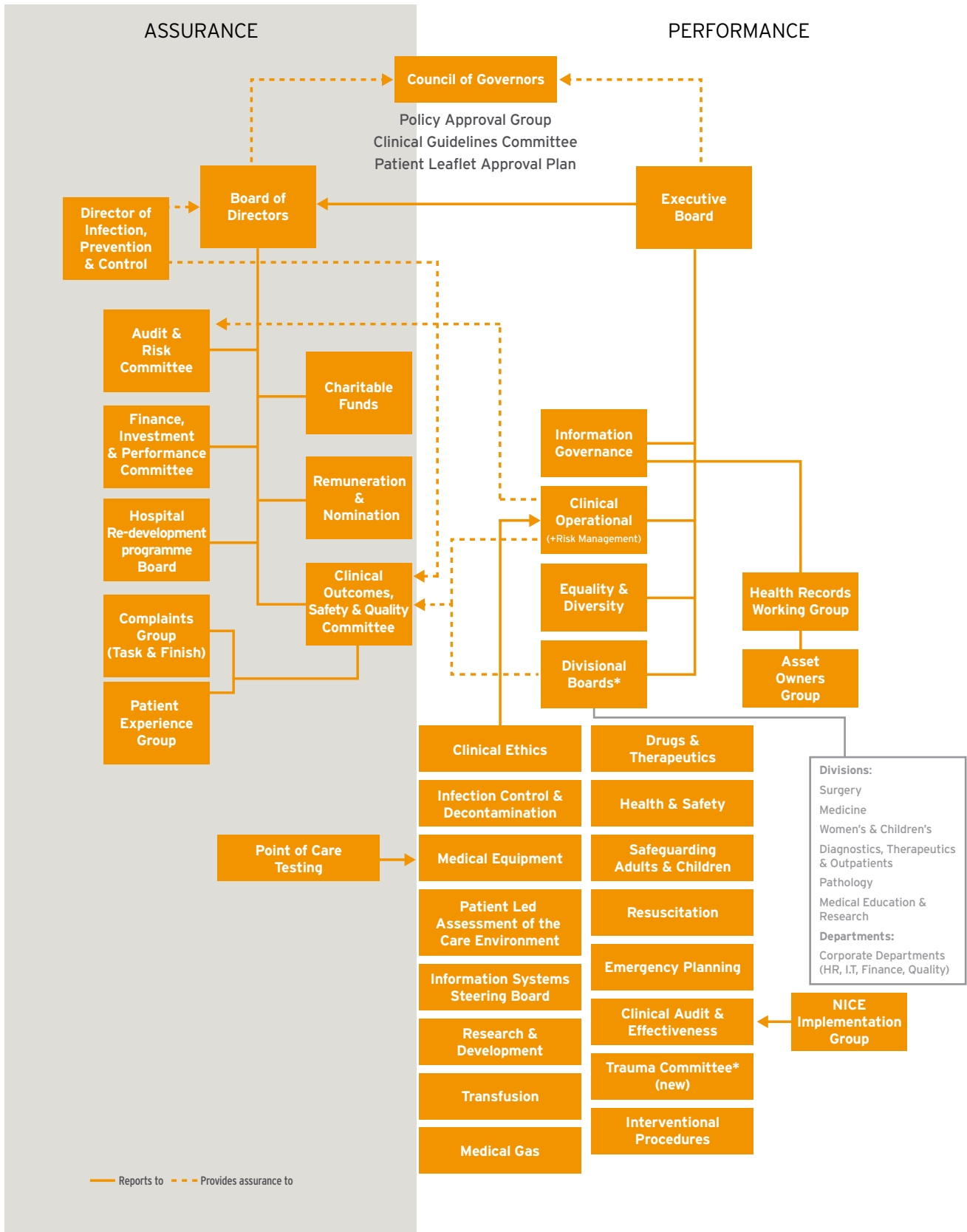
- Roll out EOL education to nurses within Critical Care, DME and Medicine division
- Implement the Individualised Plan of Care documentation and nursing care plan
- Run documentation review in Q3 and Q4 as part of the EOL CQUIN

Title/Topic	Record Keeping Audit (Maternity Intrapartum Notes) N=56
Directorate/Specialty	Obstetrics & Gynaecology
Project Type	Audit
Completed	May 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> To measure compliance with standards set out by NHSLA, CHKS, NMC and local guidelines <p>Findings:</p> <ul style="list-style-type: none"> This audit focused just on the new Intrapartum notes which were commenced in practice in June 2013, so were only being used for 4 months prior to this audit It is evident from the results that the Intrapartum notes are not being used to their full advantage. The notes were introduced to aid and assist the midwife and doctors in the care they give to the women. Prompts and checklists were included to help The results suggest a moderate evidence of compliance with the standards however significant improvement is required in certain areas Full compliance (100%) was identified against 7 (6%) standards i.e. <ul style="list-style-type: none"> The consent form has been signed The reason for surgery is given There is a completed operation form There is a completed anaesthetic form Name of anaesthetist is identifiable on anaesthetic form If shoulder dystocia was documentation tool completed The woman's name is clearly identified on the front of the labour and birth record High compliance (91% - 99%) was recorded against 19 (16%) standards, while 29 (24%) standards were proved of moderate compliance (75% - 90%) Low compliance (<75%) was identified against 67 (55%) standards mainly in the areas of: <ul style="list-style-type: none"> Initial labour assessment Management of labour CTG Partogram Labour and birth summary Post delivery Admission to MLBU <p>Key recommendations:</p> <ul style="list-style-type: none"> Completion of the labour admission and risk assessments to be highlighted in the newsletter and to be discussed monthly at the Obstetric study day Documentation of admission to MLBU including Swab, needle and Instrument checks to be discussed at the Normality Study day To put alerts in weekly newsletter To send alerts to staff regarding the checking procedures Re-audit of Intrapartum notes

Title/Topic	Patient Experience Survey N=50
Directorate/Specialty	Orthodontics Department
Project Type	Survey
Completed	April 2014
Aims, Key Findings, Actions	<p>Main aims:</p> <ul style="list-style-type: none"> • To identify levels of patient satisfaction within the Orthodontics department • To identify specific areas for improving patient experience <p>Findings:</p> <ul style="list-style-type: none"> • Overall the vast majority of patients believe that within the orthodontic department, the staff were friendly and take an interest in their patients • They were treated by clinicians who took time to clearly explain procedures and listen to patients • They felt confident to trust the orthodontist seeing them • Were central in the decision making for their treatment • Their treatment was progressing well • They encountered very clean surroundings • They were treated with dignity and respect • They would highly recommend the service they received <p>Key recommendations:</p> <ul style="list-style-type: none"> • Limit delays during clinics. This is difficult as the department a large number of people each day • Provide information regarding the duration of the anticipated delay. This may be applied where there is an expected delay of over 15 minutes

Appendix B - Trust Committee Structure

Luton and Dunstable Hospital Governance and committee structure



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

