LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

2013/14 QUALITY ACCOUNT/REPORT Appendix to the Annual Report

28/4/14

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What is a Quality Account?

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

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

A review of our quality of services for 2013/14 is included in this account alongside our priorities for quality improvement in 2014/15. This report summarises how we did against the quality priorities and goals that we set in 2013/14. It also tells you those we have agreed for 2014/15 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 2014/15.

The second section looks at our performance in 2013/14 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 2014/15 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 641 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 70,000 admitted patients, over 300,000 outpatients and ED attendees and we delivered over 5,100 babies.

We serve a diverse population most of which are the 210,000 people in Luton. Luton is an ethnically diverse town, with approximately 41% of the population from non-white British communities. Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. (Reference: Annual Public Health Report 2012/13). We celebrate the diversity of our population and are committed to ensuring that issues of Equality and Diversity have a high profile.

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 and Orthopaedic	Plastic Surgery ENT Cancer Services Medical Oncology Ophthalmology Oral and Maxillofacial Surgery Anaesthetics Pain Management

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

During 2013/14 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 Seminars.

In June 2014, the Trust will publish a five year strategic plan, focussing on transforming the L&D into a hyper acute emergency hospital, a women's and children's hospital and an elective centre, whilst maintaining the organisations' status as a University Teaching Hospital.

Part 1

1. A Statement on Quality from the Chief Executive

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. The organisations transformation of performance on fractured neck of femur during 2013/14 is just one example of this.

In the coming year as the organisation begins 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, being at the forefront of delivering excellence in clinical practice will be our top priority. This will also enable us to build on the achievements of recent years.

During 2013/14, as in previous years we consistently delivered against national and local quality and performance targets, we:

- Increased the level of consultant cover across specialities
- Introduced a 'Home from Hospital' team resulting in a decrease in emergency admissions and patient's length of stay
- Achieved a 33% reduction in the falls resulting in severe harm
- Achieved a 41% reduction in hospital acquired pressure ulcers
- 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 the mortality rate of those with a fractured neck of femur from 154 in March 2013 to 84 in March 2014
- Achieved all of the national waiting time targets in A&E, 18 weeks and cancer
- Achieved the target set for the % of stroke patients spending 90% of their inpatient stay on the stroke unit
- Further strengthened the governance arrangements for mortality and complaints
- 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
?? May 2014

Corporate Objectives 2013/14

The Trust's corporate objectives for 2014/15 were selected 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.

The Trusts strategic direction is underpinned by seven corporate objectives:

1. **Deliver Excellent Clinical Outcomes**
   - Year on year reduction in HSMR in all diagnostic categories
     - Implement earlier recognition of Acute kidney injury (AKI) illness severity and earlier senior clinical involvement
     - Implement a new model of integrated care for older people

2. **Improve Patient Safety**
   - Year on year reduction in clinical error resulting in harm
     - Ensure that we have the appropriate level of clinical expertise available to deliver consistent inpatient care irrespective of the day of the week
     - Roll out the Perfect Day across the hospital
     - Ongoing development of Safety Thermometer, improving performance year on year
     - Improve the management of the deteriorating patient
     - Reduce Avoidable harm caused by prescribing and administration processes by implementing an Electronic Prescribing and Medicines Administration (ePMA) system:
   - Year on year reduction in HAI
     - Continue to reduce HCAI rates year on year
     - Increase compliance with hand hygiene year on year

3. **Improve Patient Experience**
   - Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance
     - Revolutionise the outpatient booking system
     - Decrease diagnostic wait times
     - Improve the experience and care of patients at the end of life and the experience for their families.

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. **Develop all staff to maximise their potential**
   - Deliver excellence in teaching and research as a University hospital
   - Ensure a culture where all staff understand and promote the vision and values of the organisation

- Recruit and retain a highly motivated and competent workforce

7. **Optimise our Financial Plan**
   - Deliver our financial plan 2014-2016 with particular focus on the implementation of re-engineering programmes

Part 2

2. Report on Priorities for Improvement in 2013/14

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

Priority 1: Patient Safety

Key Patient Safety Priority 1

- **Ensure that we have the appropriate level of clinical expertise available to deliver safe and effective care 24/7**

Why was this a priority?

There continued to be an increase in emergency demand nationally; therefore the optimum level of medical expertise is needed to provide safe and timely medical care.

What did we do?

A new medical model of care for patients admitted as an emergency has been implemented in 2013/14. The emergency take is now consultant led from 10:00 to 22:00 each day with support out of hours from an on-call physician and an on-call geriatrician. The on-take consultant works between the emergency Department and the Emergency Assessment Unit to ensure that all newly admitted patients receive senior clinical review as early as possible either prior to, or immediately after, admission. Patients admitted after 22:00 are seen by the on-call consultants at the start of the next day. This model of care ensures that the majority of emergency admissions receive consultant review within 14 hours of admission.

We have also recruited additional Emergency Medicine Consultants. This has allowed us to provide more consultant cover on the shop-floor with at least one consultant present between 08:00 and 00:00 each day.

There has also been an increase in weekend working in 2013/14. The new medical model operates 7 days a week to ensure patients admitted at weekends receive the same level of service as those admitted during the week. The duty consultant also performs Ward Rounds on our Medical Short Stay Units to ensure patients' discharge is not delayed over the weekend and to support flow through the hospital. Ward Rounds also take place on the Respiratory and Cardiac Units at weekends and both of these specialties also undertake outreach work to support appropriate patients on other units at weekends and to ensure patients admitted over the weekend do not need to wait until Monday for a specialist review.

How did we perform?

The new medical model of care was a success in 2013/14. Despite an increase in emergency activity over the year, particularly during the winter, the Medicine Division managed this demand through a reduced number of beds with a much reduced requirement for the opening of additional ward space and a reduction in the number of 'outlier' patients. By front-loading the division's senior decision making resource many patients had a reduced length of stay as the plans for their care were devised and implemented in a more timely manner. As a result the number of short stay admissions increased by 5% and the number of patients staying in hospital for more than 5 days reduced by 7%.

Key Patient Safety Priority 2

- **Ongoing development of Safety Thermometer, exceeding performance year on year**

Why was this a priority?

The NHS Safety Thermometer gives nurses a template to check basic levels of care, identify where things are going wrong and take 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 Trust has continued to use the NHS Safety Thermometer as a method for surveying patient harms and analysing the results so that we can measure and monitor local improvements to increase the percentage of harm free care to our patients. The Trust has improved throughout the year and continues to deliver a high percentage of harm free care.

The safety thermometer objectives for 2013/14 were:

- Eliminate all avoidable hospital acquired grade 2, 3 and 4 pressure ulcers.
- Continued roll out of the falls care bundle in all wards leading to an overall reduction in the incidence of falls resulting in moderate or severe harm or death, by at least 10%.
- Reduction in the use of urinary catheters and improved compliance with best practice guidelines.

What did we do?

Pressure Ulcers - The Trust has rolled out the 'Stop the Pressure' change management programme across all wards to support the reduction in the number of hospital acquired avoidable pressure ulcers.

Falls - Work continues on ensuring that patients are assessed for their risk of falling and the appropriate preventative measures put in place.

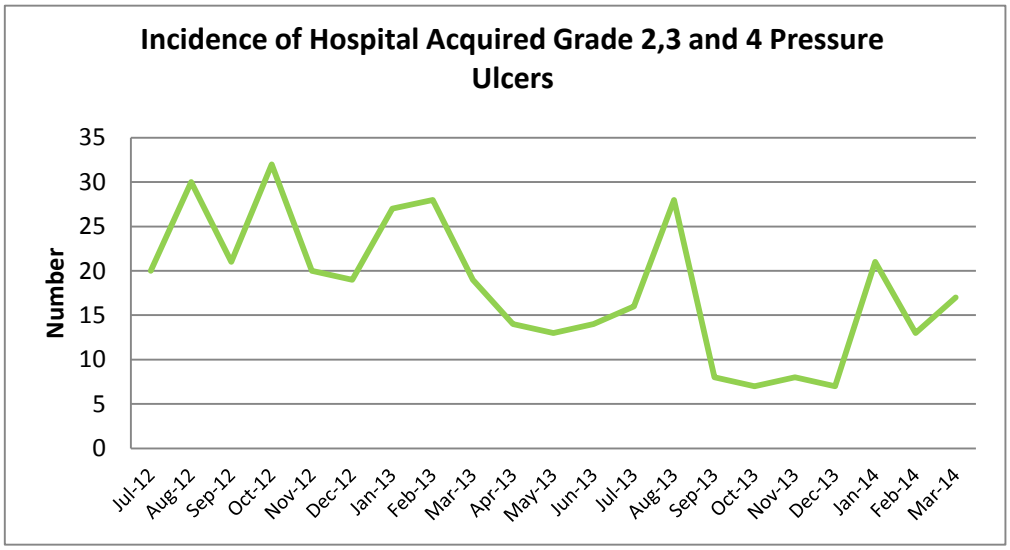
VTE - The Trust assesses all patients for their risk of acquiring a thrombosis and that the appropriate preventative treatments have been prescribed. Throughout 2013/14, the Trust has also undertaken root cause analysis of all hospital acquired thrombosis cases to ensure that any improvements to practice can be identified.

Catheter related urinary tract infections - The Trust set out to reduce the number of urinary catheters that are used for patients as fewer catheters reduce the risk of catheter associated

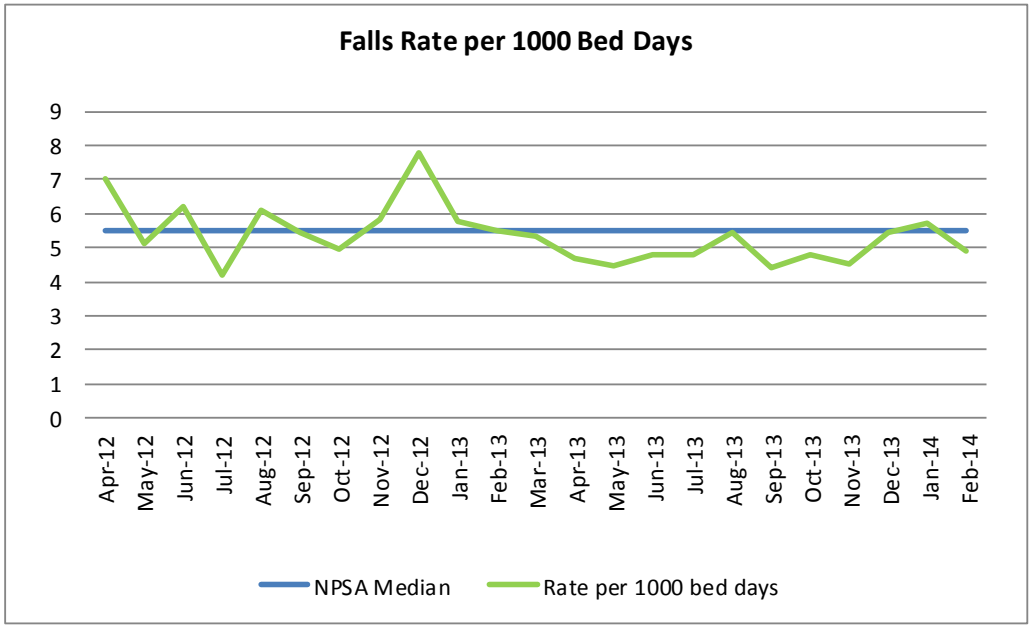
infection. The Continence specialist nurse has been working with clinicians to ensure that catheters are only used when there is a clinical need.

How did we perform?

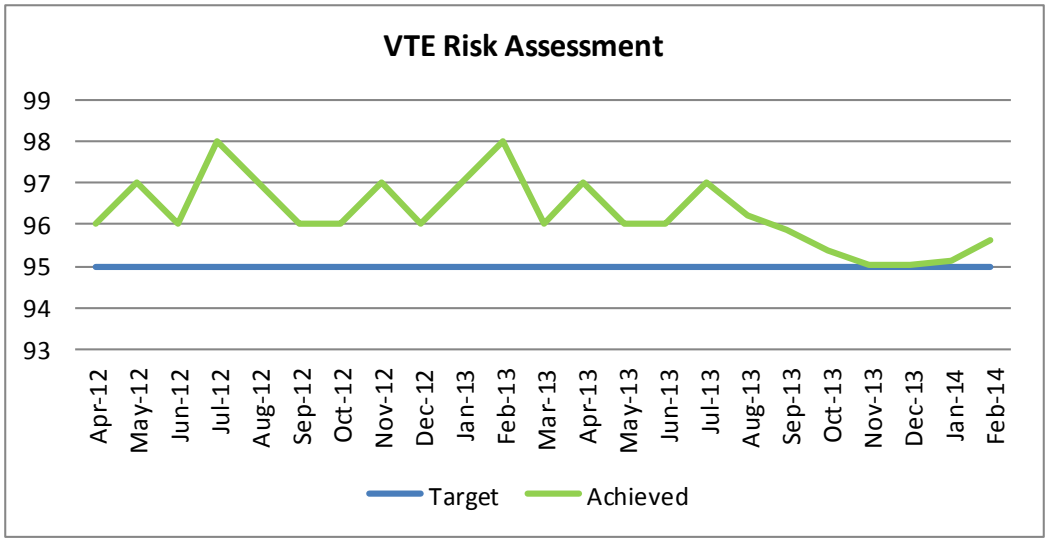
Pressure Ulcers - The Trust has delivered a 41% reduction in the incidence of grade 2, 3 and 4 hospital acquired pressure ulcers.



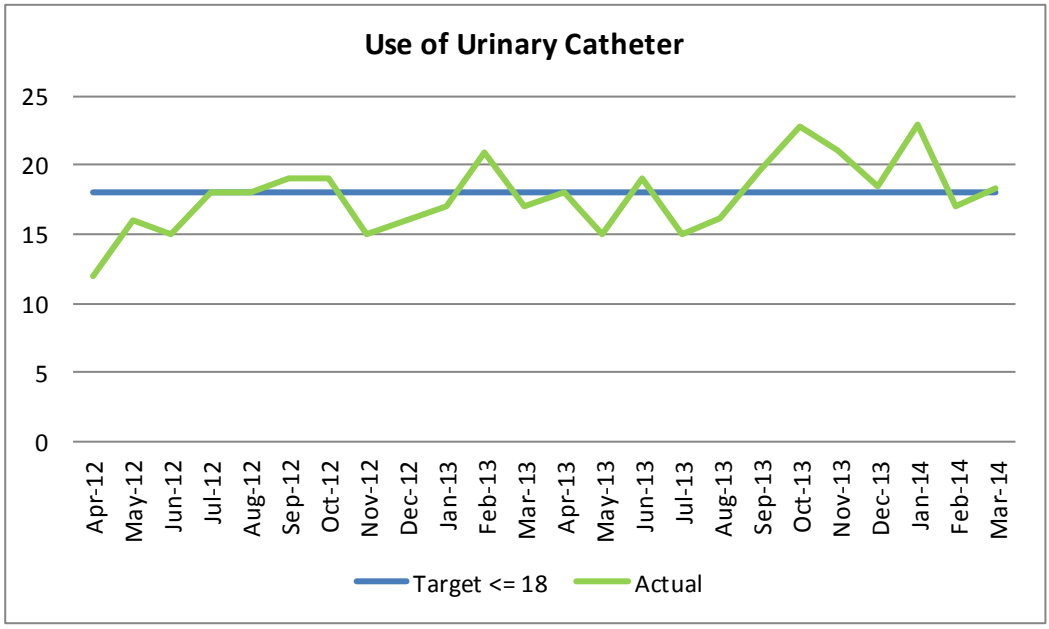
Falls - The Trust has delivered an 18% reduction in the number of falls and a 33% reduction in the number of falls with severe harm.



VTE - The Trust has consistently achieved the VTE risk assessment target of 95%.



Catheter related urinary tract infections - Since January 2014, the Trust has seen a 7% reduction in the use of urinary catheters which is now in line with the national average.



Priority 2: Patient Experience

Key Patient Experience Priority 1

- **To revolutionise how we handle complaints.**

Why was this a priority?

The fundamental purpose of the hospital is to deliver excellent patient experience and clinical excellence by constantly improving clinical outcome. Patient experience is of significant importance and the core values set out the determination of the organisation to put patients first and ensure that every patient has the highest quality experience.

During 2012/13 it was recognised that there are improvements needed in the process to ensure that complaints received from patients are managed and responded to in a more acceptable timeframe. Complaints are a valuable and vital source of patient feedback which allows the identification of areas of improvement that are needed. During the last year the Trust recognised that whilst the quality of responses to complaints was good, response times needed to be improved.

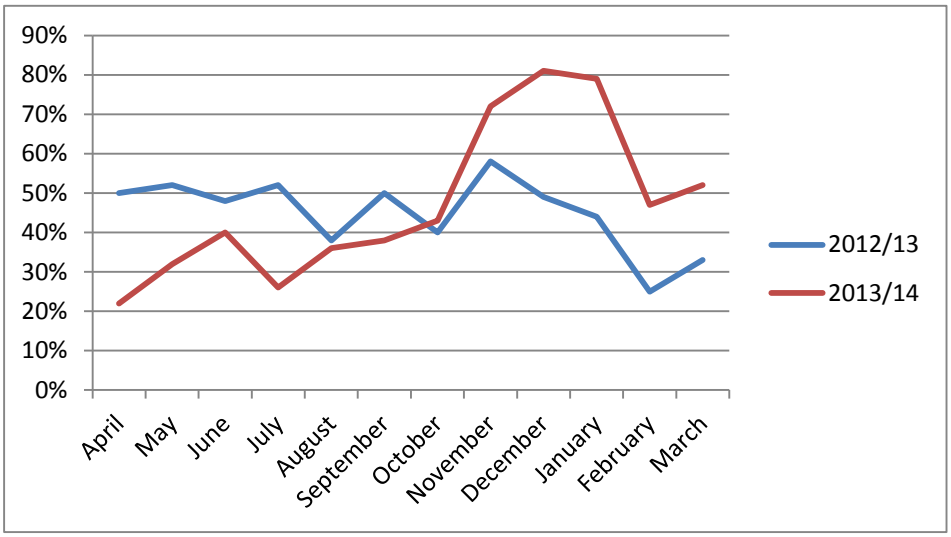
What did we do?

A programme of work was initiated through the development of a Complaints Board which sits every month. The reports to the Board include:

- The number of overdue responses currently outstanding
- The average response times for each division
- The percentage, broken down by division, of complaints responded to within the target response period
- The number of complainants who are dissatisfied with our initial response and write with further enquiries
- The number of significant complaints
- The number of upheld/partially upheld complaints
- The themes identified

How did we perform?

Our target of clearing the backlog of overdue complaints by 1st October resulted in a substantial improvement in the percentage of complaints responded to on time. Staffing levels within the divisions have been increased to ensure this improvement is maintained long term. This target is monitored and reported on a monthly basis.



During 2013/14 we received 639 formal complaints compared to 604 in 2012/13. The NHS as a whole has seen an increase in the number of complaints received. This is as a result of members of the public being more willing to raise their concerns because they no longer fear their care will be jeopardised as a result, increasing awareness of the complaints process and making it easier for service users to make a complaint.

We are now able to monitor and report the number of occasions a complainant feels it necessary to submit a further complaint upon receipt of our first response. In 2013/14 this happened on 94 occasions. The further correspondence received raised a variety of issues, such as the information we provided raised further questions, that new or additional queries had come to mind, and, in some cases, that the response we had provided did not address all the concerns that had been raised in the initial letter of complaint. We will continue to monitor this activity and now we have a benchmark, will be able to ensure that in striving to improve and maintain the percentage of complaints responded to in a timely manner; the quality of the responses does not decline.

The Patient Safety Lead is driving the triangulation of data from Complaints, Incidents and Claims. The dissemination of the lessons learnt as a result of these activities, across the Trust, remains a priority.

A central log is kept of the members of staff who have been the subject of a complaint. This information allows for trends in behaviour to be identified. Complaints, Claims and Incidents are now discussed as part of the revalidation process.

Key Patient Experience Priority 2

- **Continue to implement the Outpatient Transformational programme**

Why was this a priority?

The Outpatient Transformation programme continued to build on its successes throughout 21013/14. During 2013 the foundations were established in terms the importance of delivering a high quality experience for patients with almost all outpatient staff completing their via the Customer Care NVQ qualifications. A number of outpatient facilities were also improved and a range of processes and systems were improved. However, there is still a lot to be done to totally transform the outpatient experience and the remit of the group will remain to improve the overall experience for patients.

A key focus for 2013/14 will be the need to align consultant availability to clinic capacity more effectively in order to minimise short notice cancellations and also to redesign the overall appointment pathway to reduce the time between an appointment being made and the actual appointment date. The longer this time, the greater the chance of cancellation by the hospital or for the patient to forget their appointment and then fail to attend.

What did we do?

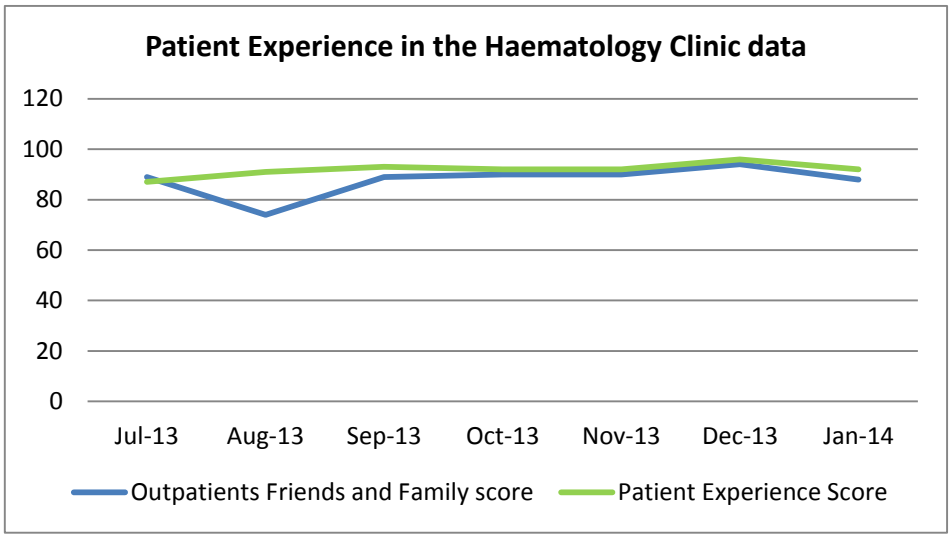
- Outpatient administrative staff completed an NVQ Outpatient customer service training programme and developed their OPD CARE service commitment with Training and Development
- The Outpatient team participated in a McKinsey Health Institute (MHI) programme focussing on improving patient experience in Phlebotomy and Haematology
- Introduced an Outpatient based phlebotomy service in Zone C
- Introduced an interactive appointment confirmation system to remind patients of their appointment and provide opportunity to confirm or reschedule
- Completed the procurement of outsourced Outpatient appointment correspondence which will allow more pre-appointment information to be sent to patients
- Completed consulting room upgrades to Zone C
- An Outpatient Operations Board was established to support Divisional business manager involvement in driving improvements in service capacity and planning
- Established an OPD specific patient experience facility capturing patient feedback
- Developed Outpatient based patient experience key performance indicators to report to the Divisional Board on a monthly basis
- Reduced the number of patients impacted by short notice clinic cancellations initiated by the Hospital
- Reduced in year the percentage of Outpatient appointments not attended

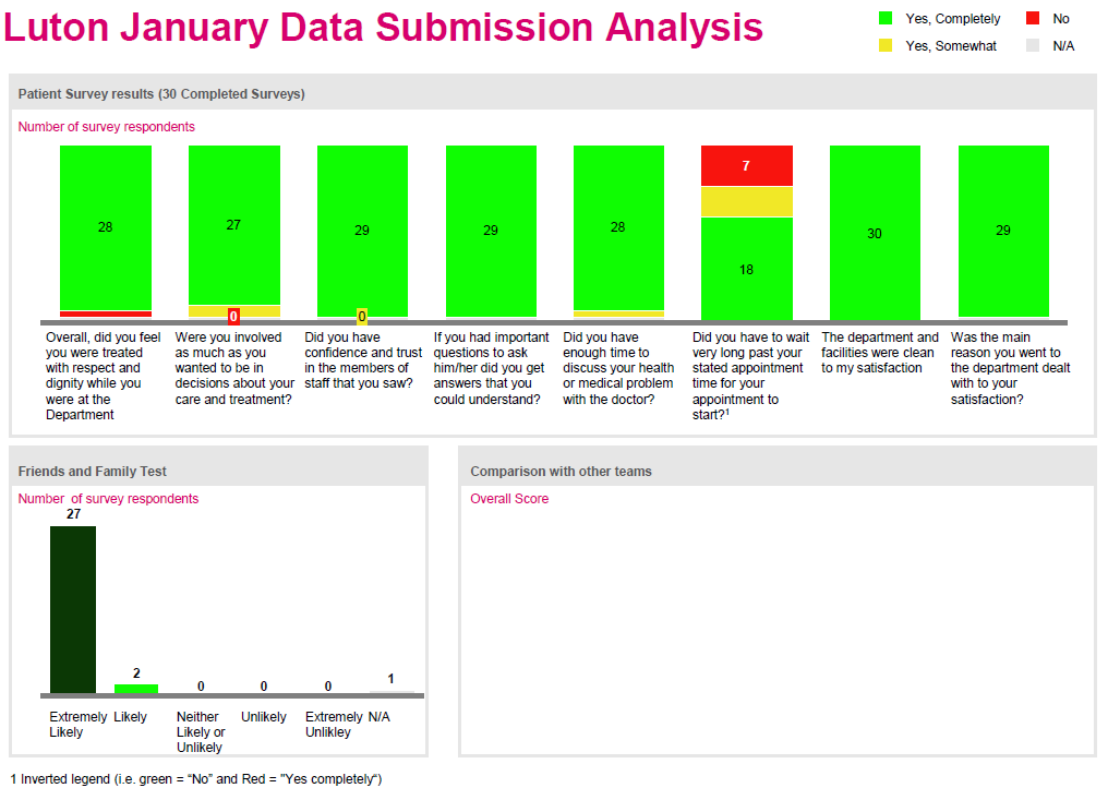
How did we perform?

Patient experience data collected during participation in the MHI programme demonstrates high levels of satisfaction in Haematology, where significant improvements have been made over the course of the programme. Further improvements are needed in reducing patient waiting times.

- **McKinsey patient experience in Haematology clinic data**

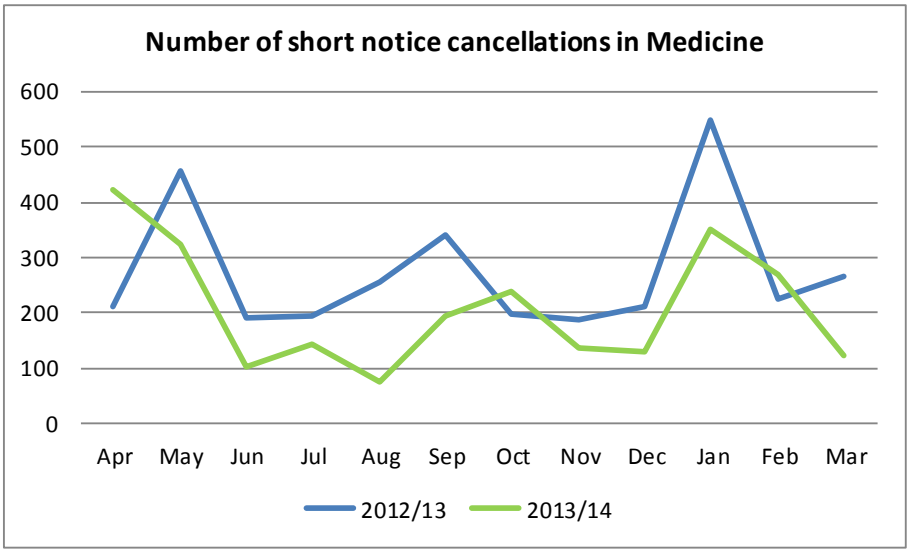
There was only one complaint within this six month period.

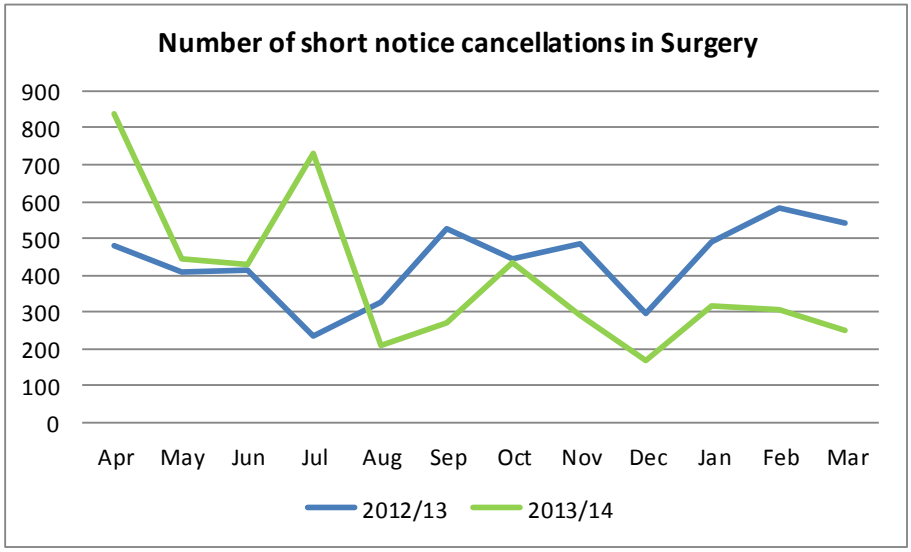




- **Hospital initiated short notice clinic cancellations**

The Trust Hospital initiated short notice cancellations of appointments (less than 6 weeks notice) over the course of the last year have been reduced and work continues to reduce further, representing just over 1% of total appointments in March 2014 (4% in 2013/14). Last year the two Divisions that had the most cancellations were surgery and medicine. Focussed work throughout the year has demonstrated significant progress in reducing the short notice cancellations.



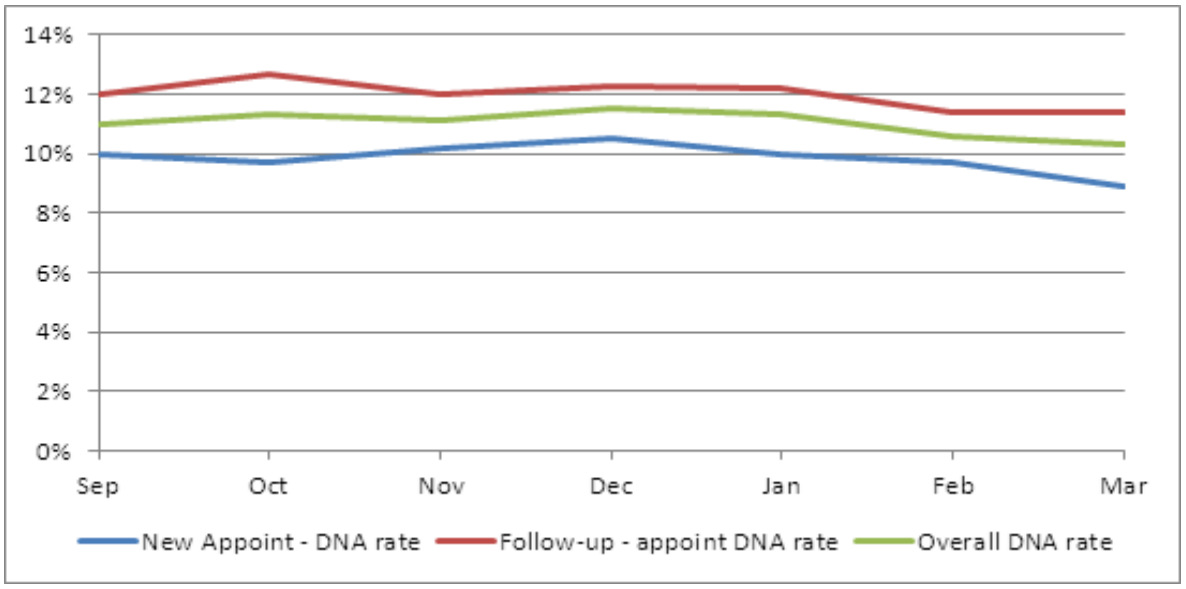


- **Patient experience dashboard**

Results of patient experience feedback following outpatient attendance demonstrate a number of areas whereby patients report a high level of satisfaction. Telephone call response times and waiting times in clinic, however, need to be improved and will be a focus for improvement this year.

	Jun 13	Jul 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14
% of patients who know what to expect prior to attending	72%	70%	98%	96%		100%	96%	100%
% of staff treating / examining patients who introduced themselves	89%	81%	92%	91%		98%	94%	94%
% waiting > 30 minutes	35%	50%	44%	30%	35%	44%	43%	50%
% welcomed at reception and privacy	83%	78%	98%	96%	100%	100%	98%	100%
% Confidence / trust in the doctor	95%	91%	98%	98%	96%	98%	96%	94%
% Confidence / trust in the Nurse	96%	92%	100%	98%		100%	100%	100%
% Rating service (good to excellent)	90%	79.5%		92%	88%	97%	91%	94%
% of calls answered within 30 seconds			77%	70%	79%	67%	54%	57%

- **Outpatient appointments not attended (DNA rate)**



Appointments not attended (DNA rates) have reduced over the last several months and the imperative is to reduce these further to provide greater efficiency and reduce wastage of appointment slots.

Priority 3: Clinical Outcomes

Key Clinical Outcome Priority 1

- **To improve performance by reducing average length of stay for older people**

Why was this a priority?

The 2012 Hospital Guide produced by Dr Foster includes 13 measures of efficiency for each Trust. An area in which the hospital did not perform well on was the length of stay for elderly patients, indicating that this is longer when compared to trusts in England. It was recognised that that staying in hospital for longer than clinically necessary can put patients at risk and frequently leads to increased dependence for older patients.

What did we do?

In 2013/14 we implemented a new medical model of care that facilitated earlier review of all medical patients who were admitted as an emergency. By reviewing patients in a more timely way effective management plans were put in place for patients earlier reducing the length of time patients have to stay in hospital.

A long length of stay board was established. This provided a forum in which to discuss patients who had particularly long spells in hospital in order to remove any barriers to safely discharging patients from an acute setting and to ensure patients were not unnecessarily delayed in hospital.

Hospital at Home was launched. This service provides acute nursing support for patients in their own homes. By facilitating on-going care in a patients own home, rather than in a hospital setting it is possible to avoid having patients in hospital longer than is necessary and improves the overall experience for patients who are able to recuperate more effectively in a familiar environment.

How did we perform?

There has been a 15% reduction in the number of patients under the care of our Elderly Medicine Physicians who stayed more than 5 days in hospital and a 6% reduction in the number of patients staying longer than 15 days.

Key Clinical Outcome Priority 2

- **Improve performance on overall hospital mortality across fractured neck of femur and all specialties**

Why was this a priority?

The Trust HSMR for the calendar year 2012 was 97.2 compared to 94.6 for 2011. Whilst the HSMR continued to be excellent for some patient groups such as myocardial infarction (heart attack), and whilst there has been an improvement of HSMR for fractured neck of femur, it was recognised that there remained further improvements to be made.

In March 2013 the data from the National Hip Fracture Database report did confirm the Trust as an outlier in terms of mortality rate for fractured neck of femur. Mortality rate for repair of fractured neck of femurs decreased from a peak of 197.4 in September 2012 to 154.0 at the end of March 2013. Therefore a continued commitment to reduce the mortality rate amongst this group of patients remains a priority for the hospital in 2013/14.

What did we do?

During 2013/14, the multidisciplinary group led by the Divisional Director for Surgery and including members of the clinical team from all staff groups, continued to drive forward the improvement in the outcomes for patients admitted with fractured neck of femur.

The group successfully implemented an integrated pathway, and focussed on achievement of the key standards for treatment of fractured neck of femur patients.

Full case note reviews for all patients who died following admission with fractured neck of femur were undertaken by the consultant orthogeriatrician and reviewed by the multidisciplinary team.

The fractured neck of femur steering group presented performance to the Board of Directors through the Clinical Operational Board (COB) and regular performance dashboards were shared with staff to communicate the improvement.

Training was provided to senior anaesthetic staff on the use of peri-operative fluid optimisation to ensure that patients had the shortest possible recovery time post-surgery. This was monitored with the Clinical Commissioning Groups as part of delivery of our CQUIN targets for the year.

How did we perform?

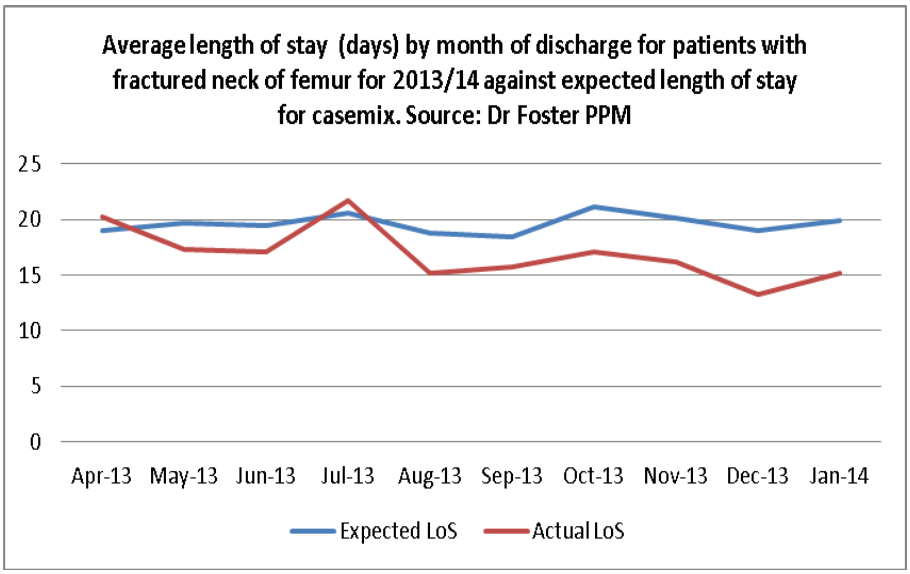
During 2012/13, the Trust had successfully reduced fractured neck of femur mortality rate to 154. This downwards trend continued during 2013/14 and at the end of 2013/14 our rate has fallen to its lowest point at 84.0.

The number of patient deaths following repair of fractured neck of femur during the twelve months April 2013 to March 2014 was 21, compared to 33 the previous year.

All key performance indicators have shown an improvement since previous years including 99% of patients being seen within 72 hours by an Orthogeriatrician compared to 87% the previous year, and 85% of patients went to theatre within 36 hours compared to 80% during 2012-13.

Indicator	June 12 – March 13	April 13 – March 14
Admissions (number)	279	293
Cases per month	28	24
% with pain score completed in A&E	32%	43%
% admitted to #NOF ward directly	79%	85%
% in theatre within 36 hours	80%	85%
% orthogeriatric review <72hrs	87%	99%
% AMT recorded pre-op	90%	92%
Crude deaths per year (local Data)	33	21
Crude deaths (%) (local Data)	11.8%	7.1%

Our length of stay continued to reduce during the year for patients admitted for repair of fractured neck of femur, and now stands at an average of x days. We are achieving below the expected length of stay for our case-mix of patients according to Dr Foster data.



3. Priorities for Improvement in 2014/15

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

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

Why is this a priority?

The Trust HSMR for the calendar year 2013 was 96.0 compared to 97.2 for 2012. In March 2013 the data from the National Hip Fracture Database report did confirm the Trust as an outlier in terms of the mortality rate for fractured neck of femur. However through a continued commitment and focus on reducing the mortality rate amongst this group of patients, this has now significantly reduced to a current HSMR of 91.

The Mortality Board monitors the overall HSMR & SHMI. Currently there are no diagnoses where the HSMR is 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 will be a priority for 2014/15 and has been agreed as a CQUIN scheme.

What will we do?

- Develop an electronic alert system to detect changes in serum creatinine that may be indicative of AKI thus enabling early identification of patients and implementation of prompt management plans.
- Develop an educational programme for all trainee doctors based on the prevention of AKI so that they are able to recognise and respond appropriately to the diagnosis of AKI.
- Introduce a formal clinical management care bundle for patients with AKI to reduce the severity and length of stay.

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

- Improved management of the patient with AKI as evidenced through audit.
- Reduction in the number of patients who require renal support.

Key Clinical Outcome Priority 2

- **Implement a new model of integrated care for older people**

Why is 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. (Further information about the integration project is detailed in Appendix 2.)

What will we do?

- Co-ordinate care around the individual through the creation of co-located joined-up health and social care teams.
- Provide more proactive rather than reactive care, reducing the amount of 'crisis' admissions into hospital.
- Deliver patient care in the most appropriate setting and as a result fewer people are treated in the hospital.
- Help patients maintain and maximise their independence.
- Improve the support and training provided to carers.
- Improve how patients access their care by implementing a single point of contact for patients and professionals.
- Reduce organisational fragmentation by focusing on care pathways rather than organisational boundaries.

How will improvement be measured and reported?

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

Success Criteria

- Improved patient care and experience.
- Improved accessibility and responsiveness of services.
- Reduction in overall levels of unplanned admissions and hospital attendances of older people.
- Reduction in delayed transfers of care. Once the patient is medically stable they are discharged to the appropriate care setting.
- Improvement in planned hospital admissions, admissions are both planned and managed between the community MDT team and hospital geriatrician.
- Reduction in the number of re-admissions to hospital within 30 days as the right packages of care are available within the community setting.
- Reduction in hospital LOS – patients follow a planned admission pathway into the hospital for treatment and once medically stable, follow a planned discharge pathway to the appropriate community setting.

Priority 2: Patient Safety

Key Patient Safety Priority 1

Why is this a priority?

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

Considerable evidence has emerged in recent years linking poorer outcomes for patients admitted to hospital as an emergency at the weekend. This variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates.

This evidence has led to the need for greater consultant presence at weekends with the aim of improving patient outcomes and also providing greater support and training for junior doctors. Ensuring patients receive consistent, high quality care across seven days of the week will be a key priority for the Trust.

What will we do?

- Develop a plan to meet the key clinical standards for 24/7 working, with agreed targets as part of the CQUIN scheme for 2014/15.
- Review all inpatients by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patients' care pathway.
- All emergency admissions will be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of arrival at hospital.
- Consultant interventions and investigations and completed reporting will be provided seven days a week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day. This will include interventions which will enable immediate discharge or a shortened length of hospital stay.
- Ensure that diagnostic and support services are available to support 24/7 working.

How will improvement be measured and reported?

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

Success Criteria

- Rapid and appropriate decision making through timely investigations.
- Improved safety, fewer errors.
- Improved outcomes through improved diagnosis and appropriate treatment.
- Improved patient experience due to appropriate and skilled clinicians and availability of information.
- Improved supervision and training of junior doctors.
- Timely discharge planning.

Key Patient Safety Priority 2

- **Roll out the Perfect Day across the hospital**

Why is this a priority?

This innovative model involves a completely new workforce design 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 support staff element of the workforce has also required a radical review.

An Implementation Board has been set up to manage the roll out of the model across the organisation. A key task of the Board will be to ensure affordability. The model is currently being embedded in practice on four wards. A number of workstreams have been set up to look at the support roles to define the standards and identify the education and training requirements for each role.

What will we do?

- Develop and implement the generic support worker role (Bands 1-3) to further enhance the new way of working.
- Establish a programme of work to roll out the Perfect Day Model across the hospital.

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

- Improved patient experience scores.
- Reduced complaints.
- Improved nursing metrics.
- Improved staff experience.

Key Patient Safety Priority 3

- **Ongoing development of Safety Thermometer, improving performance year on year**

Why is this a priority?

The NHS Safety Thermometer provides 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.

Continued use of the safety thermometer for 2014/15 will provide 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.

What will we do?

- Continue to use the prevalence data from the Safety Thermometer as an improvement tool to continue to reduce the amount of harm patients experience
- ***Pressure Ulcers.*** The Trust has made significant progress in reducing the numbers of hospital acquired pressure ulcers. To continue upon this improvement, we have established 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 effectiveness of this approach will be measured by the number of reported incidents of avoidable 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. The Trust has been successful in reducing the overall number of falls and those falls that result in severe harm. To further improve this, a greater focus on risk assessment and delivering on all elements of the 'falls care bundle' will be required.
- ***Catheter related Urinary Tract Infections.*** Work is underway to reduce the use of urinary catheters across the Trust. A key priority area is to focus on post operative patients. A quality improvement plan that includes key interventions continues to be implemented.
- ***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?

- 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 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.

Success Criteria:

Further improve clinical outcome by:

- 15% reduction in the prevalence of hospital acquired, avoidable grade 2 and 3 pressure ulcers
- 5% reduction in the proportion of patients with harm from a fall
- Deliver a 5% reduction in the proportion of patients with a urinary catheter
- Maintain 95% (minimum) patients to have had a VTE risk assessment on admission
- Undertake Root Cause Analysis (RCA) on all cases of hospital associated thrombosis where known.

Key Patient Safety Priority 4

- **Improve the management of the deteriorating patient**

Why is this a priority?

The recognition of acute illness is often 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 avoidable deaths. 'Wardware', the electronic observation system, has been introduced to assist with addressing these issues. Wardware has assisted with providing the organisation with details on a ward by ward and day to day basis of the performance of observations.

Analysis of the cardiac arrests is undertaken by the Resuscitation team and this has highlighted some areas for improvement regarding nursing and medical response to abnormal observations. Work is being undertaken to assist with categorising this, and the reasons for failures to respond in a timely manner and to identify the actions that are required to address the issues raised. This will include the following key objectives:

What will we do?

- Implement a robust process to ensure the effective coordination and management of the 'deteriorating patient pathway'.
- Develop a measurement system for categorising the effectiveness of the management of the deteriorating patient pathway to create a baseline.
- Improve the visibility of patients' observations through the purchase of additional hardware will enable the immediate recognition of a deteriorating patient.

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 of 50% on the baseline for the following measures:

- Timely and appropriate observations
- Appropriate and timely escalation when a patient is deteriorating
- Timely medical response as a result of escalation of concerns
- Effective action to prevent further deterioration
  Reduction in number of cardiac arrests

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 is this a priority?

Work is already underway to build and test an Electronic Prescribing and Medicines Administration system which will make the Drug Chart electronic, with all the attendant safety and process benefits. In 14/15 we will 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 will we do?

- Implement, integrate and configure the already procured ePMA system.
- Train and change the process for both prescription and administration.
- Deliver sufficient hardware in the right place for staff to access the ePMA system seamlessly within the bedside processes for prescribing and administering.
- Measure the benefits revisiting base lined areas of safety focus.
- Deliver of a locally agreed medicines management CQUIN.

How will improvement be measured and reported?

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

Success Criteria

- Implementation of the ePMA system across all inpatient areas, excluding maternity.
- Reduction in the types of interventions and a move to targeted specialist support from pharmacy.
- 50% reduction in number of transcribing errors.
- 50% reduction in missed doses.
- 20% reduction in the time to deliver the end to end TTA process.
- Ability to derive accurate patient level drug costs.
- 50% improvement with adherence to IV to oral switching and duration.
- Reliable capturing of allergy alerts on admission.

Priority 3: Patient Experience

Key Patient Experience Priority 1

- **Revolutionise the outpatient experience for our patients**

Why is this a priority?

The Outpatient Transformation programme will continue 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 but will deliver in the June 2014. This will enable a fundamental redesign of supporting processes around outpatients. The last year has seen the introduction of an outpatient based phlebotomy service and further improvements to consulting rooms. An outpatient appointment confirmation system using interactive technology has been introduced aimed at reducing Outpatient non-attendance rates and allowing patients to cancel appointments where necessary. This service has been rolled out across the Trust and combined with the successful substantial reduction in short notice clinic cancellations and the publishing of the 10-day look forward appointment availability, will drive improved efficiency and availability of appointments and provide patients with greater access and choice.

During the latter part of 2013/14 members of the Outpatient team participated in a McKinsey patient experience project. The CARE commitment has been developed with Outpatient staff to exemplify and promote the values of delivering good outpatient customer care. 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 will become a major focus of development in 2014.

What will we do?

- Commence a remote check in service to reduce queuing times and to help drive a reduction in delays in clinics.
- Introduce outpatient room booking software to improve clinic scheduling and ultimately to create more capacity and reduce waiting times.
- Introduce a new contact centre, to move towards a single point of contact for patients and GPs.
- Introduce improved appointment booking systems and processes.
- Consult with Outpatient nursing and administrative staff to introduce substantive evening and weekend clinics as commissioned by the clinical Divisions.
- Electronic transfer of all Outpatient correspondence to GPs.

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

- Improved feedback via Friends and Family test and participation in a locally commissioned Healthwatch Luton survey being conducted in Outpatients.
- Improvement in the National Outpatient Experience Survey.
- Achieve 2% consistent reduction in Do Not Attend (DNA) appointment rates.
- Achieve 90% rebooking of recyclable patient initiated cancelled appointments.
- Achieve a further reduction of 50% in the number of patients experiencing hospital initiated clinic cancellations.
- Continue to improve Outpatient environment and facilities.
- Increased patient choice in scheduling of new and follow up appointments, with 90% of patients requiring follow up leaving with their appointment having been booked.

- Reduced delays in clinics with 90% of patients seen within 30 minutes of their scheduled appointment time.
- Achieve faster Outpatient call centre response times – 95% calls responded to in less than 30 seconds.

Key Patient Experience Priority 2

- **Decrease diagnostic wait times**

Why is 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 has the challenge of meeting increased demand year on year as new and improved diagnostic services are introduced. In 2014 the imperative will be to expand services to meet 24/7 Keogh recommendations and reduce waiting times in line with Trust and Departmental strategic objectives. The foundations for delivering expanded service delivery have already been laid with the introduction of a radiographer shift system in the summer of 2013, enabling Imaging services to be expanded more affordably to meet patient and service needs.

What will we do?

- Expand access across specific Imaging modalities to facilitate increased evening and weekend opening times.
- Substantively expand MRI scanning capacity from 8am to 8pm Monday to Friday, and 8am to 6pm Saturday and Sunday.
- Replace the existing CT scanners with higher specification equipment and improve the CT scanning environment and patient waiting area.
- Conduct modality reviews to examine means of facilitating improved scanning times and patient pathways.
- Promote improved recruitment and retention of staff with increased training, development and career progression opportunities.
- Expand consultant radiologist availability 7 days a week, rationalising the on call rota and delivering speedier and more affordable in-house reporting.
- Introduce new service developments such as CT Coronary Angiography to enable patients to have their specialist cardiac care delivered rapidly and locally.
- Agree revised key performance indicators with Divisions to meet service need.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Finance, Investment and Performance Committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- Reduce waiting times for routine scans in CT, MRI and Ultrasound from current 6 weeks targets to 2 weeks by Q4 2014.
- To ensure all 2 ‘week wait’ patients are appointed to agreed Key Performance Indicators (KPIs).
- Reduce waiting times to other modalities to be consistently under 6 weeks.
- To ensure all routine scans are reported to agreed KPIs.

- Meeting emergency Imaging and reporting requirements as per trauma network accreditation standards.

Key Patient Experience Priority 3

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

Why is 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 will be on implementing a new care plan and providing training for doctors and nurses.

What will we do?

- Develop an 'End of Life' care plan.
- Train on care planning for the end of life with nurses and doctors across the Trust.

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

- Delivery of the locally agreed 'end of life' CQUIN scheme for 2014/15.
- Evidence of symptom control.
- Evidence of conversations with the families and or patient regarding their care and preferences.
- Evidence of support for families.
- Presence of a DNAR and personal resuscitation plan in the patient records.
- Francis Report.

4. Statements related to the Quality of Services Provided

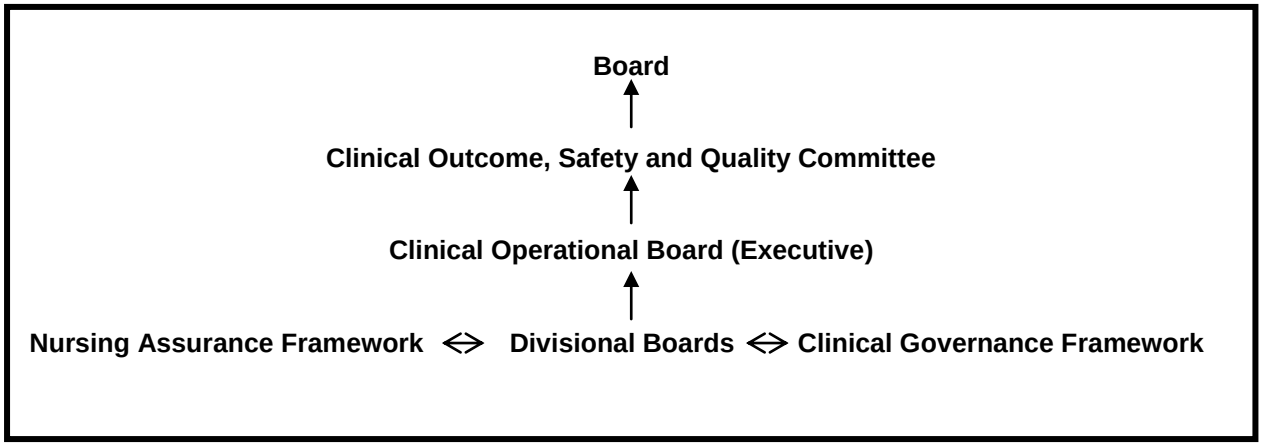
4.1 Review of Services

During 2013/14 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 2013/14 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:

- The Board by the Institute of Directors;
- Delivery of the Cost Improvement Programmes;
- Transforming Outpatients
- Benchmarking with UCL Partners and McKinsey Hospital Institute
- Facilities Management
- Imaging Services

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

Quality Assurance Monitoring



The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2013/14.

4.2 Participation in Clinical Audits and National Confidential Enquiries

During the period the Trust was eligible to participate in 34 of the 51 National Clinical Audits that met the Quality Accounts inclusion criteria

The Trust participated in 28 (82%) of the eligible national audits

Details are provided within the table 1 below.

Final figure outstanding – checking three audit submissions

Name of audit / Clinical Outcome Review Programme (*See notes column)	Audit management	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Peri & Neonatal						
Neonatal intensive and special care (NNAP)	The Royal College of Paediatrics and Child Health	Yes	Yes	2013/14	All cases	100%
Perinatal Mortality	MBRRACE-UK, National Perinatal Epidemiology Unit	Yes	Yes	January 2013 - December 2013	All cases (includes Intrauterine Deaths and Neonatal deaths, also includes any maternal deaths	No maternal deaths (none occurred). To date 24/28 cases have been submitted for Intrauterine Deaths. To date 17/21 neonatal deaths have been submitted (this data is joint with NNU)
Children						
Paediatric asthma	No	Yes	No			
Epilepsy 12 audit (Childhood Epilepsy)	Royal College of Paediatrics and Child Health	Yes	Yes	Jan to Mar 2014	28 cases	27 cases
Paediatric intensive care (PICANet)	University of Leeds	No	No			
Child Health Programme	CHR-UK	Yes	No			
Acute Care						
Moderate or severe asthma in children (care provided in emergency departments)	The College of Emergency Medicine	Yes			Submission of a maximum of 50 cases selected consecutively from between 1st August 2013 and 31st March 2014	

Name of audit / Clinical Outcome Review Programme (*See notes column)	Audit management	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Paracetamol Overdose (care provided in emergency departments)	The College of Emergency Medicine	Yes			Submission of a maximum of 50 cases selected consecutively from between 1st August 2013 and 31st March 2015	
Severe sepsis & septic shock	The College of Emergency Medicine	Yes			Submission of a maximum of 50 cases selected consecutively from between 1st August 2013 and 31st March 2016	
Adult community acquired pneumonia	British Thoracic Society	No	No			
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	2013/14 and on-going	All ITU admissions	100% approx. 400
Emergency use of oxygen	British Thoracic Society	Yes	Yes	15/08/2013 to 01/11/2013	All the inpatients on wards with Oxygen	24
National Audit of Seizures in Hospitals (NASH)	University of Liverpool	Yes	Yes	01/01/2013 to 30/09/2013	30	30
National emergency laparotomy audit (NELA)	Royal College of Anaesthetists	Yes	Yes			83 cases have been entered so far.
National Joint Registry (NJR)	HQIP	Yes	Yes	2013/14	All	1128 cases submitted
Non-invasive ventilation - adults	British Thoracic Society	No	No			
Severe trauma (Trauma Audit & Research Network, TARN)	University of Manchester	Yes	Yes	2013/14	A minimum of 80% of cases required	Data collection on-going for March 2014

Name of audit / Clinical Outcome Review Programme (*See notes column)	Audit management	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death	NCEPOD	Yes	Yes	2013/14	Reported in 4.3	Reported in 4.3
Long Term Conditions						
Adult Bronchiectasis Audit*	British Thoracic Society	No	No			
Chronic kidney disease in primary care*	BMJ Informatics	No	No			
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme*	Royal College of Physicians (London)	Yes	Yes	February 2014 – May 2014		Data collection In progress
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)*	Health and Social Care Information Centre	Yes	Yes (NaDIA) No (NDA)	25/09/2013 one day snap audit	N/A	96
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes		All	137 cases submitted = 100%
Inflammatory bowel disease (IBD)*	Royal College of Physicians (London)	Yes	Yes	April 2013 to October 2013	50	50
Renal replacement therapy (Renal Registry)	UK Renal Registry	No	No			
Specialist rehabilitation for patients with complex needs		No	No			
National review of asthma deaths	NRAD	Yes	No			
Rheumatoid and early inflammatory arthritis*	Northgate Public Services	Yes	Yes	2014	on-going	
Elective Procedures						
Elective surgery (National PROMs Programme)	Health and Social Care Information Centre	Yes	Yes	2012/13 prov. Data Feb 2014	**Hospital Procedures All: 879** Groin Hernia :257 HipReplacement:264	**Hospital Procedures All: 580** Groin Hernia

Name of audit / Clinical Outcome Review Programme (*See notes column)	Audit management	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
					KneeReplacement:287 VaricoseVein:71 **Post Operative: All 580** Groin Hernia :167 HipReplacement:195 KneeReplacement:207 VaricoseVein:11	:167 HipReplacement:195 KneeReplacement:207 VaricoseVein:11 **Post Operative: All 562** Groin Hernia :165 HipReplacement:189 KneeReplacement:198 VaricoseVein:10
Cardiovascular						
Acute coronary syndrome or Acute myocardial infarction (MINAP)	National Institute for Cardiovascular Outcomes Research	Yes	Yes	2012/13	Min. 20 required for specific analysis	nSTEMI patients 1636
National Adult Cardiac Surgery Audit	National Institute for Cardiovascular Outcomes Research	No	No			
Cardiac arrhythmia		No	No			
Congenital heart disease (Paediatric cardiac surgery) (CHD)	National Institute for Cardiovascular Outcomes Research	No	No			
Coronary angioplasty	National Institute for Cardiovascular Outcomes Research	No	No			

Name of audit / Clinical Outcome Review Programme (*See notes column)	Audit management	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	Yes	Yes	2013	Min. 20 cases	328 cases submitted to date
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	2013/14	All cardiac arrest calls where compression was commenced	149
National Vascular Registry*	Royal College of Surgeons of England	No	No			
Pulmonary hypertension (Pulmonary Hypertension Audit)	Health and Social Care Information Centre	Yes	Yes			
Cancer						
Bowel cancer (NBOCAP)	Health and Social Care Information Centre	Yes	Yes	1st April to 31st March 2013	All	164 patient records and 202 treatments , 164 tumours submitted
Head and neck oncology (DAHNO)	Health and Social Care Information Centre	Yes	Yes	1st Nov 2012 to 31st Oct 2013	All	121 patient records 1) MDT n77 2)Nursing n68 3)SALT n24 4)Surgery n49 5)Nutrition n42
Lung cancer (NLCA)	Health and Social Care Information Centre	Yes	Yes	1st Jan 2012 to 31st Dec 2012	All	Data collection previously manually input. 1st electronic upload due June

Name of audit / Clinical Outcome Review Programme (*See notes column)	Audit management	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
						2014
Oesophago-gastric cancer (NAOGC)	Royal College of Surgeons of England	Yes	Yes	1st April to 31st March 2013	All	69 patient records with demographic details entered only. Further clinical specific data required against these patient. 1) Clinical data had not been collect and not available to upload required data. 2) Reporting system currently being developed . Data collection tool developed . Further support for clinical team required to record backlog.
Prostate Cancer	Royal College of Surgeons of England	Yes	Yes	Starting 1st April 2014	All	In progress

Name of audit / Clinical Outcome Review Programme (*See notes column)	Audit management	Eligibility	Participation	Data Period	Cases Required	Cases Submitted
Older people						
Falls and Fragility Fractures Audit Programme (FFFAP)	Royal College of Physicians (London)	Yes	Yes		All	315 cases submitted
National Audit of Dementia (care in general hospitals)	Royal College of Psychiatrists	No	No			
Sentinel Stroke National Audit Programme (SSNAP)*	Royal College of Physicians (London)	Yes	Yes	1st April 2013 to 28th Feb 2014	All	To date entered 462 cases, March 2014 data outstanding awaiting for clinical coding (approx. 486 Inc. March 2014)
Mental Health						
National audit of schizophrenia	Yes	No	No			
Mental Health Programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NCISH	No	No			
Prescribing Observatory for Mental Health (POMH-UK). (Prescribing in mental health services)	No	No	No			
NHS Transplant						
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	Yes	Yes	Feb-13	All women booked February 2013 who were Rh negative = 49	48 cases submitted

Other National & Regional Audits

During the report period, the Trust also participated within three time-limited national/regional audit projects (Table 2)

Audit	Organiser	Target Cohort	Returns
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research	74 for implanting PPm implants centre	109
Thrombosis Venous Thromboembolism Annual Survey (FOI Request)	All Parliamentary Thrombosis Group	Organisational & Performance questionnaire	Annual (submission usually Sept/October
National Anticoagulation Clinical Reporting System	DAWN Benchmarking	All system entries	Twice annually July 2012 Jan 2013
Rare Disorders of Pregnancy	UK Obstetric Surveillance System (UKOSS)	Case submissions by UKOSS criteria	Continuous

Submissions to national cancer data sets (Table 3)

Cancer National database / Registries	Organisation	Data submissions
British Association of Surgical Oncologists (BASO): Screen detected breast cancers	BASO	All screen detected breast cancers Submitted via Regional QA Centre Dec. 2012
Cancer National Databases: - Upper GI - Head & Neck - Colorectal - Lung	 AUGIS DAHNO NBOCAP LUCADA	 On-going - limited On-going - regular On-going - limited On-going - regular
Cancer Registry (East of England): - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast	Eastern Cancer Registry & information Centre (ECRIC)	On-going. All cases discussed at Cancer MDT meetings. Submissions within 25 working days from month end. Process is currently being developed from new Infoflex system
Open Exeter: a) Month of First Treatment	NHS Connecting for Health	Monthly: Within 25 working days

b) Month of Subsequent Treatment - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast		of the month end.
Open Exeter: Referrals via NHS Screening Services: - Breast - Gynaecology - Colorectal	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Two week Wait Referrals: - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Breast Symptomatic 2 week wait Referrals:	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Rare Cancer Referrals treated within 31 days of receipt of referral: - Haematology - Children's Cancers - Testicular	NHS Connecting for Health	Monthly: Within 25 working days of the month end.
Open Exeter: Routine referrals which are upgraded by clinician & treated within 62 days: - Upper GI - Pancreatic - Urology - Haematology - Skin - Lung - Gynaecology - Head & Neck - Colorectal - Breast	NHS Connecting for Health	On-going

Local Clinical Audits

In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of fourteen 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	Lower Limb Amputation	NCEPOD	N/A	No – not carried out at the Trust
2	Alcohol Related Liver Disease	NCEPOD	(1/3) 33%	Yes
3	Subarachnoid Haemorrhage	NCEPOD – Secondary questionnaire	(2/3) 67%	Yes
4	Tracheostomy Care	NCEPOD	Insertion - 5/11 (45%) Critical care - 9/11 (82%) Ward - 3/11 (27%)	Yes
5	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

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

4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton & Dunstable University Hospital in 2013/2014 and who were recruited during that period to participate in research approved by a Research Ethics Committee was 618. This research can be broken down into 143 research studies (120 Portfolio and 23 Non-Portfolio).

Participation in clinical research demonstrates the Luton & Dunstable University Hospital's commitment to improve the quality of care we offer and to make a contribution to wider health improvement. Our clinical staff keep up-to-date with the latest treatment possibilities and active participation in research leads to improved patient outcomes. The Trust is compliant with the National Institute for Health Research (NIHR) Research Support Services Framework with a Trust adopted Research and Development Operational Capability Statement (RDOCS).

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

A proportion of Luton and Dunstable Hospital income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between the Luton and Dunstable 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 2013/14.

Goals and Indicators

Goal no.	Description of goal	Quality Domain(s) [1]	Indicator number[2]	Indicator name	Indicator weighting	Indicator Percentage
1	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework	Patient Experience	1.1	Friends and Family Test - Phased Expansion	0.0375%	1.5%
		Patient Experience	1.2	Friends and Family Test – Increased Response Rate	0.05%	2%
		Patient Experience	1.3	Friends and Family Test - Improved Performance on the Staff Friends and Family Test	0.0375%	1.5%
2	Reduction in the prevalence of pressure ulcers and falls	Quality Patient Safety	2	NHS Safety Thermometer – Improvement For further discussion	0.125%	5%
3	The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services	Patient Safety Clinical Effectiveness	3.1	Dementia – Find, Assess, Investigate and Refer	0.075%	3%
	Named lead clinician for dementia and appropriate training for staff	Clinical Effectiveness	3.2	Dementia – Clinical Leadership	0.0125%	0.5%
	Ensuring carers feel supported	Quality	3.3	Dementia – Supporting Carers of People With Dementia	0.0375%	1.5%
4	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	Patient Safety Clinical Effectiveness	4.1	VTE Risk Assessment	0.125% (for both indicators)	5% (in total for achievement of both indicators)
	The number of root cause analyses carried out on cases of hospital associated thrombosis	Patient Safety Clinical Effectiveness	4.2	VTE Root Cause Analyses		
5	Fractured neck of femur	Patient safety	5.1	Intraoperative Fluid Optimisation	0.5375%	21.5%
			5.2	FRAX		
6	Implementation of Enhanced Recovery Programme	Patient safety Clinical effectiveness	6.1	Reporting on the National ER Database	0.1375%	30%
			6.2	Surgery Performed on the Day of Admission	0.275%	
			6.3	Goal Directed Fluid Therapy	0.275%	

[1] Safety / Effectiveness / Experience / Innovation
[2] May be several for each goal

Goal no.	Description of goal	Quality Domain(s) [1]	Indicator number[2]	Indicator name	Indicator weighting	Indicator Percentage
			6.4	Reporting of LOS for Patients with ERP Procedure Codes	0.0625%	
7	Respiratory	Patient safety	7.1	Discharge Bundle	0.26875%	21.5%
		Clinical effectiveness	7.2	Non-invasive ventilation	0.26875%	
8	Stroke	Clinical Effectiveness	8	Developing information and communication support for families and carers of stroke patients	0.175%	7%

Q1 and Q2 CQUINs were achieved. Q3 and Q4 have some non-achievement, particularly in relation to fluid optimisation where the Trust did not quite achieve the values required. The Impact on the quality of care of the work towards the achievement has been high.

The Trust monetary total for the associated CQUIN payment in 2013/14 was **[TBC]**

4.6 Care Quality Commission Registration

CQC Performance

The Care Quality Commission (CQC) is the organisation that regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with 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 2013 and 31st March 2014 and we have not participated in special reviews or investigations by the CQC during the reporting period.

The CQC carried out an inspection on 16, 17, 24 and 28 September 2013. This included a visit in the early hours of the morning. They visited Accident and Emergency Department (A & E), medical, surgical and elderly care wards, and the Maternity Unit. They observed the care provided to people in all areas we visited, and spoke with approximately 45 patients or their relatives, and more than 55 members of staff. They found that most people were satisfied with the care and

treatment they received. They told us they had been treated respectfully and kept fully informed about the options of treatment available to them. This enabled them to make informed decisions. There was appropriate equipment, which was well maintained, available in all areas of the hospital that were visited. They found some inconsistencies with record keeping on some wards, however we responded with an immediate audit to ensure this was resolved without delay. They also had concerns regarding staffing in the maternity unit and talked to us about the action we were taking to ensure that staff received adequate support and staffing levels in this area were increased. The staffing level concerns were resolved by November 2013. The CQC found we had effective systems in place for monitoring and assessing the quality of service provision, and was responsive in learning from complaints. They also identified that we worked openly with external partners to promote a seamless transition of care between services.

Full compliance with the standards was declared in January 2014 and the Trust is expecting a further inspection to confirm the status.

CQC Assessments

The CQC made radical changes in 2013/14 to the way they 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. is a clear programme of improvement.

We have in place a robust 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.

The first Intelligent Monitoring Report received put the Trust as band 3 and identified that the L&D has four elevated risk outliers: diagnostic waiting times, patients waiting over 6 weeks for a diagnostic test; data quality of Trust returns to the HSCIC; whistleblowing alerts; and safeguarding concerns.

The second report was issued on the 13th March 2014 and puts the Trust in band 6. The report identified three outliers; safeguarding concerns (elevated risk), data quality of Trust returns to the HSCIC (risk) and PROMs (patient rated outcome measure) for Hip Replacement (risk). The Trust is continuing to respond to and review the issues raised 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 2013/14 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 Hospital NHS Foundation Trust submitted records during 2013/14 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:

- 99.5% for admitted patient care; 99.8% for out patient care and 96.0% for A&E care.

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

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

Clinical coding error rate

The Luton and Dunstable 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 9% was reported for diagnosis coding (clinical coding) and 5.6% for Procedure coding.

Information Governance toolkit attainment levels

The Luton and Dunstable Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2013/14 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.

Part 3

5. A Review of Quality Performance

5.1 Progress 2013/14

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 2013/14 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	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	2	2	3	N/A	The Trust has maintained low rates of MRSA
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	94.6*	97.2*	96*	100	Lower than 100 is positive.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	34	17	19	N/A	An external report showed that the Trust only had one potential case of cross contamination.
Incidence of avoidable hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	N/A	51**	30	N/A	There has been a decrease in incidence of pressure ulcers
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	0	4	4	N/A	The Trust is maintaining performance.
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.5	1.8	1.6	N/A	The Trust is maintaining a low level of cardiac arrests.

Performance Indicator	Type of Indicator and Source of data	2011* or 2011/12	2012* or 2012/13	2013* or 2013/14	National Average	What does this mean?
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	4.2 days	3.7 days	3.6 days	N/A	We have seen a slight improvement on length of stay and further work is planned as part of the hospital re-engineering transformational work
Rate of falls per 1000 bed days	Clinical Effectiveness Trust Board Report	5.92	5.5	4.87	N/A	A further reduction n 2013/14 is noted
% of stroke patients spending 90% of their inpatient stay on the stroke unit (n)	Clinical Effectiveness	77.7%	78.3%	84.7%	Target of 80%	The Trust has achieved the target for this year.
Rate of fractured neck of femur to theatre in 36hrs (n)****	Clinical Effectiveness Dr Foster	N/A	80%	85%	N/A	An improvement has been noted.
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	66.5*	52.5*	76*	100	Lower than 100 is positive.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	78.7*	87.7*	91*	100	Lower than 100 is positive.
Readmission rates*: Knee Replacements Trauma and Orthopaedics (n)	Clinical Effectiveness Dr Foster	5.5%	11.4%	4.7%	N/A	Significant improvements are noted.

Performance Indicator	Type of Indicator and Source of data	2011* or 2011/12	2012* or 2012/13	2013* or 2013/14	National Average	What does this mean?
% Caesarean Section rates	Patient Experience Obstetric dashboard	26.5%	25.5%	25.7%	Trust goal <23%	This is proving difficult to reduce however we have pathways in place to promote vaginal delivery whenever possible
Patients who felt that they were treated with respect and dignity***	Patient Experience National in patient survey response	8.7	8.7	9.0	Range 7.9 – 9.7	We have demonstrated a good improvement in this indicator
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	N/A	This result indicates an increase in the rate of complaints however, we have encouraged patients to speak up
% patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	7.8*	8.0*	7.9*	Range 7.1 – 9.2	A slight improvement has been noted
Venous thromboemolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95% by Q4	Achieved >95% all year	Achieved >95% all year	N/A	Sustained performance above the 2013/14 CQUIN target of >95%

(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.

The data on the % patients who would rate the outpatient service as excellent, very good or good was removed as there has not been a national survey since 2011.

5.2 Major quality improvement achievements within 2013/14

Improving clinical outcomes, safety and experience for our patients while delivering value for money is key to the Trust's overarching quality strategy. During 2013/14 we developed a number of ambitious trust-wide quality priorities. These were based on local as well as national priorities including the recommendations from our own internal review of the Francis, Berwick and Keogh reports.

These reports provided a stark reminder of the need to ensure the very basics of care need to be embedded within all organisations if they are to deliver the good quality health care that patients deserve and expect. The Francis Report made it clear that these priorities are not 'nice to haves' but form the cornerstones of effective and high performing hospitals and they need to be both strategic as well as operational priorities for all organisations.

We considered the recommendations from each of these reports and ensured that the learning and themes were central to our strategy for quality improvement. In order to drive forward and monitor progress against our quality improvement agenda, the following forums were developed;

5.2.1 Fractured Neck of Femur

The successful implementation of the fractured neck of femur plan continued in 2013/14, and the team worked hard to strengthen the clinical protocols and pathways for this group of patients. In September 2012 the mortality rate for fractured neck of femur peaked at 197.4, and reduced to 152 by the end of March 2013. The reported figure for March 2014 is 84 which has been the result of a steady and consistent monthly improvement during the last 12 months.

The length of stay for fractured neck of femur patients continued to improve and have introduced new fluid optimisation techniques during surgery for appropriate patients to ensure the shortest recovery time possible post-operatively. Across the year 99% patients were seen with 72 hours by an Orthogeriatrician compared to 87% the previous year, and 85% of patients went to theatre within 36 hours compared to 80% during 2012-13.

The Trust is in the process of recruiting a dedicated performance monitoring lead for fractured neck of femur pathway which will enable us to continue to closely monitor the performance against internal standards and ensure continued compliance with best practice management for these patients.

5.2.2 Mortality Board

The Mortality Board was established in May 2013 and 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.

The Board uses the following elements of surveillance;

- *Data* – the Board looks at the Dr Foster data and decides where further interrogation may be required to establish the quality of services being provided.
- *Governance* – the Board receives confirmation that the mortality reviews undertaken follow the appropriate monitoring and reporting systems.
- *Analysis and action* – the Board instigates the analysis of deaths and acts on the findings to minimise avoidable deaths. The Board has responsibility in learning lessons to support improvements and sharing these across the organisation.

An example of a review was following the national concerns related to higher mortality rates for patients who were admitted over the weekend period. We were able to demonstrate that there was no correlation between deaths and the day of admission.

The Mortality Board at its January 2014 meeting noted that there is continued improvement in the Trust Mortality rate in both the HSMR and SHMI data with a significant improvement in the fractured neck of femur HSMR.

5.2.3 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.

October 2013 saw the publication of 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. We are encouraged by the number of recommendations we already have in place and the Complaints Board will consider all recommendations for action.

5.2.4 Advancing Quality Steering Group

It is essential that we build on the engagement and enthusiasm of our staff and we have set up a steering group – 'Advancing Quality' that monitors progress against these numerous quality work streams and whose primary role is to ensure we learn from both the Francis and Keogh reports.

The Advancing Quality Group has two aims:

- To match organisational need for quality improvement against capability and capacity and to prioritise, direct and monitor progress against an agreed improvement agenda.
- To advance quality improvement projects through support and challenge

5.3 Friends and Family Test

The Friends and Family test is a simple comparable test which, when combined with follow up questions, provides us with a mechanism to identify both good and bad performance and encourage staff to make improvements where services do not live up to expectations.

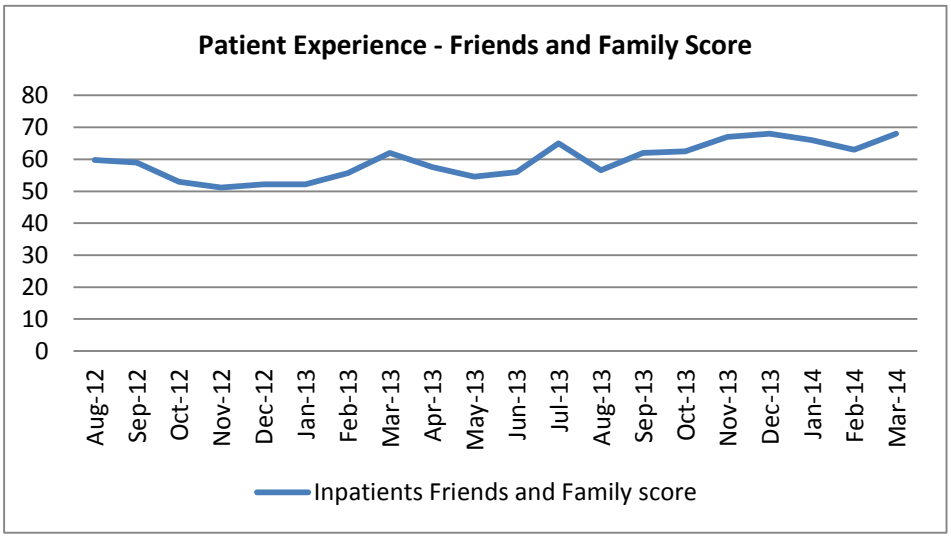
We offer a variety of ways in which we seek feedback from patients and these include postcards that can be filled out and left in the hospital. Patients can also go onto the hospital website to complete a survey. The patient experience call centre contacts patients within 48 hours of leaving hospital to ask them about their experience of our care and services and this includes the Friends and Family test. We also ask patients to complete a patient experience card when they are discharged from hospital.

5.3.1 Inpatients

During 2012/13, we introduced the Friends and Family test to patients that had been in-patients within the adult wards. The question that is asked is:

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

A quarterly patient experience review is reported to the Clinical Outcome, Safety and Quality Committee. This review identified the areas for improvement. We started to collect this information from patients during August 2012 and we have seen gradual and consistent improvements in the score.



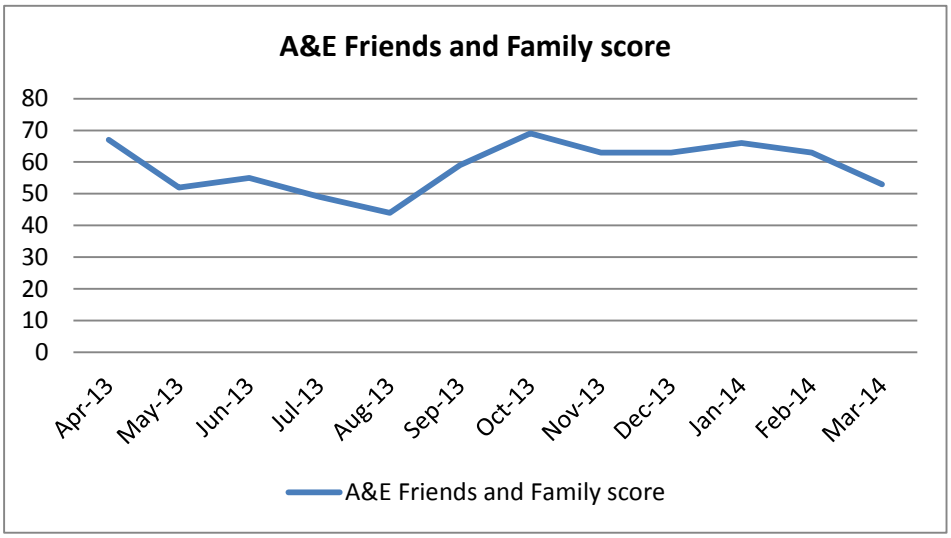
The Friends and Family cards are supported by a the Patient Experience Call Centre. The call centre gathers real time information 48 hours following a patients' discharge from hospital. Feedback from this route has resulted in the following improvement examples:

- One ward had a number of complaints about the noise at night and this was due to the noise of bins being used on the wards. New bin closers were purchased for the wards that significantly improved the concerns about noise at night. This was also cascaded to other wards.
- As a result of complaints about communication from Doctors on one ward, a ward round after the doctor has visited has been implemented to clarify their questions about treatment.
- Being aware that patients were not being offered enough to drink helped one ward instigate a more frequent drinks rounds.
- One ward is being more proactive in meeting timely discharges by getting Doctors to write up take home drugs earlier and feed back has helped staff look at what information a patient needs and to make it more relevant
- Much of the feedback that is about Estate issues is also of concern to staff as they report issues but then it is out of their control and dependent on Estates work schedule

5.3.2 Accident and Emergency (A&E)

In April 2013 Friends and Family test was introduced to patients using the Emergency Department. The question that is asked is:

"How likely are you to recommend this service to friends and family if they needed similar care or treatment?"



The Trust achieved a total response rate for inpatients and the Emergency Department of 24.37%.

From April 2013 this information is also published on NHS England and NHS Choices.

5.4 National Inpatient Survey 2013

The inpatient survey was received on the 9th April 2014 and the results are detailed in the table below.

Results of the national in-patient survey 2013

Category	2010	2011	2012	2013	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	No change	The same
Waiting lists and planned admission, answered by those referred to hospital	6.7	6.3	9.0	9.1	Increased	The same
Waiting to get to a bed on a ward	7.3	6.6	7.0	6.5	Decreased	Worse
The hospital and ward	8	7.8	8.1	8.1	No change	The same
Doctors	8.4	7.9	8.2	8.4	Increased	The same
Nurses	8.3	7.9	8.1	8.2	Increased	The same
Care and treatment	7.3	7.1	7.5	7.6	Increased	The same
Operations and procedures, answered by patients who had an operation or procedure	8.1	8.3	8.3	8.2	Decreased	The same
Leaving hospital	6.8	6.8	7.0	7.1	Increased	The same
Overall views and experiences	6.5	6.0	5.5	5.5	No change	The same

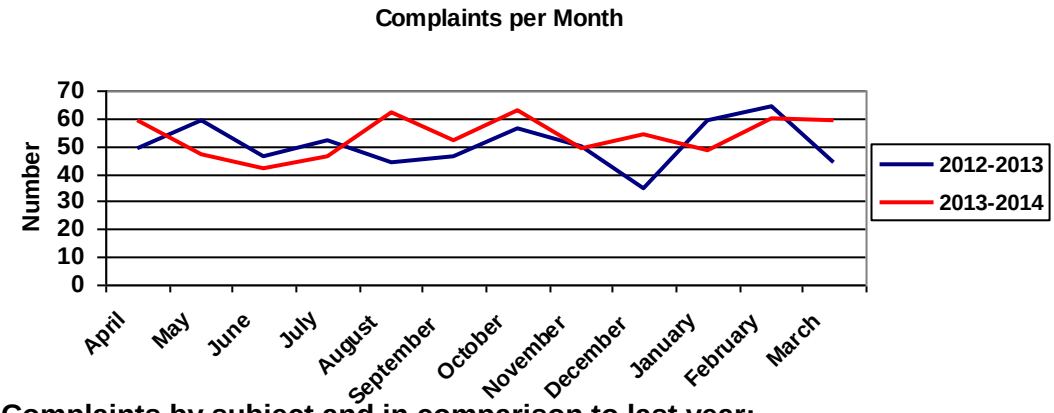
Note all scores out of 10

An increase in performance has been noted for many of the areas. However, there are two areas where the Trust has decreased performance; waiting for a bed on a ward and issues around operations and procedures. Work is underway to develop an

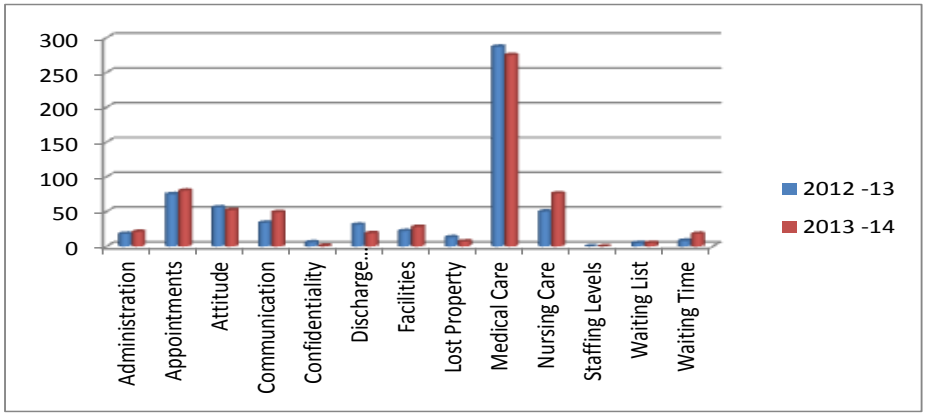
5.5 Complaints

During 2012/13 it was recognised that whilst the quality of responses was good, response times needed to be improved. This was made a quality priority and is reported within part 2 of the quality account.

During 2013/14 we received 639 formal complaints compared to 604 in 2012/13. Reviewing the numbers by month identifies a sustained increase in the number of complaints 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.



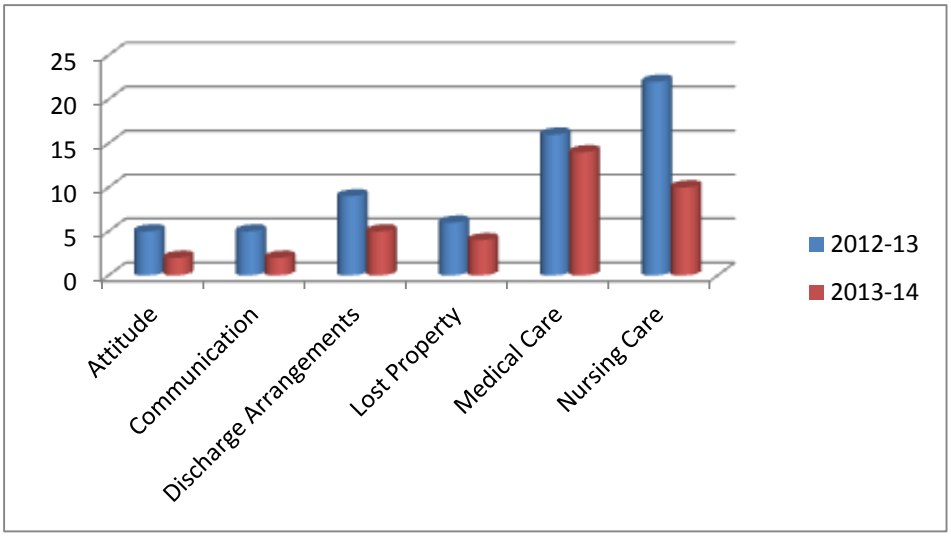
Complaints by subject and in comparison to last year:
There have been reductions in the number of complaints in relation to Attitude, Confidentiality, Discharge Arrangements, Lost Property, and Medical Care.



Complaints related to patients who have a learning disability:

There have been 4 complaints in 2013/14 related to the care of patients with a learning disability, and increase of one compared to the previous Financial Year. The use of the Learning Disability care pathway is embedded in practice to support individual patients' needs whilst they undergo investigations and procedures. Effective use of this is overseen and monitored by the Learning Disability Liaison Nurse.

Complaints re Care of the Older Person



There has been a decrease in the number of complaints from DME patients or their families in 2013/14. Practice within DME is that consultants and ward sisters meet with patients and relatives to address questions or concerns and commit to resolving them at the time. We believe that the low complaint numbers are a result of this active process.

5.6 Performance against Key National Priorities 2013/14

		2010/11	2011/12	2012/13	2013/14	Target 13/14
Target 1: Clostridium Difficile	To achieve contracted level of no more than 15 cases per annum (hospital acquired)	36	34	17	19	15
Target 2: MRSA	To achieve contracted level of no more than 2 cases per annum	1	2	2	3	2
Target 3: Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	98.6%	98.3%	99.6%	99.8%	96%
Target 4: Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	88.5%	87.5%	90.3%	91.5%	85%
Target 5: Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	97.4%	96.7%	95.6%	95.7%	93%
Target 6: Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	N/A	98%	98.9%	100%	94%
	Anti-cancer Drugs	N/A	98.2%	99.8%	100%	98%

		2010/11	2011/12	2012/13	2013/14	Target 13/14
Target 7: Patient Waiting Times	Referral to treatment - percentage treatment within 18 weeks - admitted *	N/A	NA	Target achieved in all 12 months of the year	93.6%*	90%
Target 8: Patient Waiting Times	Referral to treatment - percentage treatment within 18 weeks - non admitted **	N/A	NA	Target achieved in all 12 months of the year	97.1%*	95%
Target 9: Patient Waiting Times	Referral to treatment - percentage patients waiting so far within 18 weeks - incomplete pathways ***	NA	NA	Target achieved in all 12 months of the year	96.5%*	92%
Target 10: Accident & Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.2%	96.6%	98.5%	98.4	95%
Target 11: Learning Disability	Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Achieved	Achieved	Achieved	Achieved

* Year to date to February 2014

5.7 Performance against Core Indicators 2013/14

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
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level *(The palliative care indicator is a contextual indicator*	Published Apr 13 (Oct 11 –Sep 12)	12.4%	19.2%	0.2%	43.3%	N/A
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 –Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 – Jun 13)	12.6%	20.6%	0%	44.1%	N/A

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 2013/14.

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*
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*

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:

- It is recognised that due to the types of paediatric inpatient services provided, this results in repeated attendances and requirement for readmissions
- 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 the Short Stay Medical Unit (SSMU), development of an Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team, the expansion of the Hospital at Home service and the integrated models of care

**The most recent available data on The Information Centre for Health and Social Care is 2010/11*

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*	**	0.086	0.138	0.019
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*	**	0.102	0.094	0.058
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*	**	0.261	0.545	0.373
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*	**	0.255	0.429	0.264

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 divisions

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
- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

** Relates to April to September 2013 (most recent data published in March 2014 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?

Data due to be on HSCIC website on the 22nd May 2014

	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				

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:

- We will be introducing an Electronic Prescribing system and this will improve timeliness of available medications for patients to take home and will allow more time for nurses and pharmacists to explain medications to patients and their families.

- The hospital will be implementing the Perfect Day structure to wards and this will result in more nurses based at the bedside and improve experience of patients an their families.
- Reviewing the capital programme to assess the high risk environmental areas that need attention.

**Data not available on The Information Centre for Health and Social Care*

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.	2010/11	57%	66%	95%	38%
	2011/12	57%	65%	96%	33%
	2012/13	61.5%	63.3%	94.2%	35.3%
	2013/14	66.7%	67.1%	93.9%	39.6%

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
- launching a programme to support identification of cultural strengths and weaknesses and organisational values
- 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
- The ward buddy system has been launched in which all Executive Directors are linked to a buddy ward and undertake visits during which they talk to the staff and patients every month.

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%

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 above compliance throughout 2012/13.
- We have audited compliance with use of appropriate prophylaxis and this has been 95% and above throughout 2013/14.
- We will 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		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.
- An external audit team supplied by KPMG has recently checked the accuracy of the Infection Control [report to be included following the Audit by the end of May 2014]

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
- Initiating a C Diff screening for all admitted patients
- 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 The Information Centre for Health and Social Care*
+ 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	Highest score (worst)	Lowest 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	12.37+	Not Avail*	Not Avail*	Not Avail*
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	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
- 36 Serious incidents were reported in 2013/14 compared to 47 for 2012/13.
- 30 avoidable and unavoidable grade 3 and 4 pressure ulcers were reported through the serious incident process during 2013/14 a reduction from 70 in 2012/13.
- Two never events were reported.

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 the Safety Thermometer.

**Data not available on The Information Centre for Health and Social Care*
+ local data relating to March 2014

5.9 Embedding Quality – Workforce factors

Our staff continue to be our most valuable asset when it comes to delivering a high quality, safe and efficient service to the patients we serve. Therefore, we must continue the drive to ensure that we have the right staffing levels, together with ensuring that we have a skilled, motivated and appropriately rewarded workforce. We understand that in order to achieve this it is necessary for us to invest in our staff and to support this during 2013/14 one of our key corporate objectives focussed on developing staff to maximise their potential.

The tenth National Staff Survey was undertaken between September and December 2013. All Trusts are required to participate in the survey using a random sample of staff and the data from which is used by the CQC for the Benchmark Reports across all NHS Acute Trusts. The feedback from our staff is that when it comes to staff engagement we are above average, with a score of 3.90 (on a scale of 1-5 with 1 indicating that staff are poorly engaged and 5 indicating that staff are highly engaged), when compared with Trusts of a similar type. This was further improvement on the 2012 score which was 3.77.

5.9.1 Recruitment and Resourcing

During 2013/14 there were 759 posts advertised which resulted in 511 new starters (excluding medical recruitment, staff transferring from bank to permanent posts and existing staff being promoted). All new staff receive 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**

Throughout 2013/14 we have continued to concentrate on nurse recruitment. As well as continuing to recruit locally, including recruiting student nurses who have newly qualified, we also focussed our recruitment drives on other areas of the UK, Ireland and also in Europe, namely Portugal and Spain.

During the year we successfully recruited 69 qualified nurses and 56 Health Care Assistants. In addition to this, the overseas nursing campaigns have also resulted in a further 62 qualified nurses being recruited from Portugal and Spain. These nurses are due to commence between April and June 2014.

- **Medical Agency Locums**

During 2013/14 the role of Divisional based Rota-Co-ordinator for the Surgical, Medicine and Women's and Children's Division was developed. This has led to 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.

From September 2013 the Trust revised its contract to supply medical agency locums by initiating a simplified 2 tier approach to engage with agencies on the Health Trust Europe Framework. By using a 2 tier system the Trust has was able to negotiate lower standardised rates, ensure high quality of locum workers and ensure bookings were filled. This process has provided an opportunity to enhance our temporary medical resources by adopting a structured and controlled approach to the supply of agency locums whilst improving the systems and processes for the internal locum bank.

- **Staff Education Performance**

The delivery of undergraduate training continues to expand into new areas, with high satisfaction rating from UCLH students.

The Trust has a high volume of emergency activity and has been working collaboratively to improve patient pathways which makes it an interesting and dynamic place to deliver Postgraduate Education. Medical managers are fully committed to empowerment of trainees in changing the process of care delivery, and we are working with the School of Medicine to ensure that the quality of training for postgraduate trainees delivers the requirements of the curriculum and the commissioners, and supports excellence and professionalism in the trainees.

Planning is ongoing to create a wider Division of Clinical Teaching and Research, encompassing all training and development activities. As well as the performance management process for training this will ensure that the developmental work deriving from feedback from regulators, patients and other stakeholders will be formally managed within the Trust, always focussed on patient experience including safety and outcomes. The new division will include formal management of statutory, mandatory and regulator specified training, and a workforce unit to support service changes. The core activity will be the identification of training and development needs with the clinical divisions and provision of bespoke solutions. This will range from the up skilling and accreditations of HCAs to establishing new activities at tertiary care level, and ensure that both nonmedical and medical training is fully monitored and supported.

Research continues to thrive and the Trust has joined the North Thames Academic Health Sciences network. The proportion of consultants actively involved in research continues to increase.

- **Pre-Registration Education for Nurses and Midwives**

We continue to provide placements for pre–registration students and undergo a yearly qualitative and quantitative assessment through the Performance and Quality Assurance Framework, monitored quarterly against an action plan to ensure continuous improvement. Our performance against this assessment is generally good and an action plan is in place to ensure continuous improvement.

We monitor the performance of the University of Bedfordshire using nursing education quality indicators as a benchmark. Annually, 150 nurses and 60 midwives are trained in partnership with the University and we provide placements for them at the L&D.

- **Appraisal and Pay Progression**

In line with revised national Agenda for Change requirements, we have written a new appraisal document for all staff covered by these contractual arrangements. Incremental pay progression is now linked to local performance requirements defined as having an appraisal within 12 months, completion of core mandatory training and achievement of individual objectives. In addition, staff who have had a written warning in relation to capability or disciplinary matters will not be able to receive their increment while that is in place.

The revised approach to appraisal and local performance is already having a positive impact on both appraisal rates and core mandatory training. To ensure the quality of appraisals, we intend to regularly audit the paperwork.

- **Personal and Continuous Professional Development**

We ask all service managers to contribute to a training needs analysis annually which then feeds into our bid for regional funds for Continuing Professional Development. This also complements discussions at appraisal when individual personal development plans are developed with staff. Towards the end of each calendar year, we publish a comprehensive training brochure which covers a wide range of programmes include statutory training; health and safety, clinical skills, leadership and management development, communication skills and IT training.

In recognition of the national move towards a more blended approach to learning, we continue to provide access to an excellent resource for leadership and management development through the Ashridge Business School. All staff can access the Virtual Ashridge website, where there is a comprehensive range of materials in a variety of formats including ground-breaking research in the field of leadership, through the Intranet.

To ensure that registered staff update their knowledge and skills, they have attended higher education modules at three universities contracted to deliver courses through Health Education East of England. In addition, staff continue to access specialised courses linked to their professional development at appropriate centres of excellence.

We have renewed our licence for the European Computer Driving Licence (ECDL) so that we can train, assess and examine staff to achieve the qualification. There has been a steady stream of applicants over the year which enhances our overall IT literacy as an organisation.

We continue to build on interest in and uptake of qualifications for Bands 1 – 4 with over 100 learners enrolled to an Apprenticeship in the last year. In addition to Team Leading, Business Administration and Customer Service, we have Health Care Assistants enrolled on a specialist healthcare qualification and catering staff starting a Hospitality Apprenticeship. On demand, we are able to identify specialist Apprenticeships and work with providers who can draw down national funding so that we obtain the qualification package free-of-charge. The provision of Apprenticeships benefits staff that may not have been given educational opportunities previously and is in line with Health Education England's strategy for building skills for staff at Band 1 – 4.

We have successfully delivered our 'Apprenticeship Steps' Programme offering a group of adults with learning disabilities the opportunity to develop their work-based skills in partnership with Luton Borough Council. This ground-breaking project has won a regional Leadership Academy award and has achieved recognition from the National Apprenticeship Service. Through participation in the Apprenticeship Ambassador network, we are able to promote this best practice and develop further opportunities for the future.

- **Leadership Development**

A full suite of leadership programmes has been launched by the NHS Leadership Academy. We are actively promoting these to all our managers, both clinical and non-clinical, and have introduced a talent management analysis tool through our revised appraisal paperwork to support discussions with staff at all levels. Uptake across the programmes is increasing over time.

We delivered a high-quality programme with expert national speakers for Clinical and Divisional Directors. It was well-received by participants and we will consider a future programme in the spring.

The Leading Safe and Effective Quality Patient Care programmes for Matrons and Ward Sisters are continuing and will incorporate external coaching for participants through a regional coaching network in Bedfordshire and Hertfordshire which we are piloting.

The new NHS Healthcare Leadership Model has been launched and we are participating in testing the 360 feedback tool on behalf of the Leadership Academy. Uptake of 360 feedback is improving in the Trust for clinical staff and we will promote the revised feedback tool once it has been launched formally. As part of our support for doctors undertaking Revalidation, we also facilitate 360 feedback in line with GMS guidance, incorporating patient feedback, offering more than the minimum requirement of once in five years to enhance professional and personal development.

We are actively building a coaching culture through supporting senior staff to be trained as qualified coaches at Institute of Leadership and Management Level 5 and 7. The first two programmes, which have been regionally funded, have included two senior consultants. There is continuing demand for this development from doctors which we are seeking to address.

Coaching has taken place regularly for staff, where appropriate and helpful, but we are also accessing Health Coaching training, funded regionally, so that we can support patients with long-term conditions to manage their health collaboratively. To date, 6 clinicians have been trained in the Medicine Division and we are looking to expand this to other areas.

- **Medical Revalidation**

All doctors are supported to prepare for their individual revalidation with the GMC which is required every 5 years. In addition to providing access to 360 feedback twice in 5 years, we have also purchased a licence to a customised website to enable every doctor to prepare for their appraisal on an annual basis. This online web-based portfolio of evidence is a full record of the doctor's whole practice and provides comprehensive information for each annual appraisal. The Revalidation Support Office provides support for both appraisers and individual doctors to ensure that all the relevant information is included. The Revalidation Support Officer liaises closely with Medical Director, who is also the Responsible Officer for revalidation and the General Medical Council to ensure that doctors are aware of their responsibilities and can confidently prepare for and successfully go through the revalidation process. We have successfully achieved the numbers for each quarter and are confident that we are on target for doctors employed by the Trust to be prepared for revalidation.

- **Staff Health and Well Being**

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

During 2013/14 the Trust has introduced a number of initiatives to promote opportunities for staff to adopt a healthier lifestyle either onsite or by promoting external facilities that are conducive to good health.

The Occupational Health and well being Service has focussed on providing information on health promotion topics and activities, by acting as a signpost for staff to obtain information and advice on a variety of health and fitness related initiatives. This has been achieved

through the continued development of a health and well being section on the staff intranet, various electronic communications, newsletters, and awareness raising events.

In June 2013, a health and well being awareness raising day was held, which proved to be very popular entitled 'Spring into summer'. This event promoted physical exercise, such as skipping and bike riding whilst also raising awareness and encouraging healthier lifestyle choices as smoking cessation, alcohol awareness, health eating and stress awareness. A similar event is planned for 2014/15.

Particular highlights from this year include:

- We vaccinated 58.8% of our frontline staff against flu, which was a 6% higher uptake than the year previous and higher than the National average uptake amongst NHS Acute Trusts.

- The Occupational Health team were successful in gaining accreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS).

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

  SEQOHS aims to:

  - enable services to identify the standards of practice to which they should aspire
  - credit good work being done by high quality occupational health services, providing independent validation that they satisfy standards of quality
  - raise standards where they need to be raised
  - help purchasers differentiate occupational health services that attain the desired standards from those that do not

  The accreditation is valid for a 5 year period, and is dependant upon annual maintenance of the SEQOHS standards and compliance with routine monitoring.

- Following on from information gleaned from a past NHS National staff survey and subsequent feedback sessions the Trust chose to employee the services of an Employee Assistance Programme (EAP), to compliment existing support arrangements for staff within the Trust. The EAP offers all Luton and Dunstable staff access to an independent, free and confidential telephone advice service, staffed by highly experienced counsellors who can provide practical and emotional support with work or personal issues. Advice is available on debt, legal, family and more general issues, and staff can call as often as they like and talk for as long as is needed. The service is available 24 hours a day, 365 days of the year. The provision of this support during the past year has proved to be valued greatly by staff with an excellent utilization rate. Due to its success the Trust has agreed to continue this service for at least a further two years.

5.9.2 Sickness Absence

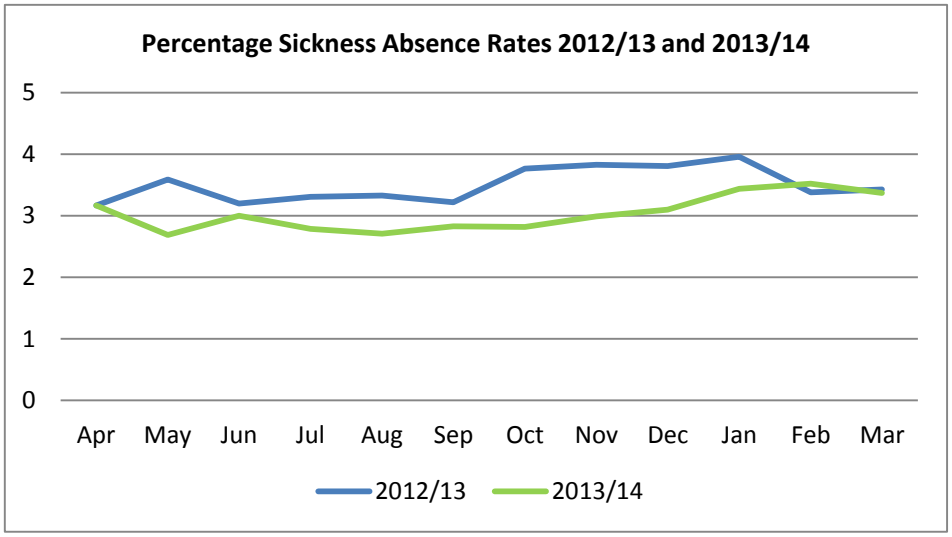
In early 2013 the sickness absence project was launched and to date we have seen a significant reduction in sickness absence levels.

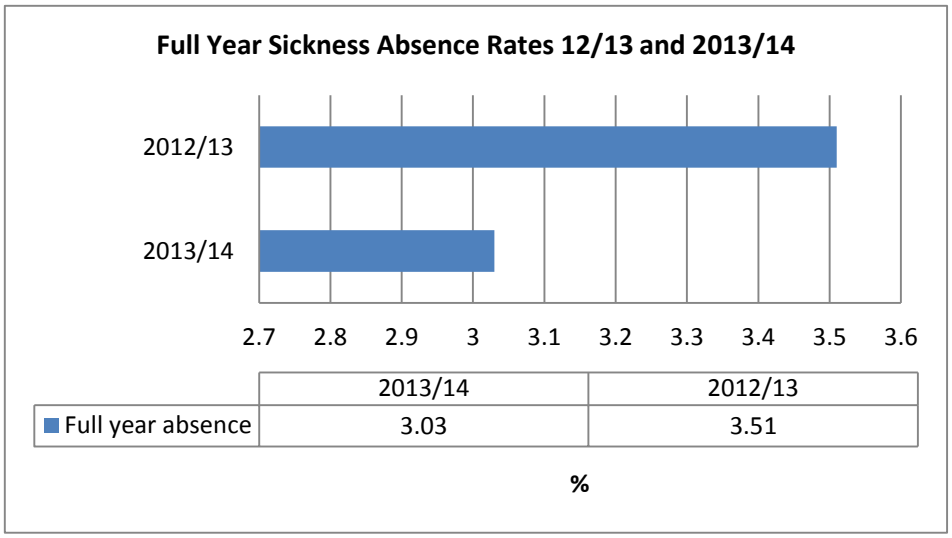
The implementation and roll out of the Absence Electronic Recording system completed in June 2013 has contributed to achieving maximum reporting through a single reporting mechanism, coupled with providing a readily available overview by departments and divisions of absence rates and any resulting trends.

Throughout the project we have seen a cultural shift towards managing sickness absence with a more proactive action orientated approach adopted by line managers to address their 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.

Overall, as a result of this focus the Trust sickness absence rate is now at the forefront of Trusts in the East of England region and one of the leading Acute Trusts across NHS England.

The project is now moving towards sustainability and this is very much aimed at ensuring the gains made during the project timescales are maintained and sickness absence does not regress to pre-project norms.





5.9.3 Staff Engagement and Consultation

We pride ourselves in having a healthy and productive relationship with our staff and this is reflected in the staff engagement scores in the Staff Opinion Survey, where again this year we have seen an improvement in our score, which puts us in the top 20% of Trusts. Partnership working is demonstrated in many varied ways for example:

- **Staff Involvement Group**

This group focus 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. This has proved very effective in recent years, which is apparent with the increased response in staff responding the 2013 survey.

- **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 we would like to draw attention to the following events:

  - a free Christmas lunch which was very well attended by staff and volunteers and during which the Chief Executive took the opportunity to give her personal thanks and that of the Board of Directors to all concerned

- In recognition of the 75th Anniversary of the Trust in February 2014 we held a Thank You Dinner which was the Trust Board's way of thanking staff who made a significant contribution to the Trust over the years. Throughout the evening alongside formally thanking staff for their work, there were also be a small number of special awards presented to individuals who had made an outstanding contribution to the Trust.

- All staff were invited to a free lunch over the course of two days to celebrate the Trust's actual anniversary on 14th February 2014.

5.10 Improving the Quality of our Environment

The Trust continues to acknowledge the scale of change necessary to transform the quality of the patient environment at the hospital and has embarked on a programme to deliver a major re-development of the hospital site. The programme of redevelopment is multi-faceted and has already begun with:

During 2013/14, the endoscopy scheme was completed, a theatre refurbishment programme carried out and the staff car parking facilities expanded. Additional work was undertaken to plan and design the Emergency Department expansion and re-location of the special care baby unit (SCBU). Both these schemes will complete in 2014 along with a scheme to expand the ophthalmology department.

During 2013/14 the hospital participated in the monitoring programme PLACE (Patient Led Assessments of the Care Environment). This new system for assessing the quality of the hospital environment came into effect in April 2013. The inspection teams include patient representatives, staff and Governors and involves an annual external assessment this year held on the 26th March 2014.

5.11 Quality and Business Strategy

The Trust's quality and business strategies are aligned. The Trust has a commitment to quality and patient-centred services and the belief that higher quality services are ultimately less costly and generate more income underlines the approach taken to the commercial activities of the organisation.

One of our key approaches to delivering high quality sustainable care is our Reengineering programme focussed on delivering care more efficiently and effectively. 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. In response to this the Re-engineering Programmes (which includes CIP /QIPP) aims to meet the financial challenge by creating overall 'system' efficiency. The Corporate schemes below show increasing contribution over the plan, and efforts will be made to accelerate some of the increased contribution into the latter half of 2014/15.

The overarching governance is through an executive group chaired by the Chief Executive 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.. These assessments are reviewed at each meeting.

5.11.1 Outpatient Transformation

The largest cohort of patients visiting the hospital are outpatients and as a high volume service (c.250,000 per annum) they have a major impact on the utilisation of medical resources. The work programme for the next phase of the project is based on a number of key transformation elements:

- leveraging the benefits derived from the EDRMS project to streamline the back office functions;
- establishing the feasibility a new system of customer management allowing all contacts with patients to be centrally recorded and managed;
- introducing self-check in and clinic management software;
- rolling out an appointment reminder system across all outpatient specialties.

The project will use a combination of dedicated project management and external consultancy (including taking part in one of the McKinsey Hospital Institute campaigns). This project is linked to a key patient experience priority 1.

5.11.2 Theatre Efficiency

Theatres represent, outside critical care, the most expensive facilities the Trust operates with a corresponding impact on income. The current programme is based around the use of a specialist consultancy firm (Altouros) to develop better systems for waiting list booking, together with the introduction of a new theatre timetable by October 2014 to give increased throughput. In addition proposals for a more efficient solution to the current Vanguard theatre are being developed.

5.11.3 Length of Stay

Length of stay is a key driver of resources given the number of beds the Trust operates. The variability in activity means that a fixed bed pool is not operated but beds are flexed up and down as appropriate. Length of stay varies due to internal factors such as availability of medical input and diagnostics, and also external factors such as access to rehabilitation. The length of stay programme seeks to establish an embedded and permanent approach to the systems which underpin and drive length of stay.

The key elements of the project are:

- development of an Ambulatory Care Unit;
- improve complex discharges;
- reconfiguration of bed stock and critical care;
- expansion of Hospital At Home;
- introduce enhanced recovery.

In addition the development of the pilot scheme in South Bedfordshire for a new model of elderly care is designed to have a fundamental impact on the overall length of stay.

Dedicated project management resource is in place and this project is linked to a key clinical outcome priority 2.

5.11.4 Medical Productivity

In the past, the Trust has not monitored or performance managed medical productivity in any systematic or rigorous way. The movement towards such an approach represents a significant cultural shift which will only be achieved over time. However this initiative

potentially represents the most beneficial element of the approach to QIPP (CIP). There are a number of different elements to the programme but the most important parts are:

- standardisation of the approach to job planning;
- introduction of annualised commitments for theatre and procedure lists and outpatient clinics;
- development of reporting tools to measure medical productivity on a consistent and ongoing basis.

The work is supported by a dedicated resource and the project is linked to a key patient safety priority 1.

5.11.5 Workforce

The Trust's approach to sickness absence is to ensure systematic and rigorous use of the absence management policy. The objective is to bring the sickness absence rate well below the benchmark for acute trusts and to reduce the number of staff with a high Bradford score to less than 200. The Trust has succeeded in reducing the number from 430 to 300 in the first year of the project.

The Trust bank and agency rates have been between 12-15% of the total pay spend and therefore this project will see the overall temporary pay bill reduced.

A second critical part of the workforce programme is the introduction of e-rostering in order to tackle the complexity of the proliferation of flexible working patterns which increase the number of constraints within a roster. It is difficult to evaluate the current cost of this problem but it is likely to represent 2-5% of costs within some rosters. The contract was let in October 2013 and the project commenced in January 2014.

Dedicated project management is in place for both sickness absence and e-rostering.

5.11.6 Procurement

The procurement work stream has, so far, concentrated on a series of individual projects (e.g. trauma prosthesis rationalisation) with an anticipated impact of £1m per annum which represents 2% of the overall non-pay budget. This work will continue with the Trust seeking to take advantage of opportunities as they arise. This work is being supplemented by another piece of work which is attempting to increase the proficiency with which support services are managed. These contracts are often managed by clinical staff who have insufficient commercial skills to navigate their way to achieve the required outcomes. The introduction of a new resource to oversee this work means that we will expect to see the outcomes from the procurement work stream increase to £1.5m or 3% per annum.

5.11.7 Outsourcing

The Trust is outsourcing domestics and catering services in order to deliver quality improvements and savings. The timescale for the project envisages a new contractor in the third quarter of 2014/15. A dedicated project team is in place. The Trust will be reviewing areas where external support can be provided with a positive effect. Scope exists to significantly improve the Trust's clinical services to underpin quality and efficiency of support across the hospital which will also allow more effective infrastructure.

5.11.8 Clinical Administration

This project is intended to improve the support we provide to the administration of our clinical activity. Many initiatives have fundamentally changed these processes in recent years, with digital dictation, electronic discharge letters, and most recently electronic document management. This project intends to reengineer and rationalise administration through role redesign. At present the Trust deploys considerable resources **providing back office clinical administration** Work has begun to learn from other Trust's approaches, and begin to design the roles that will best support clinicians in delivering care to our patients.

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

The hospital agreed the Corporate Objectives for 2012 – 2015, and these include the quality objectives for three years. The Trust Governors were engaged with the development and agreement of these objectives at the end of 2011/12.

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 among the various groups of people that have contributed to determining priorities.

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

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

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

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

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;

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 2013 to March 2014
- Papers relating to Quality reported to the board over the period April 2013 to March 2014
- Feedback from the commissioners dated XX/XX/20XX
- Feedback from governors dated XX/XX/20XX
- Feedback from Local Healthwatch organsiations dated XX/XX/20XX
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 06/05/2014;
- The 2013 national patient survey 09/04/2014
- The 2013 national staff survey 24/02/2014
- The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
- CQC quality and risk profiles dated April 2013 to August 2013 and the Intelligent Monitoring Reports October 2013 and March 2014.

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with 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

?? May 2014

.....Date.....Chairman

?? May 2014

.....Date.....Chief Executive

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

7. Comments from stakeholders:

Bedfordshire Healthwatch Response to L&D Hospital Trust's Quality Account 2012/13

healthwatch Luton

Luton and Dunstable Hospital NHS Foundation Trust Quality Account 2012/13

Statement from Luton and Bedfordshire Clinical Commissioning Groups to Luton and Dunstable University Foundation Trust Quality Account 2012 – 2013

Comments from Luton Scrutiny: Health and Social Care Review Group

Central Bedfordshire Council's Social Care, Health and Housing Overview and Scrutiny Committee

Comments received from the Trust Stakeholders

8. Independent Auditor's Assurance Report

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.
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
Elective	Scheduled in advance (Planned)
Epilepsy	Recurrent disorder characterised by seizures.
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.
INOV8	Inov8 is an Air Disinfection (AD) Unit. The AD Unit supplied by Inov8 is a piece of equipment that is part of the L&D Infection Control Prevention procedures. It is a small unit that offers levels of microbiological air disinfection.
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
Patient First	Patient First is a Luton and Dunstable Hospital Initiative that focuses on team and staff behaviour to improve the patient experience
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
Safety Express	Safety Express 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.
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
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. Please see attachment and link:-

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.

Quality Accounts 2013-14 APPENDIX A
Local Clinical Audits

Local Clinical Audits (Projects managed by the Clinical Quality Department)

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
Management of Acute Urinary Retention and Quality of Urethral Catheterisation Documentation Department of Urology N=48 NHSLA 2.6, 2.8 CQC outcome 16 Link to NICE CG97, CG139	Surgery	Audit (Retrospective)	April 2013	**Aims**: • Measure current local practice against national standards in the management of patients presenting with acute urinary retention, including documentation / completion of catheterisation • Identify areas where compliance needs to be improved The main findings were • Poor documentation was observed in terms of patient history, examinations, investigations, management, uretheral catheterisation documentation, post catheter insertion documentation and catheter care documentation. **Recommendations & Action Plan** • A proforma (checklist) will be designed which will be used for all patients who are catheterised across the Trust. The proforma will ensure the following have been undertaken and clearly documented within the patient's notes: o Patient history o Examinations o Investigations o Management o Uretheral catheterisation documentation o Post catheter insertion documentation o Catheter care documentation • A re-audit will be undertaken in 1 year to measure improvements in practice following implementation of the proforma. **Aims, Key Findings, Actions**

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				The overall purpose of the baseline audit is to measure compliance with the standards identified in NICE Clinical Guideline 85. Specifically to: • Identify whether the Luton and Dunstable Hospital Trust are adhering to NICE recommendations • Identify areas requiring improvement • Identify areas of good practice Comprehensive review of glaucoma service evaluating 42 parameters of 21 aspects of service as laid out by NICE CG85, for which high to full compliance is achieved in 53% of circumstances. However, 15 areas have low compliance. **Recommendations & Action Plan** • Improve documentation in notes • Adhere to firm guidance • All new patients to undergo dilated optic nerve assessment
Audit Of Glaucoma Guidelines Department of Ophthalmology N=50 NHSLA 2.1, 2.6, 2.8 CQC outcome 1, 4, 16 Link to NICE CG85	**Surgery**	**Audit (Prospective)**	**April 2013**	**Aim**: The overall purpose of the baseline audit is to measure compliance with the standards identified in NICE Clinical Guideline 85. Specifically to: • Identify whether the Luton and Dunstable Hospital Trust are adhering to NICE recommendations • Identify areas requiring improvement • Identify areas of good practice Comprehensive review of glaucoma service evaluating 42 parameters of 21 aspects of service as laid out by NICE CG85, for which high to full compliance is achieved in 53% of circumstances. However, 15 areas have low compliance. **Recommendations & Action Plan** • Improve documentation in notes • Adhere to firm guidance All new patients to undergo dilated optic nerve assessment

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
Voice and Swallow Outcomes in Patients following Total Laryngectomy Department of Therapies N=29 NHSLA 2.6 Link to NICE CG85	**Directorate of Diagnostics and Therapeutics**	**Audit (Prospective)**	**June 2013**	**Aim:** Audit to collect data regarding the surgical procedure itself and to capture voice and swallow outcomes not only from the SLTs perspective but also from patients themselves. The results of this audit will be used to inform future practice to ensure that we are continually striving to achieve the best possible outcome for patients. • The type of reconstruction was not documented in the surgical notes in 2 cases • It was often difficult to determine from the surgical notes the type of myotomy carried out and there was a wide range of terminology used • 21 (72%) of patients who underwent a total laryngectomy had a primary puncture and of these 18 (86%) had primary placement of a voice prosthesis (valve). In patients who did not undergo a primary puncture there were clear reasons as to why this was not carried out with the exception of 2 patients where there was no reason stated • Of the 8 patients (28%) who did not have a primary puncture, 1 went on to have a secondary puncture Only 17 of the original 29 patients with completed data collections forms went on to have voice and swallow outcome forms completed. The main reason for this was due to the death of the patients or at the point at which the outcome forms should have been completed, it was not deemed appropriate as the patient had been put on a palliative pathway. • Patients‟ rating of their own voices using the VHI showed pleasing results with the mean rating score being 15.88 (40 being the total maximum score) • Patients‟ rating of their swallow using the EAT was extremely positive with the mean rating score being only 7.29 (40 being the total maximum score) • Clinicians rated the patients‟ swallow using the FOIS, which showed that 9 patients (52.9%) were on a total oral diet with no restrictions

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Clinicians rated the patients‟ voice quality using the Sunderland Perceptual SVR Rating Scale. Unfortunately on this outcome measurement form there were several areas where documentation was not fully completed **Recommendations & Action Plan** • Ensure accuracy of data collected on Data Collection Form • Ensure all outcome forms fully completed • Continue audit for further 2 years in order to capture larger number of patients Use results of audit to inform future practice in order to improve outcomes for patients.
EAR, NOSE AND THROAT DEPARTMENT SMOKING FOLLOWING TREATMENT OF HEAD AND NECK CANCER N = 124 Links to CQC Standards: 1, 4, 16 Links to NHSLA Standards: 2.6	ENT	Survey	**July 2013**	**Main aims:** • To identify whether smoking cessation advice is provided to all patients who smoke • To identify whether patients have been offered referral to stop smoking service • To measure the effectiveness of the advice and service **Finding:** • Most of the patients audited (95%) were informed about the risks associated with smoking • Most of the patients audited (79%) were offered advice and help about stopping smoking • 65% of the patients audited were given information about the local stop smoking service • Only 56% of the patients audited were offered a referral to local stop smoking service • Only 31% of the patients, who were offered a referral to local stop smoking service, accepted the referral • 45.5% of patients who accepted referral have stopped smoking • 40% of the patients audited are still smoking

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• 16% of the patients who are still smoking, smoke more than 21 cigarettes a day **Key recommendations:** • Offer smoking cessation advice to all patients • Increase %age of patients awareness of local stop smoking service • Increase %age of patients referred to local stop smoking service Re-audit February 2015

AUDIT OF PERMEATAL TRANSTYMPANIC MYRINGOPLASTY
 	
N= 64
 	
Links to CQC Standards: 1, 4, 16
 	
Links to NHSLA Standards: 2.6
	ENT	Audit	**July 2013**	**Main aims:**
				• To access the outcome of Permeatal Transcanal Myringoplasty with tragal cartilage and perichondrium in terms of:
				  ○ Graft success rate
				  ○ Hearing improvement
				• To analyse post-operative complications and follow up trends
				
				Key Findings:
				2 (4%) patients had marginal membrane perforation
				Size of tympanic membrane perforation was 20 – 39% for 20 (41%) patients
				31 (61%) patients had left sided tympanic membrane perforation
				Tympanic membrane in the other ear was intact in 17 cases
				Otitis media was the underlying cause for 22 patients
				Type of hearing loss was conductive in 23 (45%) patients
				Recurrent ear infection was the most frequent indication for surgery 29 (57%)
				Type 1 Tympanoplasty was carried out in 39 (77%) patients
				7 (14%) patients underwent revision operation
				46 (90%) patients had overnight stay at hospital
				Current operation technique was Microscopic, Permeatal

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				transtympanic and Underlay in 47 (92%) patients Graft material was Tragal Cartillage and Perichondrium in 48 (94%) cases Middle ear mucosa was normal in 45 (88%) cases Condition of ossicles was intact in 32 (64%) cases **Key recommendations:** • Permeatal Transtympanic Myringoplasty technique should be adopted as "Day Case Procedure" not only to cut the cost but to reduce the incidence of hospital acquired infections • Tragal cartilage and perichondrium has proved to be a robust graft material which can be easily harvested • Oto-endoscopes should be routinely used for following reasons: o Superior optical properties Ability to examine ossicles and other middle ear structures non invasively prior to placement of graft o To avoid drilling of bony canal for repairing anteriorly perforations • Discuss the pros and cons of oto-endoscopes in the next audit meeting • A uniform schedule of follow up should be adopted for all cases e.g. 2 weeks, 6 weeks and 3 months post operatively • To pick up complications like infection and partial graft failure at an early stage so that they can be dealt with effectively To reassess day case rates, complication rates, hearing results, use of oto-endoscopes and cosmetic results
COMPLICATIONS FOLLOWING DERMATOLOGICAL SURGERY PATIENT EXPERIENCE SURVEY N = 47 Links to CQC Standards: 1, 4, 16	Dermatology	Patient Survey	**August 2013**	**Main aims:** • To assess whether there has been an improvement in wound infection rates following changes in practice after the baseline audit undertaken during 2009 / 2010 **Key findings include:** • All patients (100%) were given wound-care instructions at

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
Links to NHSLA Standards: 2.6				the time of the procedure and all patients carefully followed these instructions • Thirty four per cent of patients experienced bleeding / pain / problem following the procedure, of which 88% of these experienced bleeding immediately after surgery • Thirteen per cent of patients needed to see their GP but several of these were simply for removal of sutures • Sixty eight per cent of patients felt very satisfied overall with their treatment, 30% felt satisfied, and 2% of patients were dissatisfied with their treatment • There was an improvement in the infection rate from 4% at the last audit to 2% at this audit. This brings us in line with the majority of published data. • A surgical proforma is now routinely used which has improved documentation **Key recommendations:** There was an unacceptably high rate of immediate bleeding (although the time frame for this was not clearly defined). Surgeons are to ensure that all bleeding has stopped before the patient leaves the clinic and document this in the notes. 'Adequate haemostasis achieved' to be added to the surgical proforma
EVALUATION OF DERMATOLOGY RAPID ACCESS CLINIC N = 100 cases Links to CQC Standards: 4, 8, 16 Links to NHSLA Standards: 2.1, 2.6, 5.6	Dermatology	Service Evaluation	**August 2013**	**Main aims:** • To evaluate the numbers of patients o requiring surgery (to help with future structure of the clinic) and o requiring follow up (as these follow ups have to be seen somewhere, and has an impact on other clinics). This will help planning within the department • To ascertain what proportion of excisions turned out to be necessary i.e. show abnormal pathology **Key findings include:**

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• 45 patients required 53 procedures - an average of 5 procedures per clinic. The current model of 10 patients when a registrar is present and 7 cases when not is considered reasonable and the vast majority of cases were able to be completed on the day • Of the 45 cases done, the histological diagnosis exactly agreed with the clinical diagnosis in 32 cases so the procedures were done appropriately • Sixty patients required follow up, many long term for actinic damage or skin cancers. This has an impact on other clinics conducted by the clinicians who do RAC and must be taken into account when planning other clinics **Key recommendations:** • There is no need to change the current model of the RAC at this point in time. There is no evidence that we are undertaking an excessive number of procedures due to mis diagnosis as 32 from 45 cases matched histologically precisely. However, the impact of RAC follow up on other clinics needs to be explored and clinicians doing these clinics should either have a separate follow up clinic in which these patients can be booked OR, the number of new patients seen in other clinics must be reduced accordingly in order to accommodate follow up patients from RAC. This needs to be discussed at departmental level.
DIABETES ACUTE ADMISSIONS ROOT CAUSE ANALYIS AUDIT N = 36	**Medicine**	**Audit**	**August 2013**	**Main aims:** • The aim of the audit is to investigate the circumstances of adult acute admissions to hospital with a primary diagnosis of diabetes in Bedfordshire; establish the pre-admission diabetes care and support mechanisms; and to establish whether acute admissions could have been preventable by ICDS or specialist team intervention. **Key findings:** • The majority of patients (61%) had Type 2 diabetes • Current treatment varied with 12% receiving no treatment;

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				27% of patients were receiving insulin alone; 21% of patients were receiving tablets alone; and 30% were receiving tablets plus insulin • In 42% of cases the patients were not receiving regular follow-ups • Forty six percent of patients were under the care of a specialist diabetes team (L&D, ICDS, other units or joint care with GP), but 43% were not under any diabetes care at all • In 42% of cases (14 patients), the patient had previously been admitted with a primary diagnosis of diabetes. Many of these patients had complex medical conditions which contributed to instability of their diabetes • In 14% (4 cases) it was felt the admission could have been avoided: • In 38% of cases it was felt the admission could not have been avoided; and in the remaining 48% it was uncertain whether the admission could • have been avoided • Although not included in audit data collection, several patients audited were residents at care homes **Key recommendations:** • Audit findings demonstrated only 14% of acute diabetes admission were possibly avoidable; half of these were due to patient factors. The remaining were due to lack of / delay in primary care intervention/referral. This confirms the specialist teams' opinion that Integrated Community Diabetes Service (ICDS) is unlikely to have a major impact on reduction of acute diabetes admission • Reduction in acute diabetes admission should not be included as a key performance indicator for ICDS. • ICDS will continue to support primary care in patient management, patient education and empowerment, and up-skilling of primary care and community diabetes service provider including staff at care homes

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				Hospital diabetes team after assessing admitted patients, can refe 'hard to reach' to ICDS for better post-discharge support, which m risk of future re-admission. This may indirectly reduce acute diabe in the long term and thus reduce acute diabetes admissions.
END OF LIFE CARE (PART B) N = 24 Cases	**Corporate**	**Audit**	**August 2013**	**Main aims:**: • To measure standards of End of Life Care at the Luton & Dunstable Hospital • To assess care delivered to palliative patients who have died in hospital **Key findings:** • In 67% of cases, the LCP was deemed appropriate during admission • In all cases (100%), an up to date DNACPR was in place • Only 4% of cases had a Preferred Priorities of Care document or other Advance Statement • Ninety six percent of cases contained evidence that medications were reviewed within 48 hours of death • There was poor compliance with evidence of providing family's with information regarding details of hospital facilities • In 92% of cases, there was evidence that the care plan (including LCP) was reviewed every 3 days • Only 29% of cases included evidence the GP / Primary Care were informed of the death • Thirty eight percent of cases included evidence the 'What to do After a Death' leaflet was given to relatives • Only 4% of cases included evidence the 'When Someone Dies' leaflet was given to relatives **Key recommendations:** • Recent events have increased staff awareness of good EOLC and there is a need to guide and train recommended personalised care pathway • Repeat this audit on an annual basis and amend the next audit to reflect recommendations of the More Care, Less

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				Pathway Review of the Liverpool Care Pathway recently published • Participate in the National Care of the Dying Audit • Review the process and documentation of how GP's are notified of a patient's death • Create a system to ensure Ward staff inform the patient's GP and the 4 Out of Hours Services (Care UK, OOH Community Nurses, Keech Hospice and East of England Ambulance) of the patient's death • Include the following information leaflets on the hospital intranet for staff to access: o Visitors' information leaflet plus map of hospital layout o Coping with Dying' leaflet o What to do After a Death' leaflet o ' When Someone Dies' leaflet Ensure all wards have electronic copies of leaflets, where possible, which can be easily printed in ward areas
BABY RECORD/ADMISSION SHEET N = 40 Links to CQC Standards: 4, 16, 21 Links to NHSLA Standards: 1.8, 2.6 Links to CNST Standards: 5.3, 5.9	**NICU**	**Re-audit**	**August 2013**	**Main aims:** • Re-measure compliance with completeness and accuracy of the baby record/admission sheet • Identify improvements following the previous audit **Key findings:** Audit identified improvement in certain areas however poor compliance was noted in the following areas: **NICU** Documentation of baby's NHS number, birth weight, head circumference, providing Vitamin K and documentation of any obvious dysmorphism/anomalies, obstetrician, mother's occupation, booking hospital, smoking status, alcohol status, drug status, documentation of post natal examination, anal patency on visualisation, genitalia normal/abnormal, father's name, ethnicity, occupation, cause of concern, completion of antenatal paediatric referral, family history details, LMP, haemoglobinopathy, amniocentesis/CVS, pregnancy

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				complications, drugs in pregnancy, documentation of antenatal steroids, name of antenatal steroids given, number of doses given, date and time last dose was given, labour details apart from delivery date and time, resuscitation details i.e. Meconium below cords, ventilation by ETT, age at time of intubation, cardiac compression, drugs time/dose/route, age at 1st gasp, age at regular resp, colour, tone, breathing and heart rate **Post Natal Ward** Documentation of baby's name, date of birth, hospital number, and NHS number, mother's religion, occupation, alcohol, smoking and drug status, reason if vitamin K was not given and informing neonatologist, dysmorphism/anomalies, family history, congenital hip dislocation and deafness, LMP, haemoglobinopathy, pregnancy complications, antenatal steroids, CTG, Meconium, Placental abnormality, resuscitation details, age at 1st gasp, age at regular resp, staff present at delivery or resuscitation **Key recommendations:** To Continue to promote awareness and teaching to highlight importance of accurate documentation within Baby Record/Admission sheets. The importance of completing baby records accurately will be raised at the induction of Junior Doctors.
SUPERVISORS OF MIDWIVES STAFF SURVEY 2013	**Obstetrics & Gynaecology**	**Staff Survey**	**August 2013**	**Main aims:** • To measure if the supervisors of midwives are providing an environment that empowers midwives to provide high quality, woman focused midwifery care. • To review the accessibility and visible presence meets the needs of midwives • To identify if the continuing professional development needs

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				of midwives are being met through statutory supervision of midwives • To compare results with the previous staff survey from 2010 findings **Key Findings:** • The survey response rate was 48% • All midwives reported they had 24 hour access to a supervisor of midwives (SOM) • Ninety six percent of midwives responded that SOMs were always available to discuss midwifery practice issues and provide appropriate support • Ninety seven percent of midwives identified that SOMs kept them up to date with new policies and guidelines • Forty nine percent of the midwives stated that they did not receive feedback from SOMs about audit findings • Twenty percent of midwives stated they would like better access to equipment for clinical skills training **Key recommendations:** • All SOM to continue to encourage completion of the forms. All SoM to take responsibility for collecting the completed surveys and forwarding to the project leads • As well as the continued discussion of audits to be undertaken at annual reviews. SOMs encouragement, that midwives attend local clinical governance and risk management /audit meetings. SoMs to develop new ways to feedback audit findings to midwives • Statutory Supervision to be promoted for all midwives ensuring they know how to access information pertinent to supervision • Midwives to have better access to equipment for skills training • Review survey questions prior to next audit
RE-AUDIT OF CHRONIC OBSRUCTIVE	**Respirator**	**Re-Audit**	**August**	**Main aims:**

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
PULMONARY DISEASE N=40 NICE CG 101, QUALITY STANDARD, GLOBAL STRATEGY	**y Medicine**		**2013**	To improve the management of patients presenting to hospital as an emergency with suspected exacerbation of COPD. Specifically, to re-measure compliance with national and local standards of care. **Key Findings:** • A large number of patients (67%) were initially admitted to an Emergency Admissions Unit bed. The majority were admitted under the care of a General Medical team • Current smoking status was not confirmed / checked for 5% of patients admitted • Seventy four per cent of all admissions had arterial blood gases taken at admission • Oxygen formed part of the management plan for 69% of patients. However, the use of oxygen was only appropriately recorded on prescription charts for 67% of these cases • No patients required ventilatory support during their admission. • Twenty two per cent of patients required discharge with home oxygen • Length of stay ranged between 0 – 14 days (mean LoS of 4 days / median of 3 days). Two patients died during the admission period. • Re-admission within 30 days of discharge was noted in 11% of the cases with half re-admitted due to COPD related causes **Key recommendations:** Present findings at a Grand Round to highlight areas that require improvement Consolidate education by creating a poster for distribution in EAU to include: o MRC dyspnoea scale o Smoking status and history

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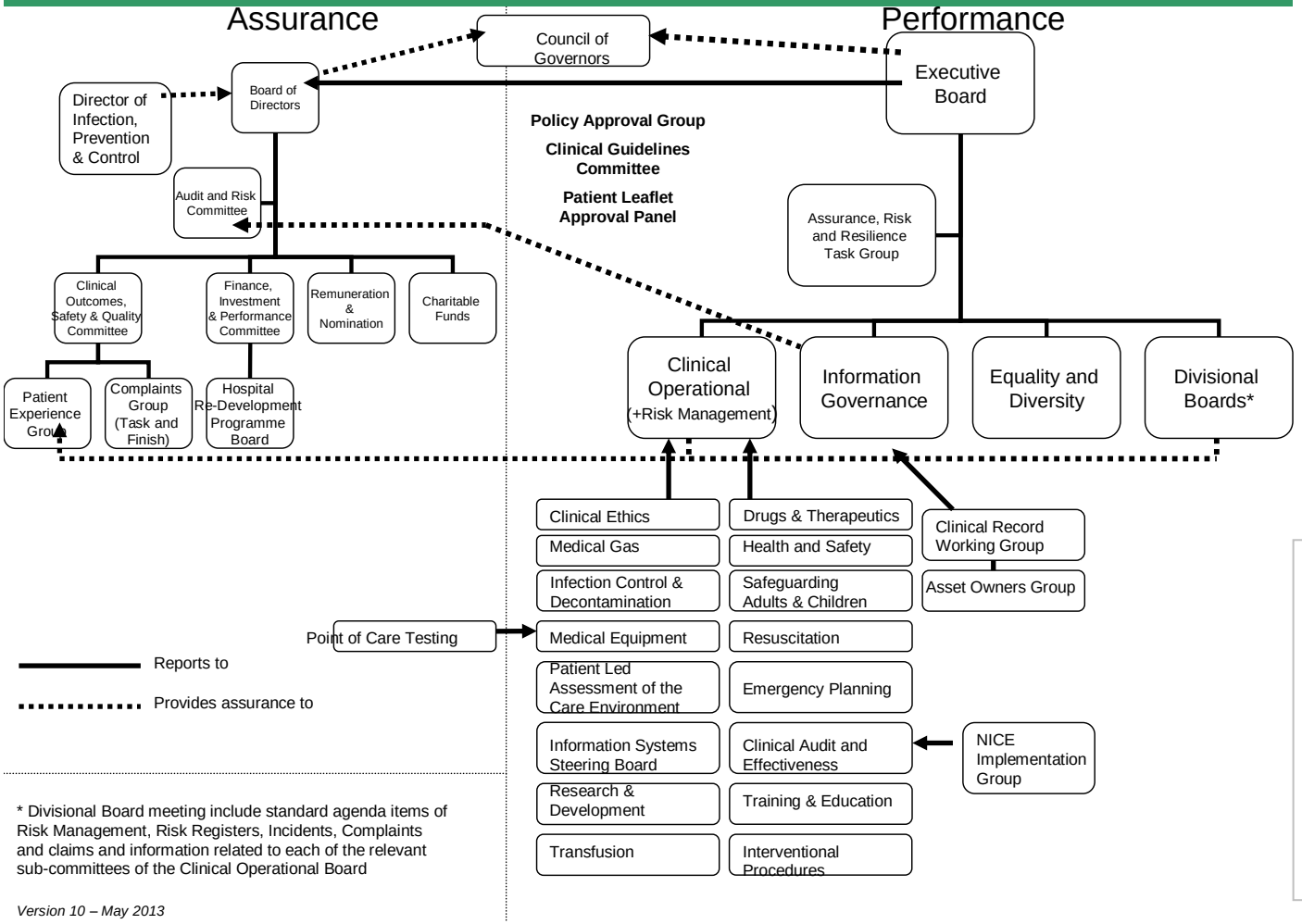
				○ Assessment of anxiety and depression to encourage appropriate referral to the Clinical Psychology specialist ○ Accurate oxygen prescribing ○ Accurate documentation of Oxygen use during ABG sampling • Continue to promote the Early Supported Discharge scheme • Undertake a snap-shot re-audit by Autumn 2014
AUDIT ON USE AND USEFULNESS OF AMBULATORY 24 HOUR ECG MONITORING FACILITIES N=97 Links to CQC Standards: 3, 11, 16 Links to NHSLA Standards: 2.1, 2.6, 2.8 Links to NICE: CG 109	**DME**	**Audit**	**September 2013**	**Main aims:** To measure current practice in the use of 24 hour ECG monitoring To measure the impact of 24 ECG monitoring in the management of patients To compare current practice with NICE CG 109 (Transient loss of consciousness in adults and young people) **Key Findings:** 39 (41%) patients referred for 24 hour tape had Stroke and TIA indications Result of standard 12 lead ECG was normal in 55 (57%) cases 9 (51%) of the requests for 24 hour tape were inpatient Delay in carrying out 24 hour tape was less than one week in 45 (46%) cases Results of 24 hour tape were found as normal in 65 (67%) cases Symptoms were found in 9 (9%) cases during 24 hour tape In 4 (44%) cases, symptoms were correlated and intervention was offered in 3/4 cases **Key recommendations:** • The referring team should take a measured approach ○ A discussion between juniors and seniors as to why a 24 hour tape is being requested ○ Education from the department about the yield of results from the 24 hour tape • Request form should be more through

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				• Discussion with cardiology team regarding new online request form • Increase the awareness of cardiac pacing meeting Education and information to departmental staff and Junior doctors
MANAGEMENT OF CHILDREN WITH NEWLY DIAGNOSED TYPE 1 DIABETES N=36 Links to CQC Standards: 1, 4, 16 Links to NHSLA Standards: 2.1, 2.6, 2.8 Links to NICE: CG15	**Paediatrics**	**Audit**	**December 2013**	**Main aims:** • To identify and measure compliance levels within the Paediatric diabetes service against NICE CG15 and best practice paediatric diabetes criteria • To identify specific areas for improving patient outcomes **Key Findings:** • Of the 35 parameters 17 are green (>80%), 10 are red (<50%) and 8 are amber (50% - 80%) Areas which performed well are: • Patient seen on the same day of referral, seen by a member of Diabetes MDT by next working day • Those in DKA managed according to DKA guideline • All patients registered on Diamond database • Screening for Thyroid and celiac disease • Provided structured education including recognition and management of Hypoglycaemia Areas that need to be improved are: • Documented evidence about providing education about cause and management of diabetes, partial remission, target HbA1c etc. education for nursing, junior doctors • Emotional support and access to mental health professional • Providing information about sport, exercise, local and national resources and support **Key recommendations:** • Diabetes information booklet to be provided to all newly

Title/Topic	Directorate/ Specialty	Project Type	Completed	Aims, Key Findings, Actions
				diagnosed with diabetes • All newly diagnosed patients to be seen by • clinical psychologist within 3 months of diagnosis • Structured education with check list to cover each aspect of diabetes education within 6 weeks

Committees of the Board of Directors

Luton and Dunstable Hospital Governance and Committee Structure



Note: A Number of tasks and finish groups report to formal committees and are not represented on this diagram.